- Business Services Organisation
- Belfast Health and Social Care Trust
- Northern Health and Social Care Trust
- Southern Health and Social Care Trust
- South Eastern Health and Social Care Trust
- Western Health and Social Care Trust
- Northern Ireland Ambulance Service
- Regulation & Quality Improvement Authority
- Other ALBs/Special Agencies (SA)
    - Northern Ireland Blood Transfusion Service
    - Patient Client Council
    - Northern Ireland Medical and Dental Training Agency
    - Northern Ireland Practice and Education Council
    - Northern Ireland Guardian Ad Litem Agency (NIGALA)
    - Northern Ireland Social Care Council (NISCC)

4.0 Management Arrangements for SQAs

To ensure that learning is shared in a prompt, targeted and effective way, the HSCB and PHA have two key groups:

- The Quality, Safety and Experience Group;
- The Safety and Quality Alerts (SQA) Team.

4.1 Role of HSCB/PHA Quality, Safety and Experience Group

The QSE group co-ordinates and supports the activities related to safety, effectiveness and patient client focus within the HSCB and PHA. Membership and Terms of Reference are detailed at Appendix 2.

A key function of this group is to promote and share learning a component of which is the identification of learning and approval of SQAs.

The group meet monthly and is chaired by the PHA Executive Director of Nursing, Midwifery and Allied Health Professionals or nominated deputy.

An Assistant Governance manager will oversee the process, maintain an up-to-date log, prepare for and support QSE Team meetings.

4.2 Role of HSCB/PHA Safety Quality Alerts Team

The Safety Quality Alerts Team (SQAT) is responsible for the dissemination, implementation and assurance of all Category 1 SQAs and some Category 2 SQAs (as required)

The SQA Team Terms of reference and membership are detailed at Appendix 3 with membership including HSCB and PHA representatives from professional groups, and Corporate Services.

The SQA Team is chaired, by the Medical Director/Director of Public Health (DPH) or nominated deputy.

To ensure timely co-ordination and implementation of regional safety and quality alerts, the Team will meet every 2 weeks. HSCB/PHA has arrangements in place to ensure that any immediate issues that need to be addressed are processed immediately.

An Assistant Governance manager will oversee the process, maintain an up-to-date log, prepare for and support SQA Team meetings.

4.3 Role of the HSCB Alerts Office

All SQAs will be logged by the Alerts office which is managed by the Governance Team within HSCB Corporate Services.

All correspondence in relation to alerts will be channelled through the HSCB Alerts mailbox at Alerts.HSCB@hscni.net. The Alerts Office will maintain a system to track progress on implementation.

4.4 Learning Notifications – The Process

Trusts and ALBs can advise the HSCB/PHA of potential regional learning via established processes as detailed in Appendix 1 or through the completion and submission of a Learning Notification (Appendix 4 – Learning Notification Template).

In completing the Learning Notification Template organisations should consider the Trigger Tool at Appendix 5.

It is important to note that it's the responsibility of Trusts / ALBs / Special Agencies as individual organisations to undertake their own risk assessments of the issue and to take steps to mitigate the risk within their own organisation and in advance of any further regional advice, guidance or solution i.e. do not delay acting to assess and mitigate risk until a regionally agreed solution is in place.

Completed templates should be forwarded to Alerts.HSCB@hscni.net.

The Notifications will be added to the SQAT database as a category 1 alert, circulated to SQAT members and automatically listed for the next SQAT fortnightly meeting.

SQAT will also consider the following in conjunction with the trigger tool referred to in appendix 6:

- regional learning and the timeliness of this learning
- the most effective method of regional learning
- are assurances required
- is it already being considered as part of another process e.g. SAI, Complaint etc.

Where an organisation has indicated a Learning Notification requires immediate action, the Alerts office will seek confirmation from the Chair of SQAT or their nominated deputy if an immediate SQA is to be issued. If a decision is made not to issue an immediate SQA, feedback will be provided to the referring organisation.

If the Learning Notification has been determined as requiring an immediate SQA, the Chair of SQAT will assign a lead officer to develop the SQA for issue, in liaison with the Assistant Governance Manager and Chair of QSE or their nominated deputy.

The target for issuing an immediate SQA is 3 working days.

Each Trust / ALB / Special Agency is required to identify a first point of contact for queries regarding SQAs (Appendix 7 – Trust Contact points).

Appendix 8 illustrates the process used to submit learning to the HSCB/PHA

4.5 Alerts Relating to Independent Sector Providers and Primary Care Providers

Independent / primary care providers are required to respond to many types of Alerts covered by this procedure. The DoH or HSCB/PHA will send Alerts that they issue to RQIA for dissemination to relevant independent providers and to the HSCB Directorate of Integrated Care for dissemination to relevant primary care providers.

RQIA can also alert the HSCB/PHA of any regional learning they may identify in the discharge of their functions which would support improvement in the health and social care service, via a Learning Notification.

The HSCB Directorate of Integrated Care will alert the HSCB/PHA of any regional learning via the internal safety and quality structures within the HSCB/PHA.

4.6 Interface with other Safety/Quality-related organisations (not ALBs)

To ensure coordinated action across the wider system, the HSCB/PHA SQA Team will also seek input from the range of organisations and bodies that contribute to safety and quality of health and social care (Appendix 9), as required.

4.7 Process for Sharing Regional Learning from Northern Ireland with England, Wales, Scotland and Ireland

A process for sharing regional learning from Northern Ireland has been put in place whereby points of contact (named individuals) have been identified for England, Wales, Scotland and Ireland in the event of learning needing shared more widely. Arrangements have been established with NHS Improvement to allow participation in an observatory capacity on the monthly National Patient Safety Response Advisory Panel.

5.0 Process

5.1 Process prior to dissemination of SQAs

The Department of Health (DoH) issues a variety of correspondence collectively referred to as Safety Alerts. These are issued to service providers to identify those actions which providers should undertake to

assure patient and client safety and best practice. The following describes the process prior to finalisation and dissemination of SQAs.

The DoH, HSCB and PHA share certain SQAs between their respective organisations for comment prior to dissemination to the HSC. These include:

- All Patient Safety Alerts (PSAs) issued by DoH;
- Learning Letters issued by PHA/HSCB.

For SQAs developed by the DoH these will be sent to the HSCB Alerts mailbox at Alerts.HSCB@hscni.net for issue to relevant health and social care professionals within HSCB and PHA, to seek comment prior to issue by the DoH to the HSC.

For SQAs developed by the PHA / HSCB these will be sent to the DoH Safety, Quality and Standards mailbox at qualityandsafety@health-ni.gov.uk for issue to relevant Policy Leads for review to ensure compatibility with DoH policy prior to issue by the HSCB/PHA.

At this stage the level of assurance may be also considered as outlined in section 5.3.

This approach is intended to ensure that the actions required of organisations are clear through a single communication.

5.2 Dissemination of SQAs

5.2.1 Dissemination of SQAs issued by DoH

SQAs from the DoH will be issued to the Chief Executive's office of relevant organisations, and copied to the HSCB/PHA Alerts mailbox at Alerts.HSCB@hscni.net, the first point of contact in Trusts for

alerts, Governance Leads in Trusts and other relevant Directors of Trusts / ALBs / SAs.

5.2.2 Dissemination of Learning Letters/Reminder of Good Practice Letters issued by PHA/HSCB

When regional learning is identified a learning letter / reminder of good practice letter may be issued to the appropriate organisations for wider circulation, application of learning and where identified assurance that learning has been embedded.

These SQAs will be disseminated via the HSCB Alerts Office to the Chief Executive's office of relevant organisations, the first point of contact in Trusts for alerts, Governance Leads in Trusts and other and other relevant Directors of Trusts / ALBs / SAs using the standard distribution list. (see Appendix 10)

5.3 Process for Determining Assurances

Category 1 Alerts will be reviewed by the Safety Quality Alerts Team to make an initial determination on:

- Whether or not regional action is required to assist Trusts or primary care with implementation, and
- The nature of the assurance required regarding implementation.

If regional action is required, the proposed actions may be discussed where necessary with Trusts and/other relevant organisations to agree the precise task.

It is important to note that any regional actions do not in any way negate the responsibilities of Trusts or other organisations to take necessary actions to implement the Alert locally; immediate necessary action should not be delayed. However, it is recognised that some aspects of

implementation may be more efficient, and may ensure a better outcome for patients, clients, staff and the public if they are developed in a standard way across the region.

To take forward work for the region, the principle of using existing systems as much as possible, will apply. However, if necessary, a Task and Finish Group may be established, including all relevant professionals and managers from relevant providers, and as appropriate, service users and/or the public.

Category 2 Alerts will be implemented primarily through existing systems. If on occasion explicit assurance or other action is required, it will be identified by the Safety Quality Alerts Team and described to Trusts and primary care providers as outlined for Category 1 Alerts.

Appendix 11 provides an overview of the HSCB/PHA Process for the Management of Safety and Quality Alerts.

5.3.1 Criteria for Identifying Regional Action and Assurance Levels

The PHA/HSCB SQA Team will determine the detail of the method of assuring implementation of an Alert. This will be proportionate to the assessed level of risk associated with the issue covered by the Alert. It will work on the principle of using existing systems of assurance as much as possible. Options for assurance methods include:

- Level 1 – material risks which cannot be managed within normal Trust clinical and social care governance arrangements;
- Level 2 – explicit assurance by Trusts, and where appropriate, other organisations, that key actions have been implemented; the key actions may be specified by the HSCB/PHA;
- Level 3 – completion of an audit specified by HSCB/PHA.

The following criteria will be used to assess whether or not regional action is required to assist implementation, and to determine the level of assurance required:

- The risk to an individual patient, client, staff member or member of the public, is high (impact);
- The number of patients, clients, staff or public who may be exposed to the risk is high (likelihood);
- Aspects of implementation are complex and outside the control of Trusts or relevant organisations (complexity);
- A regional approach is achievable (deliverability & stakeholder agreement);
- Regional action will not introduce undue delay (timeliness);
- The Alert relates to an issue with a high public/political profile (public confidence);
- Other reasons (professional judgment).

In making its decisions, the HSCB/PHA SQA Team will take account of:

- Other Alerts relating to the service area in question;
- Common themes within a range of Alerts;
- Learning from Serious Adverse Incidents and Complaints;
- Existing safety and quality initiatives in health and social care.
- Audits

5.3.2 Informing of Regional Action/Assurances Required

On completion of the processes outlined above, if regional action or assurance is required, the Chair of the Safety Quality Alerts Team will inform Trusts, primary care, and other relevant providers or stakeholders of the next steps or requirements. Communication will be to the Trust Chief Executive's office, copied to the nominated Trust Governance Lead.

5.3.3 Reviewing Compliance of SQAs

The Safety and Quality Alert Team will consider responses to SQAs and 'close' the Alert when it is assured that actions have been implemented, or there is an existing robust system in place to ensure implementation.

In addition bi-annual progress reports to Governance Committee will be prepared by the SQA Team for the following:

- Regulation and Quality Improvement Authority (RQIA) Reports and other independent reviews;
- National Confidential Enquiry into Patient Outcome and Death (NCEPOD) reports, Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK) reports and equivalent robust other national enquiries/audits;

These reports will detail the progress on implementation of report recommendations and provide the necessary appropriate assurance mechanism that all HSCB/PHA actions contained within reports are implemented.

6.0 Annual Reporting of SQAs

An annual report will also be prepared for the HSCB/PHA SQA Team, HSCB Senior Management Team, Local Commissioning Group (LCG) Chairs, HSCB Governance Committee, HSCB Board, DoH, Trusts and others as required.

7.0 Review of this procedure

This procedure will be refined on an on-going basis and not less than annually.

Appendix 1

Overview of established processes for identification of Regional Learning

National Patient Safety Alerts and other guidance

DoH Alerts

- SQS Guidance
- Letters/circulars inc RQIA Reports, NCEPOD & other confidential enquiries
- PSAs
- MHRA Notices
- SAB Notifications

(Received by HSCB Alerts Office & Co-ordinated via SQAT)

- NICE Guidance

HSCB/PHA (NICE Coordinating process via Commissioning Directorate)

(Safety/Quality Issues Flagged)

ALB identifies potential regional learning via one of the following regional reporting arrangements

- HSCB/PHA Regional Procedure for Safety & Quality Alerts
- HSCB Policy for the Management of Complaints
- HSCB Procedure for the Reporting and Follow-Up of SAIs
- PHA Post Falls Review Process
- HSCB Protocol for the reporting and follow up of Early Alerts
- Child Death Notification Process

Potential regional learning referred onto QSE for consideration

HSCB/PHA Quality Safety Experience Group

- Approve regional learning
- Agree method of dissemination

HSCB/PHA Safety Quality Alert (SQA)

*The **SQA Team** will take forward the co-ordination, dissemination and follow up of assurances where required*

Other form of Regional Learning to be taken forward
(i.e. via Regional Newsletter/Event etc.)

Links to relevant procedures that link into the HSCB/PHA Regional Procedure for SQAs

Please click on the links below to access other relevant procedures/policies:

Procedure For the reporting and Follow Up of SAIs 2016

HSCB-PHA Protocol for the reporting and follow up of Early Alerts 2017

Falls Shared Learning Template

HSCB Policy for the Management of Complaints

Complaints in HSC - Standards and Guidelines for Resolution and Learning

DoH circular HSS(MD) 01 2016 - Process for Reporting Child Deaths

DoH circular - HSS(MD) 04 2017 - Process for Reporting Child Deaths

Appendix 2

HEALTH AND SOCIAL CARE BOARD/PUBLIC HEALTH AGENCY

TERMS OF REFERENCE

QUALITY SAFETY AND EXPERIENCE GROUP (QSE)

1.0 Introduction

The Health and Social Care Board (HSCB) and the Public Health Agency (PHA) receive information and intelligence from a wide range of sources in relation to safety, quality and patient experience of services commissioned.

The purpose of the Quality, Safety and Experience Group is to identify themes, patterns and areas of concern emerging from all existing sources; and agree the actions to be taken to address these in order to improve the safety and quality of services commissioned. A diagrammatic overview of the Quality, Safety Experience Internal co-ordination arrangements for the PHA/HSCB is attached in annex 1.

2.0 Objectives of the QSE Group

2.1 To streamline and further enhance current arrangements in relation to Safety, Quality and Patient Experience;

2.2 To consider learning, patterns, themes or areas of concern from all sources of information and to agree appropriate actions to be taken, and follow up of agreed actions;

2.3 To provide an assurance to the Senior Management Team of the HSCB, the Agency Management Team of the PHA and the Governance Committees and Boards of both organisations that the QSE Group has an overview of all sources of information in relation to the safety, quality and patient experience of services and is co-ordinating appropriate action in response.

3.0 Working Arrangements between Existing Groups/Information Flow to QSE

3.1 The Regional Serious Adverse Incident Review Group (SAI) and the Regional Complaints Group (RCG) will be reconstituted as a Serious Adverse Incident Sub Group and a Regional Complaints Sub Group of the QSE Group.

3.2 The Complaints and SAI Sub Groups, which will be multi-disciplinary groups, will meet on a monthly basis, prior to each QSE group, to consider in detail issues emerging from SAIs and complaints and agree issues which require to be referred to the QSE, together with a recommendation for consideration.

3.3 Other existing groups relating to the Patient Experience, Medicines Management, SQAT, Safeguarding Board and Case Management Reviews and Quality 2020 will refer matters on an agreed basis to the QSE Group with an appropriate recommendation for consideration.

4.0 Membership of the QSE

Joint Chairs: **Director of Nursing, Midwifery and Allied Health Professionals;**

Director of Public Health/Medical Director;

Director of Performance and Corporate Services;

Director of Social Care;

Assistant Director of Social Care (Safety and Quality Lead);

Representative for General Medical Services/Safety and Quality;

Head of Pharmacy and Medicines Management;

Assistant Director of Public Health Medicine (Safety and Quality)

Clinical Director, Safety Forum;

Governance Manager;

Head of Nursing, Quality and Patient Safety;

Safety, Quality and Patient Experience Nurse, PHA;

Pharmacy Lead – Medicines Governance and Public Health;

Complaints/Litigation Manager;

Head of Dental Services (co-opt as required);

Head of Optometry (co-opt as required);

Assistant Director of Allied Health Professionals (co-opt as required);

In Attendance:

Deputy Complaints Manager

Assistant Governance Manager

Senior Nurse (Safety, Quality and Patient Experience)

5.0 Frequency of Meetings

Meetings of the Group will be monthly

6.0 Administrative Support to the QSE Group

6.1 The Action log shall be taken by the Director of Nursing Midwifery and Allied Health Professionals (or her nominated deputy).

6.2 The agenda and papers will be developed and circulated by Corporate Services staff.

6.3 Agreed actions will be followed up by Corporate Services staff.

6.4 Agenda items and papers should be forwarded to [redacted]

7.0 Review of Terms of Reference

These Terms of Reference will be reviewed in 12 months.

Appendix 3

HEALTH AND SOCIAL CARE BOARD/PUBLIC HEALTH AGENCY

TERMS OF REFERENCE

SAFETY AND QUALITY ALERTS TEAM (SQAT)

1.0 Introduction

The Health and Social Care Board (HSCB) and Public Health Agency (PHA) are responsible for the co-ordination and implementation of regional safety and quality alerts (SQAs), letters and guidance issued by the Department of Health (DoH), HSCB, PHA, Regulation and Quality Improvement Authority (RQIA) and other organisations.

The Safety and Quality Alerts Team (SQAT) was formed in April 2012 to co-ordinate the implementation of regional safety and quality alerts, letters and guidance. A subsequent procedure which outlines the management of the process was established and endorsed by the DoH in July 2013 and is reviewed on an annual basis.

4.0 Accountability of the Group

The SQA Team shall report to the HSCB/PHA Quality and Safety Experience Group (QSE).

5.0 Objectives of the SQA Team

The SQA Team provides a mechanism for gaining regional assurance that alerts and guidance have been implemented or that there is an existing robust system in place to ensure implementation. The Team 'closes' an Alert when it is assured that an Alert has been implemented, or there is an existing robust system in place to ensure implementation.

6.0 Membership of the Group

Core membership of the SQA Team will consist of the following officers, or their nominated representative, from the HSCB and the PHA:

- Medical Director/DPH, PHA (Chair)
- Director of Performance and Corporate Services
- Assistant Director Service Development & Screening
- Pharmacy Lead – Medicines Governance and Public Heath, HSCB
- Consultant in Public Health, PHA
- Safety, Quality and Patient Experience Nurse, PHA
- Assistant Governance Manager, Safety and Quality, HSCB
- GP Input via Assistant Director of Integrated Care, Head of GMS, HSCB when required

- Social Care and AHP input for Alerts relevant to those professions

7.0 Quorum

The SQA Team shall be quorate by the attendance of three members of the group; usually including representation of two professional areas. Where meetings proceed without relevant professionals present this can be endorsed at the next meeting.

8.0 Administration

- The Action log shall be taken by the Chair of the group (or nominated deputy)
- The agenda and papers will be developed by the Assistant Governance Manager and circulated by the PA to the Chair.
- The Assistant Governance Manager will oversee the process, maintain an up-to-date log, prepare for and support team meetings, and prepare an annual report. They will be supported by the Governance Support Manager and a Governance Support Officer.

7.0 Relationship/Links with Other Groups

There are a range of other quality and safety groups across the HSCB/PHA where learning and best practice can be identified and shared. To ensure continuity of learning the SQA Team will work in conjunction with various groups which include the following list of groups which is not definitive:

- HSCB / PHA Regional SAI Review Sub Group
- HSCB / PHA Regional Complaints Sub Group
- Patient and Client Experience Steering Group
- Promoting Good Nutrition Implementation Steering Group
- Regional Falls Prevention for Acute Services Group
- Regional Pressure Ulcer Prevention Advisory Group
- Regional Project Steering Group Evidencing Care through key nursing performance indicators
- Medicines Governance Advisors Groups
- Regional Child Protection Committee (RCPC)
- Regional Governance Officers Group
- HSC Safety Forum Strategic Partnership Group
- Northern Ireland Quality Network
- Regional Emergency Service Collaborative Group
- Safeguarding Board
- Medicines Safety Sub-Group (MSSG)

- PHA/HSCB SAI Professional Groups

8.0 Frequency of Meetings

Meetings of the Team will be fortnightly.

9.0 Review of Terms of Reference

The SQA Team will review its Terms of Reference on a biennial basis or earlier as required.

Appendix 4

LEARNING NOTIFICATION TEMPLATE

Subject / Learning	*Self- explanatory*			
Organisation / Trust	*Self- explanatory*			
Organisation / Trust ref no.	*Self- explanatory*			
Service Area / Speciality	*Self- explanatory*			
Contact Person	*Self- explanatory*			
Please indicate if the propsoed Regional Learning is considerded Immediate ***select as appropriate (✓)***	Yes		No	

SUMMARY OF EVENT

Guidance Notes:

Provide a ***brief factual description*** *of what has happened and a summary of the facts leading up to the event.*

Where relevant include D.O.B, Gender and Age. ***All should be anonymised*** *– the names of any practitioners or staff involved must* ***not*** *be included. Staff should only be referred to by job title.*

LOCAL ACTION TAKEN BY REPORTING ORGANISATION

Guidance Notes:

Based on the understanding of why the event happened and the identification of learning, outline the action(s), agreed and implemented locally within your organisation. This should include immediate and ongoing action.

REGIONAL LEARNING POINTS FOR CONSIDERATION BY HSCB/PHA

Guidance Notes:
Please list learning points you feel should be considered by the HSCB/PHA to share regionally indicating the programmes of care where the learning is applicable.

Please refer to appendix 5 - 'Trigger tool for submission of a Learning Notification Template' to determine if regional learning should be issued i.e. is one or more of the following criteria met:

No.	Criteria ***select as appropriate (✓)***	Yes	No
1	New or under-recognised Risk identified.		
2	Action is outside the remit of the reporting organisation		
3	Likelihood of this happening again and the potential for harm has been identified;		
4	There is a requirement for more robust barriers to be developed for regional implementation;		
5	Relevant to a specialist service		

LEARNING SOURCE			
Please identify the source of this proposed regional learning and any other relevant information as appropriate (✓)			
Example of good practice		Audit or other review	
Adverse Incident (AI)		Coroner's inquest	
Mortality and Morbidity (M&MR)		Litigation Claim	
Patient Client Experience (PCE)		Incident trends	
Other (please specify below)			
Additional Information:			

SUGGESTED METHOD OF REGIONAL LEARNING			
If your organsiation has a suggested method for dissemination of the propsoed regional learning please select as appropriate and include narrative (✓)			
Rapid / Immediate Alert		Learning Letter ***(new learning where there is no existing guidance or policy)***	
Reminder of Best Practice Guidance Letter ***(where there already is regional guidance or policy in place)***		Professional Letter	
Regional Newsletter Article i.e. Learning Matters / GMS / Med Safe Newsletter etc.		Existing Work stream or Network	
Propose Thematic Review		Establish a task and finish group	
Refer to other regulatory body		Training Event/ Workshop / Seminar	
ECHO videoconference session		Other	
Additional Information:			

Approved by:	*This must be approved by the designated point of contact within your organisation for quality and safety communication.*
Designation:	*Self- explanatory*
Date approved:	*Self- explanatory*

Please note it remains the responsibility of your organisation to have undertaken your own risk assessment of the issue and steps to mitigate the risk in advance of any further regional advice.

On completion please submit to Alerts.HSCB@hscni.net

Appendix 5

TRIGGER TOOL FOR SUBMISSION OF A LEARNING NOTIFICATION TEMPLATE

This is an aide to Provider organisations when considering the submission of a Learning Notification.

The action we take as a result of what we learn from incidents/events is vital in protecting patients/clients across the HSC from harm and ensures we continue to improve the health and social care service.

To identify if a Learning Notification Template should be submitted to the HSCB/PHA for consideration of regional action the following criteria should be considered.

1. **New or under-recognised Risk** - Talk to experts, patients and their families, and frontline staff to confirm the risk is **new or under-recognised**; these groups may have different perspectives.

2. **Outside the remit of the reporting organisation** - Check whose **remit** an issue falls under, as some aspects of patient safety are handled by other organisations and can be passed to them for action.

3. **Likelihood of this happening again and the potential for harm** - Look for up-to-date detail about the issue, research studies and other published material, and seek advice from specialists and frontline staff to help identify the **likelihood of this happening again and the potential for harm**.

4. **Requirement for more robust processes to be developed for regional implementation**- Explore whether organisations can do something more **constructive** than simply raising awareness and warning people to be vigilant against error, and the options for these actions (including interim actions while more robust barriers to error are developed).

5. **Relevant to a specialist service** - If your Trust is responsible for a s**pecialist service**, it is still important to report any safety concerns in order to identify potential regional learning across the system.

Note: The above trigger list has been based on the NHS Improvement Patient Safety Review and Response Report (April to September 2017) which has been adopted for the purposes of this procedure.

Submission of a Learning Notification

Each notification must be submitted by the agreed point of contact within each organisation (see appendix 4) and sent to Alerts.HSCB@hscni.net

Appendix 6

TRIGGER TOOL FOR THE ISSUE OF A HSCB/PHA REGIONAL SAFETY AND QUALITY ALERT

This aid is used by the HSCB/PHA in the decision making process for issuing a Safety Quality Alert (SQA). A SQA is typically issued to make providers organisations aware of and share any substantial new regional learning that will help to improve patient/client safety or to share or remind of best practice guidance.

The HSCB/PHA consider the following questions before planning or issuing a SQA:

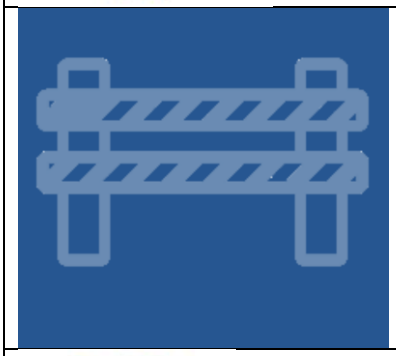
By issuing a SQA will it…		Why is this important?
	Address an issue that causes, or has potential to cause, severe harm or death or significantly improve care?	This helps providers implement improvement or target resources where they are most needed.
	Detail new learning, or will it include some new or under-recognised content?	SQAs have their greatest impact if they are part of an overall plan to support uptake and implementation of improvement.
	Reinforce information published by one or more national bodies, professional or patient organisations or networks, bearing their logo and hosted on their website?	This ensures the SQAs are developed with the necessary specialist expertise to give them credibility, and ensures they remain updated.

	Be substantial, in relation to a patient/client safety issue or area of good practice?	This question relates to whether the SQA addresses a substantial part of a patient/client safety or improvement issue.
	Practical and helpful?	SQAs must support Provider organisations to improve their services.
	Focused on patient/client safety or a key aspect of improvement?	Public health messages and other aspects of quality (such as clinical effectiveness guidelines from the National Institute for Health and Care Excellence (NICE), have their own communication routes.
	Relevant to most health and social care providers	If SQAs apply only to a specialist service provided by the minority of providers in a sector, their communication can be directly targeted instead.

Note: If a decision is reached not to issue a SQA, learning can also be shared through the other identified routes:

- Newsletter article
- Learning Event
- Thematic Review/Audit
- Shared with an existing network/forum
- Establish a Task and Finish Group

Once it has been determined to issue a SQA it is important to ensure the actions are specific and defined. Therefore the HSCB/PHA should consider the following:

Are the actions:		Why is this important?
	Developed and tested to the point we can be confident are the sole or best current approach to improving safety, are practical and do not introduce new risks?	In complex health and social care systems, even with the best possible proactive risk assessment, a change that is expected to make an improvement can have unintended effects.
	Provides an effective barrier to error **or** requires standardisation to a single consistent approach across the HSC?	Where no strong or moderately strong barrier has been identified to avoid error addressing less serious issues can be shared through other routes.
	Acceptable without wider public consultation?	For actions where the HSCB/PHA is concerned about adverse impacts or costs, or has conflicting views on which of two or more current approaches to adopt as standard, a wider public consultation may be needed.
	Relevant to most health and social care providers?	If the actions apply only to a specialist service provided by the minority of providers in a sector, their communication can be directly targeted instead.
	Is the cost proportionate to the reduction in harm the actions can be expected to achieve?	Calculating the scale and cost of current harm and the impact of the intervention is not straightforward for most patient safety issues, but we work within the principles of cost per year of quality-adjusted life used by NICE, so that finite NHS resources are directed at the patient safety issues where they have the greatest impact. For some issues, potential to reduce costs of litigation may also need to be factored in.

Note: The above trigger list has been based on the NHS Improvement Patient Safety Review and Response Report (April to September 2017) which has been adopted for the purposes of this procedure.

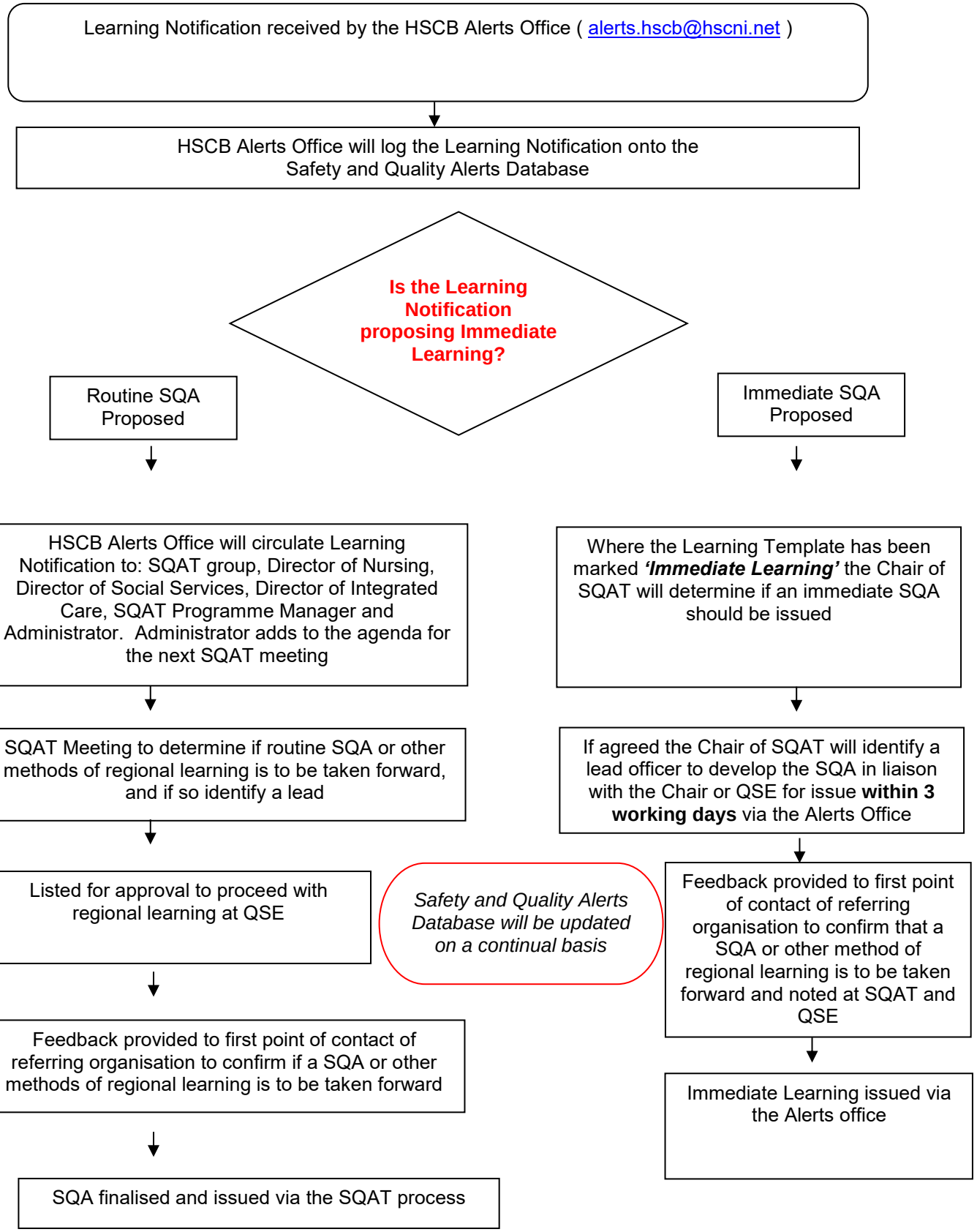
Appendix 7

HSC Trust Contacts

HSC Trust	Medical Director	Governance Lead	SQA First Point of Contact	Contact point for responses to assurances
BHSCT	Dr Cathy Jack	Claire Cairns	trusthq@belfasttrust.hscni.net	Jill Shaw O'Doherty **Copy:** • Martine McNally • trusthq@belfasttrust.hscni.net
NHSCT	Mr Seamus O'Reilly	Sinead O'Kane	Ruth McDonald **Copy:** quality.safety@northerntrust.hscni.net	Ruth McDonald **Copy:**quality.safety@northerntrust.hscni.net
SEHSCT	Dr Charlie Martyn	Irene Low	Liz Campbell **Copy:** Irene Low Linda Kelly	Liz Campbell **Copy:** Irene Low Linda Kelly
SHSCT	Dr Ahmed Khan	Margaret Marshall	Nicole O'Neill **Copy:** • StandardsAndGuidelines@southerntrust.hscni.net • Caroline Beattie	Nicole O'Neill **Copy:** • StandardsAndGuidelines@southerntrust.hscni.net • Caroline Beattie
WHSCT	Dr Dermot Hughes	Therese Brown	Therese Brown	Teresa Murray
NIAS	Dr Nigel Ruddell	Katrina Keating	Katrina Keating **Copy:** • Dr Nigel Ruddell	Katrina Keating **Copy:** • Dr Nigel Ruddell

Appendix 8

HSCB/PHA Internal Process for Managing Learning Notifications from HSC Trusts & other ALBs



Note: This appendix should be read in conjunction with the flow chart in appendix 11

Appendix 9

Safety Quality Alerts Team Membership and Links with other Safety/Quality-related organisations

HSCB/PHA Safety Quality Alerts Team Membership

- Medical Director/DPH, PHA (Chair)
- Director of Performance and Corporate Services, HSCB
- Assistant Director Nursing, Safety & Quality & Patient Experience, PHA
- Safety, Quality and Patient Experience Nurse, PHA
- Assistant Director Service Development & Screening, PHA
- Pharmacy Lead – Medicines Governance and Public Heath, HSCB
- Consultant in Public Health, PHA
- Clinical Director for Safety Forum, PHA
- GP Input via Assistant Director of Integrated Care (Head of GMS) HSCB - when required
- Social Care and AHP input for Alerts relevant to those professions
- Assistant Governance Manager, Safety and Quality, HSCB

SQA Team Roles

- Chair – Dr Carolyn Harper
- Lead Performance – Lisa McWilliams
- Lead Nurse – Mary McElroy / Christine Armstrong
- Lead Service Development & Screening – Dr Brid Farrell
- Lead Pharmacist – Matthew Dolan
- Lead Public Health Doctor / Safety Forum – Dr Jackie McCall
- Lead AHP – through Michelle Tennyson
- Lead GP – Dr Margaret O'Brien
- Lead Social Worker – through Cecil Worthington
- Assistant Governance Manager / Programme Manager – Margaret McNally
- Admin Support – Christine Thompson / Elaine Hyde

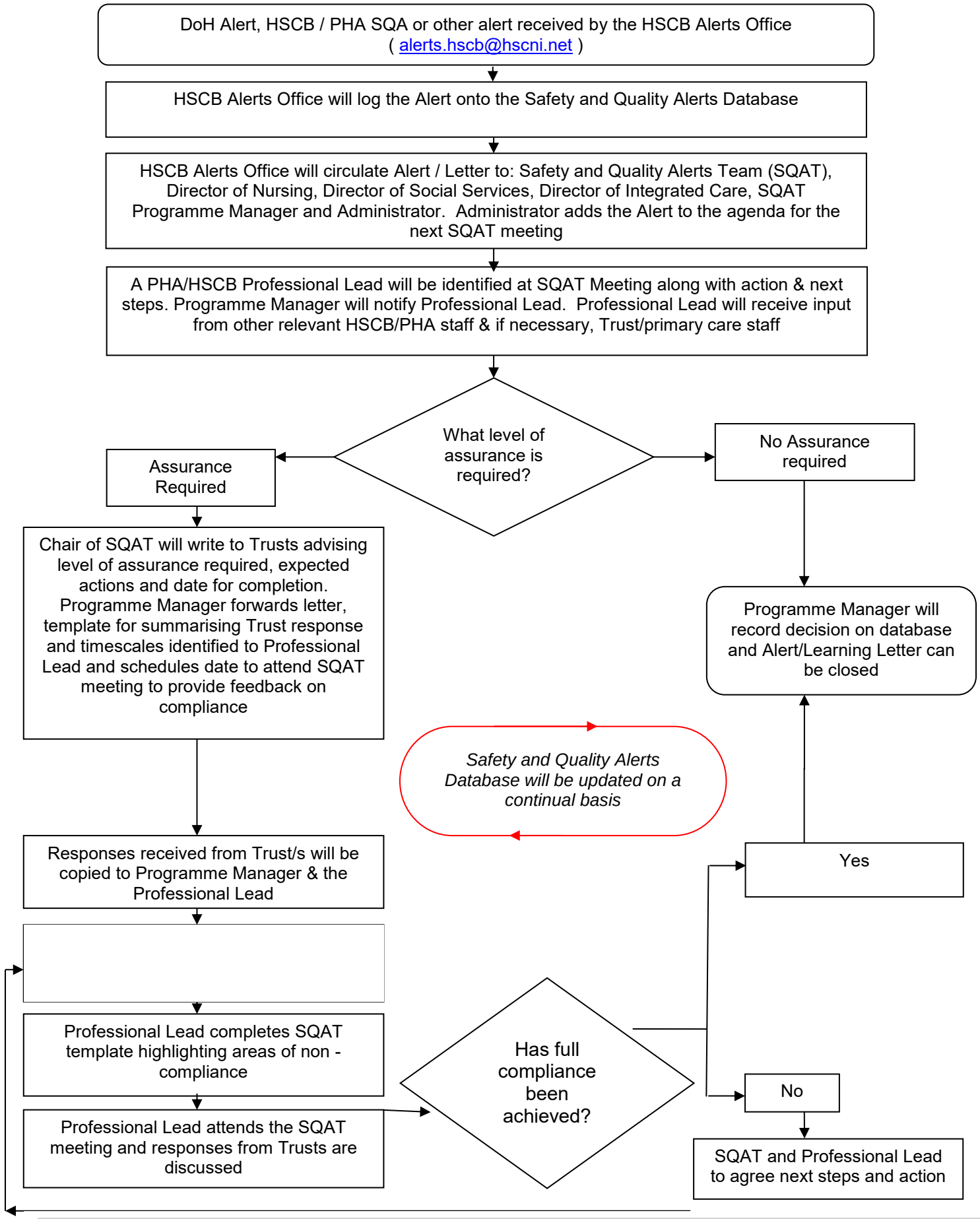
***Link as required with the following* Safety/Quality-related organisations**

- NI Social Care Council
- Safeguarding Board NI
- NI Adult Safeguarding Partnership
- Trust Leads for professional education
- Under and postgraduate training bodies
- NIAC, DoH
- NHS Improvement
- Healthcare Improvement Scotland
- NHS Wales
- Health Service Executive, RoI

Template Distribution List **Appendix 10**

	To – for Action	Copy		To – for Action	Copy
HSC Trusts			**PHA**		
CEXs			CEX		
Medical Director			Medical Director/Director of Public Health		
Directors of Nursing			Director of Nursing/AHPs		
Directors of Social Services			PHA Duty Room		
Governance Leads			AD Health Protection		
Directors of Acute Services			AD Service Development/Screening		
Directors of Community/Elderly Services			AD Health Improvement		
Heads of Pharmacy			AD Nursing		
Allied Health Professional Leads			AD Allied Health Professionals		
Directors of Human Resources			Clinical Director Safety Forum		
NIAS			**HSCB**		
CEX			CEX		
Medical Director			Director of Integrated Care		
RQIA			Director of Social Services		
CEX			Director of Commissioning		
Director of Quality Improvement			Alerts Office		
Director of Quality Assurance			Dir PMSI & Corporate Services		
NIMDTA			**Primary Care (through Integrated Care)**		
CEX / PG Dean			GPs		
QUB			Community Pharmacists		
Dean of Medical School			Dentists		
Head of Nursing School			**BSO**		
Head of Social Work School			Director of Human Resources		
Head of Pharmacy School			**Open University**		
Head of Dentistry School			Head of Nursing Branch		
UU			**DoH**		
Head of Nursing School			CMO office		
Head of Social Work School			CNO office		
Head of Pharmacy School			CPO office		
Head of School of Health Sciences (AHP Lead)			CSSO office		
Clinical Education Centre			CDO office		
NIPEC			Safety, Quality & Standards Office		
NICPLD			**NI Social Care Council**		
NI Medicines Governance Team Leader for Secondary Care			**Safeguarding Board NI**		
Coroners Service for Northern Ireland			**NICE Implementation Facilitator**		

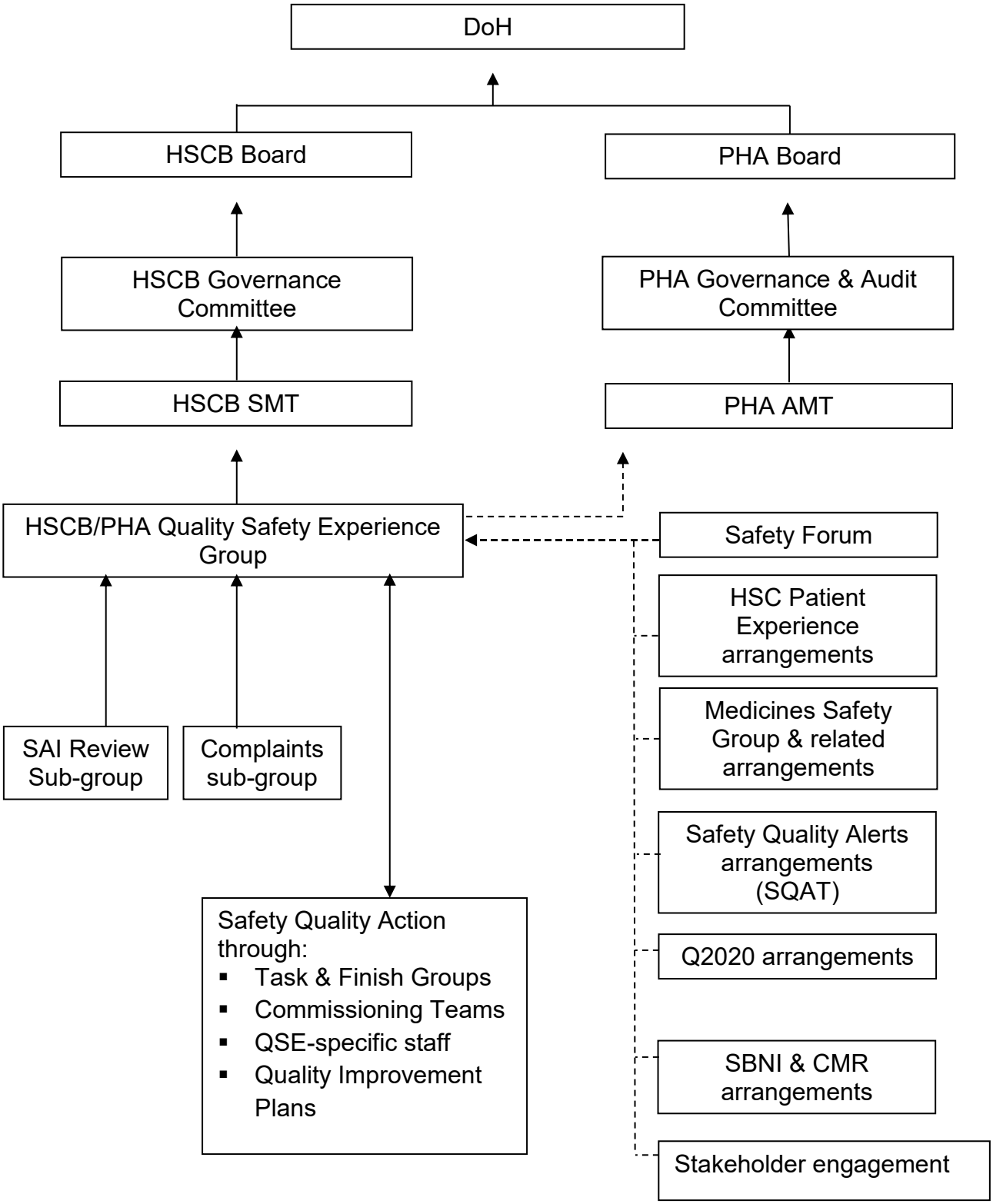
HSCB/PHA Internal Process for the Management of Safety and Quality Alerts



Note: Category 2 Alerts are not automatically listed for SQAT meetings. These are received and logged by the Alerts Office. The Lead Public Health Doctor/Safety Forum reviews these on receipt and escalates to SQAT as required.

Annex 1

Diagrammatic Overview of Quality Safety Experience Internal Coordination Arrangements – HSCB/PHA



Cancer Tracking Resource – Analysis of demand and capacity, June 2018

(V.3 Updated 22.8.18)

1. Introduction

The cancer access waiting times standards were implemented by the Department of Health in September 2005. The purpose of the waiting times was to ensure that patients presenting to their GP with symptoms suggestive of cancer, or diagnosed as having cancer as an incidental finding or through the screening programmes, were dealt with within the secondary care system along regionally agreed specific pathways. Trusts are responsible for achieving three cancer access standards. Central to the success of managing the patients along the pathways and achieving the cancer access targets is the tracking/administrative function. This role is commonly referred to as 'Patient Trackers'.

There is recognition that red flag referrals have increased significantly across the region since the implementation of the cancer access standards and that funding for cancer patient trackers has not been reviewed in line with this. There has been feedback regionally that additional investment in tracking resources may have a positive impact on patient pathways by allowing teams to be more responsive at maintaining 'live' tracking of patients so that pathways can be kept as close to the key milestones as is clinically possible within the limitations of clinical capacity available.

Co-ordination and support of the cancer multi-disciplinary team (MDT) meetings is the second key element of the tracker role and it is recognised that the number of MDTs and number of patient discussions has increased over recent years due to the increased red flag rates and to achieve NICE Improving Outcomes Guidance.

In the context of the significant increase in referrals and MDT meetings/discussions, Trusts were asked via the Cancer AD forum to submit briefing papers on cancer tracking resource outlining issues and position with regards to demand and capacity.

2. Summary of Briefing papers

Papers were submitted by each Trust which demonstrated the obvious increase in demand both in terms of red flag referrals and MDT support. A variety of methodologies were used by each Trust to identify the additional tracking resource required and the majority of Trusts have requested additional resource.

It was also apparent that although the key duties of the role are tracking and MDT coordination, there may be additional duties and more or less intensive tracking depending on the tumour site supporting infrastructure. Some Trusts also referenced a range of internal PTL and escalation arrangements that has led to improved tracking efficiency.

3. HSCB Methodology

In order to ensure a consistent approach, HSCB has developed a methodology focussed on the two core functions of the role – patient tracking and MDT co-ordination. An outline of the methodology is summarised below.

Tracking

Trust methodologies generally used an average number of minutes per week multiplied by total patients on weekly PTL. Rather than use a snapshot of PTL, the HSCB methodology calculates an estimate of the hours required per year using a bottom up approach based on the total episodes tracked within the calendar year.

The starting point for the calculation was to obtain the following 2017 information from a HSCB information CaPPS query:

- The total number of episode IDs tracked by each Trust (includes ITTs).
- The total number of confirmed cancers by Trust first seen.
- The total number of confirmed cancers by Trust first treated.

The HSCB methodology has used the following categories:

A. Time spent tracking confirmed cancer episodes seen by the Trust
B. Time spent tracking confirmed cancers episodes treated by the Trust
C. Time spent tracking episodes downgraded after first appointment or triage
D. Time spent tracking episodes closed as no cancer which were not downgraded after first appointment or triage (i.e. further appointments/investigations were required before patient was closed as no cancer).

The estimated number of patients for categories C and D was calculated using regional downgrade and conversion rates from the HSCB red flag analysis.

Trust methodologies did not include a consistent number of minutes spent per episodes and estimates ranged from 45 seconds to 12 minutes per week. Trust papers generally accepted that this was difficult to estimate. It was also noted that more/less intensive tracking is required depending on the tumour site supporting infrastructure within the Trust.

The following time in minutes and number of times checked or 'tracked' were applied to the number of episodes within each category.

A. **For confirmed cancers first seen by the Trust:** Estimate an average of 5 checks at 8 minutes per check.
B. **For confirmed cancer treated by Trust**: Estimate an average of an additional 5 checks at 8 minutes per check.
C. **For episodes downgraded after triage or first appointment:** Estimate an average of 2 times at 5 minutes per check.
D. **For episodes who don't have cancer and go beyond 1st appointment**: Estimate tracked on average 5 times at 8 minutes per check.

MDT co-ordination

The approximate number of hours to support one hour of MDT meeting varied across Trust submissions. For the purposes of consistency, only hours spent coordinating MDTs within host Trusts have been applied. A slightly higher number of hours have been applied to regional/specialist MDTs.

The following methodology has been applied:

Local MDMs

- Assuming that an additional 4 hours is required to support every one hour of MDM
- Formula: MDM hours per week in host Trust X 5 hours X 52wks

Regional/Specialist MDMs

- Assuming that an additional 5 hours is required to support every one hour of MDM
- Formula: MDM hours per week in host Trust X 6 hours X 52wks

Total resource required

The total number of hours per year for both tracking and MDT coordination were added together and converted into WTE based on a 46 week year.

This was compared against the current funded WTE.

4. Conclusion

Please note that this methodology has been developed in order to apply a consistent approach across the region in relation to tracking demand and MDT support.

	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT	Total
Funded Band 4 WTE	11.2	4.8	4.5	3.9	8.0	32.4
WTE Demand per methodology (see excel)	14.5	7.9	8.9	8.6	8.4	48.4
Band 4 WTE Gap	3.3	3.1	4.4	4.7	0.4	16
FYE costs (pay & non pay)	*£96,934*	*£91,059*	*£129,246*	*£138,058*	*£38,774*	*£494,071*

Notes

- *Belfast and SET both received additional funding as part of MDT IPTs during last few years (0.8WTE and 0.5WTE)*
- *Southern Trust is funded for 3.9 WTE but have 6.6 WTE in post as they recruited at risk due to the demand.*
- *Western Trust received an additional 3 trackers as part of the NWCC business case.*

From
Cara Anderson,
Assistant Director of Commissioning

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

Strategic Planning and Performance Group
12-22 Linenhall Street
Belfast
BT2 8BS

Tel: Personal Information redacted by the USI
Email: Personal Information redacted by the USI
Date: 24th January 2023

By email
Lesley Leeman
Director of Planning & Performance,
SHSCT

Dear Lesley,

CANCER TRACKING RESOURCE

In recognition of the growing demand on tracking services, SPPG can confirm a recurrent allocation of £106,404 CYE to enable the Trust to expand its tracking resource. This equates to 3WTE Band 4 trackers and increases the funded establishment to 11.6WTE. It is our expectation that this additional resource will support timely tracking and closure of cases, reporting of accurate cancer waits and safety netting of patients that may have had their pathway suspended or delayed due to COVID.

The Trust is expected to complete a review of the impact of investment (Post Project Evaluation), and this should be submitted to the HSCB by 31st July 2023. A copy of the PPE template is included with this correspondence for your convenience.

As funding is directly linked to activity it is important to ensure that all activity associated with this service is recorded as part of the Trust's monitoring processes. If the commissioned outcome is not achieved the SPPG reserve the right to reconsider this investment.

If you have any queries please do not hesitate to contact me(Personal Information redacted by the USI).

Yours sincerely,

Personal Information redacted by the USI

C
Assistant Director, Hospital & Community Care

cc Barry Conway (SHSCT)
Sharon Glenny (SHSCT)
Karen McKay (SPPG)
Sinead McAteer (SPPG)
Emma McKee (SPPG)

Terms of Reference for Urology Review Stocktake

Proposed Outline of Work

The Board has agreed to undertake a 'stock take' of the Review of Adult Urology Services which was completed in 2009. In undertaking this process the Board will work with Mr Mark Fordham who will act as a clinical advisor to the Northern Ireland Urology Service. As previously he will act as 'critical friend' to the Health and Social Care Board and in doing so identify actions to improve or modify the implementation of review recommendations. The key tasks of the urology review stocktake will include:

- Undertake a 'stock-take' assessment of the implementation of each of the urology review recommendations;
- Review the current three team model and advise the Board if the current model proposed in the Urology Review is sustainable across the Trusts;
- Identify actions to improve clinical leadership and team dynamics, which may have been hampered by local issues such as junior doctor vacancies, on-call arrangements, sharing resources and governance/risk sharing across the teams;
- Identify key limiting factors (eg theatre access, equipment) which may be impacting on the delivery of full capacity;
- Review the expected case mix and activity assumptions of specialist verses core urology consultant posts, including the input of middle grade staff who operate independently;
- Assess the specialist operating requirements within the region, including increased utilisation of technology, to ensure delivery of the full ranges of urology procedures;
- Review the service delivery to those Acute Hospital Sites which do not have an on-site urology team
- Assess the increased demand for urology services, especially the growth in suspect cancer referrals – including potential impact from the implementation of NICE Guidance CG175

Proposed process:-

1. Meet with each of the 5 Trust Director of Acute Services or their Deputy and the Urology Clinical Lead including other key urology consultants, anaesthetic and senior managers as appropriate to identify the key issues. The Trusts sites to be visited are Altnagelvin (Western Trust) and Causeway (Northern Trust) in the North West Team; Craigavon (Southern Trust) in the Southern Team; Belfast City Hospital (Belfast Trust) and Ulster Hospital (South Eastern Trust) in Team East. In addition, a meeting will be arranged at Antrim Hospital [acute Trust with no resident urological team].

2. Complete activity analysis including procedure based details for each Trust.

3. Individual meetings with the Regional BAUS Lead, NICaN Urology Tumour Group Lead Clinician, Regional Audit Lead and Regional Training and Education Lead.

4. Consider the need for a regional urology meeting involving all key stakeholders

5. Provide feedback to the Trust Chief Executives

Expected outcomes:
An evaluation report, highlighting the key issues and associated recommendations to be completed by April 2014.
Support for the implementation of the recommendations arising from the stocktake during 2014/15.

Narrative report on the Stock-take for the Health and Social Care Board of Urology Services in Northern Ireland; February to May 2014

Introduction

Following the implementation of the "Review of Adult Urology Services in Northern Ireland – A modernisation and investment plan" of March 2009 the HSCB requested a stock-take of adult urology services in Northern Ireland to assess progress after the 5 years since the review. To provide external independent advice to the HSCB, Mark Fordham the consultant urologist from the Royal Liverpool University Hospital Trust who had provided support as a "critical friend" for the original 2009 review was invited to provide a similar service for this project.

Terms of reference

The terms of reference for this 2014 stock-take of urological services in Northern Ireland were prepared by the HSCB (A – H).

A) Undertake an initial 'stock-take' assessment of the implementation of each of the urology review recommendations

B) Review the current three team model and advise the Board if the current model proposed in the Urology Review is sustainable across the Trusts

C) Identify actions to improve clinical leadership and team dynamics, which may have been hampered by local issues such as junior doctor vacancies, on-call arrangements, sharing resources and governance/risk sharing across the teams.

D) Identify key limiting factors [eg theatre access, equipment] which may be impacting on the delivery of full capacity

E) Review the expected case mix and activity assumptions of specialist verses core urology consultant posts, including the input of middle grade staff who operate independently

F) Assess the specialist operating requirements within the region, including increased utilisation of technology, to ensure delivery of the full range of urology procedures

G) Review the service delivery to those acute hospitals sites that do not have an on-site urology team

H) Assess the increased demand for urology services, especially the growth in suspect cancer referrals – including the potential impact from implementation of `Nice guidance CG175' [Prostate cancer management].

Plan for conducting the stock-take

A team consisting of Personal Information redacted by t and David McCormick from the HSCB and Mark Fordham as the external advisor was established. Arrangements were made for:

1) Visits to be made to each of the hospital trusts which provide in-patient urological services to meet the urological clinical and management teams (Ulster Hospital, BCH, Craigavon, Causeway, Altnagelvin and Antrim Hospital)
2) To meet with clinicians who have a specific responsibility for providing regionally based administrative services for the organisation and planning of provision of urological care. This was to including meeting the regional BAUS representative (John McKnight), the training programme lead (Siobhan Woolsey), the urological cancer lead (Aidan O'Brien), the lead for audit in urology (Siobhan Woolsey), the RCS representative for Professional affairs in surgery (Terry Irwin) and the regional lead nurse consultant in the Public Health Agency(Siobhan McIntyre).
3) To have access to and review urological data reflecting the way the workforce is organised and the current level of the workload including the waiting list backlogs, together with an assessment of the current commissioning arrangements.
4) To review data germane to this work that is in the public domain relating to urological activity, care pathways, guidelines, contributions made by the urological staff, published audits and research.

1) Reports on the review meetings at Hospital Trusts

Present at all these meetings were Mark Fordham and Personal Information redacted by th with David McCormick at all except Antrim Hospital.

The aim of the meetings was to allow each Trust team to describe how they saw their current position and any challenges that existed, and what progress they had made since the 2009 Review. The HSCB did not offer any comments on the data presented.

Belfast Trust
Date: Tuesday 11th March
Present: Representative Urology consultants and management
Points raised by the Trust:
Challenges

1. Specific problems of the "Team East" arrangements that the 2009 Review had initiated, especially the on-call arrangements between the Ulster hospital and BCH.
2. Increasing workload especially from increasing numbers of cancer referrals to its Cancer Centre
3. Consultant changes and increasing emergency work [especially acute stone cases] resulting in significant reduction in workforce capacity and in the skills base in particular surgical reconstruction services.
4. Recruitment of clinical staff remains difficult
5. Growing waiting lists especially for core urology and outpatient services

6. Primary care catchment areas overlapping with other providers making allocation of referrals challenging.
7. Limited space for day diagnostic services and limited theatre sessions, but helped by using the theatres at White Abbey Hospital to provide some diagnostics and day cases
8. The Trust raised the issue of the provision of Robotic Surgery
9. On ongoing problem with a small group of patients awaiting complex reconstructive surgery was described.

Achievements

1. Established Cancer Centre along Improving Outcome Guidance recommendations; weekly MDT with video links to cancer units;
2. Well-established training services for junior urologists

South Eastern Trust

Date: Wednesday 12th March

Present: Urology consultants and management representatives

Points raised by the Trust:

Challenges

1. Specific problems of the "Team East" arrangements that the 2009 Review had initiated, especially the on-call arrangements between the Ulster hospital and BCH.
2. Current 3 consultant team is overstretched: 4 peripheral sites covered as well as the main hospital; BCH provides clinical work at Lagan Valley
3. Rising demand for both cancer and core urology services

Achievements

1. Strong support from the 2 specialist nurses including delivering flexible cystoscopy and outpatient work
2. Activity delivered to contract but a growing waiting list
3. Target length of stay and day-case rates satisfactory
4. Potential for excellent training of junior urologists

Northern and Western Trusts (at Causeway Hospital)

Date: Thursday 13th March

Present: Representative urology consultants from Western Trust as well as consultant urologists from Northern Trust together with management teams from both Trusts.

Points raised by the Trusts :

1. The 2009 Review had recommended that the Northern Trust and the Western Trust urology services were amalgamated into a single team. A helpful document summarising the teams work towards this amalgamation was presented. The 2 teams have worked on and proposed a method for achieving this and have conducted an assessment of their proposals with the input of a senior and very well respected consultant urologist. To create a combined Northwest team the plan proposes continued cross team co-operation and development of working relationships, establishment of 2 new operating theatres on the Altnagelvin site to support increased urological activity, build a dedicated diagnostic and treatment facility on the Causeway site, increase within Team NW numbers of consultant [to 6], staff grade [to 4], urology

trainees/fellows [to 2] and specialist nurses. An analysis of capacity based on the recommended workload per clinician and current and likely increase in demand was presented to support the manpower and facility development proposals. It is recognised by the Trusts that investment will be needed to achieve these objectives.

Challenges

1. Waiting times for outpatients and surgical procedures remain high with significant numbers of patients on the operative waiting lists particularly for core urology procedures.
2. The arrangements for cross cover on-call arrangements between the two sites are not yet fully operational.
3. The 2 new operating theatres on the Altnagelvin site are not yet completed and do not have an agreed timescale for construction.
4. The loss of the defined cancer operations to the Cancer Centre has not been backed up with clear annual outcome data to assess whether improvements have resulted. The work to deliver these data is not within the scope of team NW.
5. The costing for some of the Team NW proposals are not yet fully worked out and no clear decision regarding possible funding has been taken.
6. Recruitment of clinical staff has remained difficult (both consultants and specialty doctors).

Achievements

1. A determined collaborative undertaking with external assessment to develop a plan to achieve the 2009 review recommendations.

Additional comments:

1. The clinical director for surgery pointed out that losing urological inpatient services from the Causeway Hospital Trust could have a negative effect on the functioning of the Trust, and he hoped that the service would remain as it is.

<u>Northern Trust at Antrim Hospital</u>

Date: Friday 14th March

Present: Consultants in general surgery and in gynaecology

Points raised by the Trust :

1. Patients with urological conditions are admitted via A&E under the care of the general surgeons. Although there is acute support from the urologists in the Northern Trust in Causeway Hospital and there are arrangements for urological input from the Belfast City Hospital team, in reality patients may not experience optimal care and may remain in hospital for longer than would be the case in hospitals with a urology directorate particularly for the patients who are undiagnosed or have medical type urology pathologies.
2. The 6 gynaecologists in Antrim Hospital would welcome the presence of a urological service to collaborate with providing functional urinary services as well as some operative procedures.
3. Operating theatre space is limited but facilities at Whiteabbey Hospital have traditionally been used by outreach urology services from Belfast Trust.

Southern Trust

Date: Thursday 3rd April

Present: Urology consultants and management staff

Points raised by the Trust:

A helpful document summarising the directorates progress on implementing the 2009 review recommendations was presented.

Challenges

1. The waiting lists particularly for outpatient services have very long waiting times.
2. Access to operating theatre sessions is limited resulting in waiting lists for operative procedures in particular core urology cases.
3. The commissioned service and budget agreement aims are based on the workforce capacity rather than the demand.
4. Recruitment of clinical staff [consultants, juniors and specialist nurses] has until very recently been a problem. Recent consultant appointments are hoped will improve clinical services in time. The 3 funded specialty doctors remain vacant.
5. Numerous outreach day surgery and clinics involve significant travel times and absence from Craigavon Hospital site.
6. Engagement between primary and secondary care has been limited. The development of regionally agreed care pathways has not been fully instituted or adopted by referring services in primary care and A&E.
7. Administration time for consultants is significant and is not reflected in their job plans. There is a particular worry in delays in consultant to consultant referrals, MDT referrals and triage.

Achievements

1. An improved diagnostic and treatment outpatient facility has been completed which will enable one-stop services to be improved and developed.
2. Recent new consultant appointments are hoped will allow a significant improvement in waiting times and reduction in waiting lists.
3. An elective admission ward has helped improve day surgery numbers and improve theatre utilisation

Additional comments

1. General surgeons provide urological care at Daisy Hill Hospital and SWAH; vasectomy services at Craigavon Hospital are provided by the general surgeons.

2) Reports on the review meetings with regional leads

Regional BAUS representative; John McKnight
Date: Wednesday 5th March
Present: John McKnight and Mark Fordham
Points discussed

1. Regional meetings and updates
2. Regional audit
3. Sharing best practice
4. Supporting trainees
5. Ways to improve consultant recruitment
6. Managing competing needs of local hospital urology services while delivering regional urology services
7. Availability of Mark Fordham to meet and speak with the consultant urologists at any time about the stock-take.

Regional Programme director for urological trainees; Siobhan Woolsey
Date: Monday 10th March
Present: Siobhan Woolsey, Mark Fordham, Personal Information redacted by t, David McCormick
Points discussed:

1. Training arrangements for juniors
2. Expansion of training posts and training accredited hospital locations
3. Opportunities for juniors to present research and audit studies

Regional Urology Audit lead: Siobhan Woolsey
Date: Monday 10th March
Present: Siobhan Woolsey, Mark Fordham, Personal Information redacted by t, David McCormick
Points discussed:

1. Local and regional audit meetings
2. Opportunities for local and regional presentations of audited best practice
3. Development of care pathways and referral and treatment guidelines

Regional Urology Cancer Lead; Aiden O'Brien
Date: Thursday 3rd April
Present: Aiden O'Brien, Mark Fordham, Lisa McWilliams [NICaN Manager], Personal Info Personal Informatio, David McCormick
Points discussed:

1. Annual meeting to review audited numbers and results, complications and outcomes from the regional urological cancer services teams to include reports from the regional radiotherapy, medical oncology and surgical urology cancer centre teams. This annual meeting has not yet happened.
2. Plans and preparations for the Urological Cancer Peer Review planned for July 2015
3. Recent changes in the urologist cancer lead.

4. Opportunities for sharing best practice
5. Developments in the roles of specialist urology nurse practitioners for diagnosis, treatment and follow up of urology cancer patients.
6. Preparation for the June NICaN meeting

Regional RCS representative for Professional affairs; Terry Irwin
Date: Friday 14th March
Present: Terry Irwin, Mark Fordham, [redacted]
Points discussed:

1. Emergency surgery services including urology
2. Consultant responsibilities between hospital and regional based services
3. Appraisal and Revalidation

PHA Regional lead nurse consultant: Siobhan McIntyre
Date: 2 April 2014
Present: Siobhan McIntyre [by video link], Mark Fordham, [redacted]
Points discussed:

1. Opportunities for training of specialist urology nurses
2. Specialist nursing skills recognition between hospital trusts
3. Numbers currently of specialist urology nurses
4. Numbers of Macmillan trained urology specialist nurses
5. Recognition of urology nursing associations [British and Irish]
6. Links with University training courses
7. Value of developing links with past president of BAUN [Jerome Marley] who works at University of Ulster and Craigavon Hospital Trust.
8. Appropriate use of specialist nurse workforce including robust job plans and recording of activities
9. The data below was kindly collected by questionnaire circulated by Siobhan McIntyre to the Trusts. The 0 to 4+ grading is approximate to give an indication of activity.

Clinical Nurse Urology Specialist data	**Number of CNS in urology**	**Access to training and development [0 to 4+]**	**Community continence nurses**	**Community catheter care and change [0 to 4+]**	**Attendance at national and local meetings [0 to 4+]**
Belfast Trust	2	++++	10	++++	++
Northern Trust	2	+++	4	++	++
SET	2	++++	4	+	+
Southern Trust	2	+	-	-	++
Western Trust	5	++++	7	++++	++++

3) Requests were made for data reflecting workload, waiting lists and waiting times, workforce numbers and workforce job planning, current methods and assumptions underpinning commissioning service level agreement contracts

3.1 The HSCB provided data on waiting lists and waiting times
3.2 Requests were made to hospital urology management teams for details of the urology workforce and their job plans.
3.3 Discussions took place with HSCB to understand the methods underpinning the way Service and Budget Agreements (SBA) are devised and commissioned.

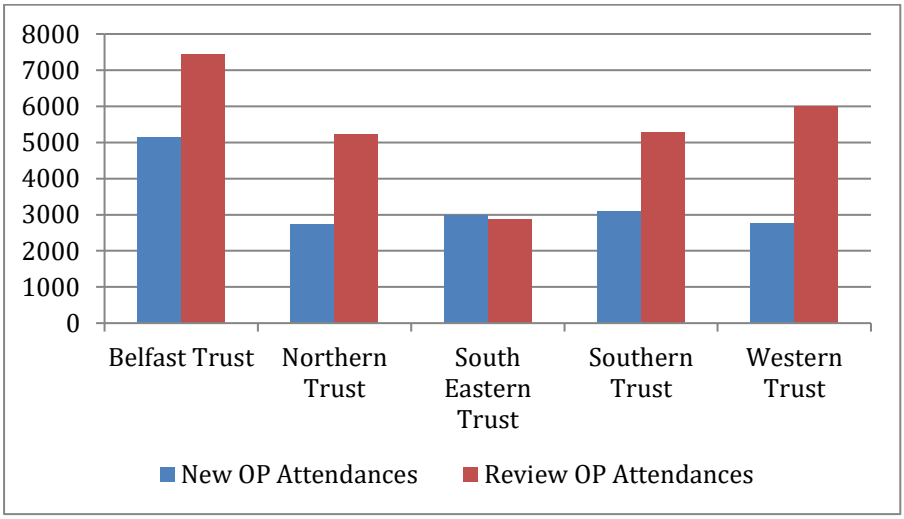
3.1 The HSCB provided data on waiting lists and waiting times

Reviewing the data over the last 5 years for primary care referral rate, hospital outpatient waiting times and operative procedure waiting lists for the 5 trusts providing urology care the primary referral rate has risen by ~10% year on year with red flag referrals rising by 25% year on year.

The 2012/13 New : Review outpatient ratio is 1.6 (16,711:26,806) with DNA rates for first and review visits at 7.5% and 8.8% comparing favourably with the Dr Foster urology data for England. However this does not take into account for some units the very large numbers of patients waiting for out-patient appointments in particular review appointments.

The overall outpatient work for 2012/13 for the 5 Urology Directorates is shown in the table and histogram

2012/13	New OP Attendances	Review OP Attendances
Belfast Trust	5131	7447
Northern Trust	2717	5233
SET	2998	2870
Southern Trust	3095	5271
Western Trust	2770	5985

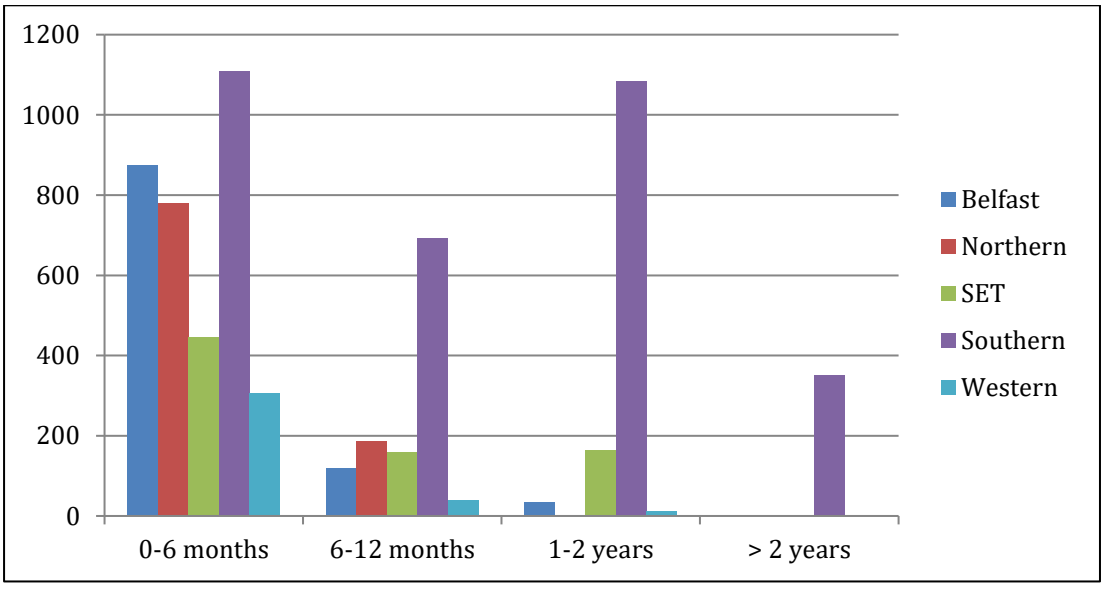


The waiting list and waiting times for patients booked for a review out-patient appointment are shown in the table and histogram below;-

Numbers of patients awaiting review out-patient appointments [time elapsed since the appointment was due is shown in the table below i.e. 'a backlog']. However it is also worth noting that in addition to these there are a number of patients currently still within their clinically indicated review appointment waiting time but yet to be seen are: BHSCT 3170; NHSCT 800; SET 1025; SHSCT 1300; WHSCT 1270. This represents a significant workload which may result in additions to the patients who breech their review clinic waiting time.

	0-6 months	6-12 months	1 – 2 years	> 2 years	Total
B HSCT	874	118	35	0	1027
NHSCT (Causeway)	778	185	0	0	981
SEHSCT	446	159	164	0	769
SHSCT	1109	692	1083	351	3235
WHSCT	304	39	11	0	354
Total	3529	1193	1293	351	6366

The same data is presented in a histogram



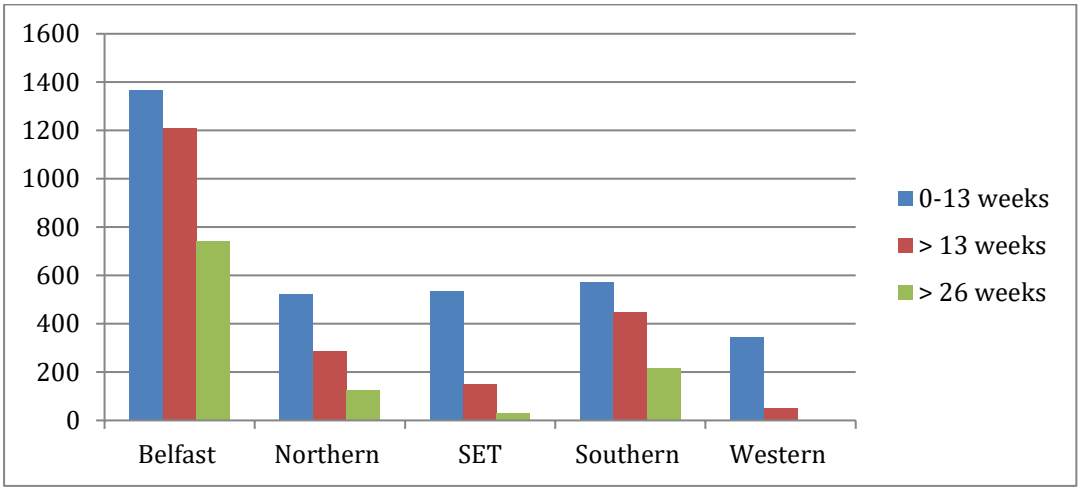
Despite the rising referral rate the in-patient operative activity shows overall stability with day case activity increasing gradually year on year and in-patient operative work largely stable.

In-patient bed usage appears satisfactory with average regional lengths of stay (LoS) at 2.71 days for elective and 5.24 days for non-elective cases, with little variation between the trusts.

Using data from the Theatre Management System [TMS] theatre utilisation shows almost no overruns throughout the region but each Trust has some theatre usage below 80%. This may in part result from the regional average operative cancellation rate of about 12% with a range from 7% to 25%. It should also be noted this utilisation is measured against available Trust reported capacity and not necessarily the capacity funded by the commissioner. This point was raised by several consultants who highlighted that theatre operating time was a key limiting factor.

The in-patient and day case waiting lists numbers (at 3/2/2014) are presented in this table and histogram below, these may increase when all the out-patient appointments have been completed:-

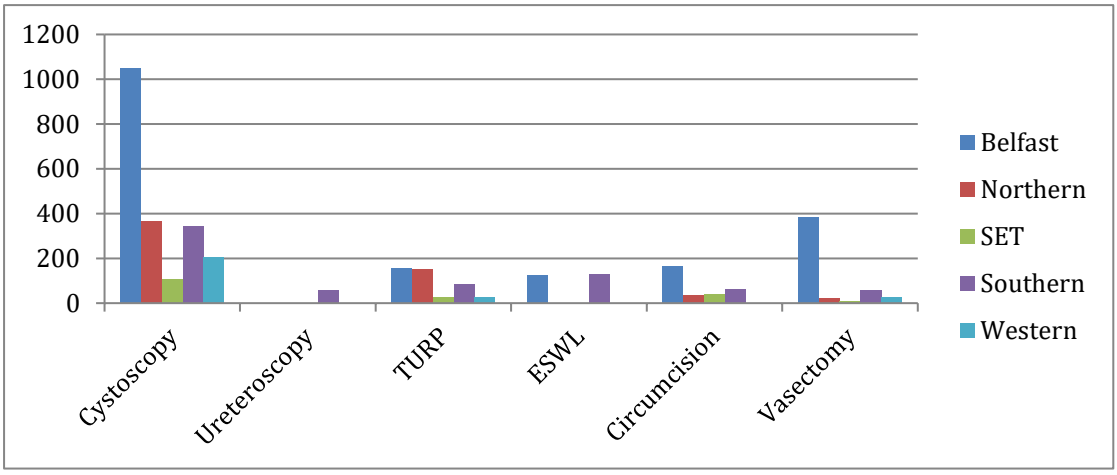
	0-13 weeks	**>13 weeks**	**> 26 weeks**
Belfast Trust	1368	1206	741
Northern Trust	521	267	126
SET	534	148	30
Southern Trust	573	449	217
Western Trust	345	52	4



The waiting list for operative procedures is shown in the table with the total number given together with 6 specific procedures with higher numbers of patients awaiting treatment.

	BCH	Northern	SET	Southern	Western
Total	2576	808	682	1022	398
Cystoscopy	1047	364	105	342	204
Ureteroscopy	0	0	0	58	0
TURP	155	150	24	83	27
ESWL	123	0	0	129	0
Circumcision	165	34	40	64	0
Vasectomy	381	22	7	56	27

The same data as above is presented in a histogram



3.2 Requests were made to hospital urology management teams for details of the urology workforce and their job plans.

The table below reflects the workforce (both staff in post and vacancies) in each Hospital Trust as accurately as can be assessed from the information provided.

Hospital	Consultants	Staff grades	Specialist urology nurses
BCH	9	2	2
Northern	3	2	2
SET	3	0	2
Southern	5	4 (inc 1 GPSI)	2
Western	3	1	5

Only a few complete job plans were submitted together with some tables representing the global clinical commitment of the urology teams within a hospital. From the information received it was possible to see that more imaginative ways of using the contracted time might be worth considering.

3.3 Discussions took place with HSCB to understand the methods underpinning the way SBA are devised and commissioned.

As part of the task of understanding the balance between the capacity of the urology service and the demand from both primary care referrals and emergency patient work Mark Fordham, [redacted] and David McCormick spent time establishing and examining the assumptions underpinning the calculation of the specific numbers of consultations, diagnostic procedures and therapeutic operations that are the basis of the commissioned service level agreements between the HSCB and the individual Trusts.

Three observations were made:-

1) The use of the BAUS workload numbers, particularly for outpatient work, do not fully reflect modern ways of providing patient centred services [one stop services including diagnostic tests] . Local estimates are needed based on patient referral types and modernised patient centred services and commissioned in a way which incentivises innovation.

2) This traditional method of commissioning clinical work has an inherent unintended consequence. By defining the work expected of the workforce [based on the BAUS recommendations], no cognisance is taken by the Trusts of the demand placed upon the system. Consequently any mismatch between capacity and demand will result in an excess workload that has not been costed or commissioned leading to a backlog of patients requiring treatment that will require additional extra-contractual arrangements and expenditure to always be funded by the Board.

3) Because the responsibility for dealing with demand over the service level agreement lies with the commissioners ie the HSCB, the clinical directorate and the Hospital management team are absolved from the responsibility of looking for imaginative and innovative ways of delivering the clinical service. It would seem this stifles any new or modern ways of delivering a better and more cost efficient service.

4) To review data germane to this work that is in the public domain relating to urological activity: care pathways; guidelines; contributions made by the urological staff; published audits and research; publications by public bodies and political committees

The impressive work that is undertaken by the urological consultants of Northern Ireland is easily available on the Internet on various sites where their work features. There are numerous publications, both academic and popular together with minutes of meetings and documents dealing with ways of improving services. In addition there are many documents published by the various health related public bodies and political committees that provide information regarding the best ways of delivering health care for patients, and in particular urological patients.

Research, audit, guidelines and care-pathways:-

A small sample of the contributions of the urological consultants include:-
Brian Duggan chaired the Northern Ireland urology clinical guidelines panel which produced draft guidelines for a range of urological conditions [lower urinary tract symptoms; haematuria; scrotal masses; raised PSA; renal colic; acute kidney obstruction; acute urinary retention] which have been accepted by the regions urologists. He has published papers on urethroplasty.
Paul Downey was part of the BAUS team that produced the nationally accepted guidelines for the management of patients with suspected kidney stones. He oversaw the safe introduction of laparoscopic renal surgery in UK urological practice through a national audit. He has published papers on flexible cystoscopy and reduced length of stay for TURP patients.
Aidan O'Brien is part of a national research project investigating a new drug for the treatment of angiomyolipoma disease.
Patrick Keane has been instrumental in developing the role of the specialist urology nurse, chairing the various regional urology cancer committees and co-authored the NHS guidelines on PSA testing; he has had a major role in aspects of training, education and examining trainees.
Siobhan Woolsey has published on stone disease, urodynamics, reconstructive and functional urology
Colin Mulholland has been responsible for developing a PSA tracker and its economic benefits.
Chris Hagan was part of the team that conducted a comparative audit on the care of prostate cancer patients in Northern Ireland in 1996, 2001 and 2006 and an audit on the prostate red flag referrals.

Cancer agenda:

The minutes of NICaN show what progress has been achieved under the various chairmen and members of the committee, in particular the work to make the 2009 Review become effective. More recently plans have been developed to make the MDTs effective, introduce patient representation and develop the regional annual plan.

Transforming Your Care:
This is a major review of Health and Social care in Northern Ireland produced at the Assembly's request incorporating comments from a large number of participating groups from the general public as well as professionals within the Health Service.
It covers topics that are relevant to urology such as:-
The ageing population [between 2009 and 2020 there will be a 40% increase in people> 75 years old] – no specific point are made about catheter care, but this will certainly impinge on urology services.
Long term conditions; this will include chronic conditions such as prostate and bladder cancer; incontinence; stone disease.
Patients with physical disabilities; the area of caring for adults who have required surgery as children eg spina bifida patients who may need treatment for stone disease, continence problems and renal impairment.
Acute care: the report makes the point that these are the sickest patients and they need the best informed clinical care.
Technology: the document endorses the best use of modern technology to offer both the best treatment for patients and in many cases the most cost efficient.

The Assembly's Committee for Health, Social Services and Public safety
This committee, chaired by Maeve McLaughlin [Sinn Fein]and vice chairman Jim Wells [DUP], has recently been hearing evidence from experts about the ways of improving patient care by managing waiting lists and waiting times. The video recordings and the Hansard records of the presentation and the discussion are all available on the Committee website:-
http://www.niassembly.gov.uk/Assembly-Business/Committees/Health-Social-Services-and-Public-Safety/Minutes-of-Evidence/

The evidence presented is of the highest quality and is worth looking at. There is much debate about recording Referral to Treatment Time [RTT].

Comments on the stock-takes findings related to the Terms of Reference

A) Undertake an initial 'stock-take' assessment of the implementation of each of the urology review recommendations

In summary the Review of Urology Services published in March 2009 looked at 2 main areas of concern:-

1. Specialisation within urology
2. Delivering timely urological care

1) Specialisation within urology;
In particular moving urological procedures from general surgery into urological practice and moving urological cancer services into line with the 2000 NHS cancer plan such that defined cancer operations as described by the Improving Outcomes Guidance [IoG] were performed in sufficient numbers in a cancer centre and for all defined cancer cases to be discussed at a regional MDT.

2) Delivering timely patient-centred urological care:
This was to cover new and review outpatient services, operative procedures and on call arrangements for the care of urological emergencies.

The review described 3 main proposals aimed to achieve these objectives:-

1) Referral patient pathways and care protocols to be agreed amongst the urological consultants so patients with urological symptoms would be seen by the right specialist first time and would have an agreed best care plan wherever they were seen in Northern Ireland.

2) To fund an increase in the urological consultant numbers [to 23 wte] and specialist urology nursing workforce [at least 5 cancer nurses] to allow the best redesign of diagnostic [one stop] and review clinics and day-case and in-patient operative capacity in line with the BAUS capacity recommendations to minimise delays in patient care supported by any necessary changes to the job plans of the clinical workforce

3) A regional urological clinical service model of 3 teams [NW; E and S] created by the amalgamation of the current urology directorates within the existing 5 acute hospital trusts, each team with responsibility for acute on call services and clinical support services for the hospitals within their defined area and where necessary support from management to negotiate new contractual and job plan arrangements.

Progress seen from the stock-take:-

1) Specialisation within urology:-

1. BCH has become the defined urology Cancer Centre and this has led to a net importing of complex work without any concomitant reduction in the core urology service.
2. The other urology cancer units no longer undertake the IOG defined cancer operations.
3. A weekly regional MDT takes place with video linkage from the cancer units to the cancer centre. The exact composition of this MDT is not yet clear and those attending should be reviewed.
4. An annual meeting to review audited data including numbers, complications and outcomes to be presented by the Cancer Centre team including the Radiotherapists, Medical Oncologists and Urological Surgeons to all users of the urology cancer service has not yet taken place.
5. A peer review is due in July 2015. This will need careful preparation.
6. As a consequence of specialisation for cancer surgery other urology units have begun to specialise in stone services
7. Female urology and andrology are poorly developed at present.

8. Some urological procedures [e.g. vasectomy] are still performed by general surgeons. If this ceases it will impact on the urology waiting lists and waiting times.

2 Delivering timely patient-centred urological care;

1. Investigation and treatment pathways have been developed but no regional audit has assessed how well they are used and whether they offer best practice
2. The total number of consultants has increased but recruitment has been difficult
3. There are significant waiting lists in the region with some very long waiting times for both out-patient and in-patient services.
4. Emergency care for urological patients is variable with some areas with a service that is not optimal.
5. The use of specialist urology nurses is variable, but where they are established they contribute a significant addition to the clinical workforce making an important contribution to timely and patient-centred care.
6. There are some areas of urological practice that cannot be provided within the current skill or technology base
7. The number and distribution of urological teams favours some areas over others to the detriment of patient care.

B) Review the current three team model and advise the Board if the current model proposed in the Urology Review is sustainable across the Trusts

The amalgamation of the Belfast and Ulster Hospital urology teams for on-call services has been thoroughly assessed. It is clear that the area to be covered, the lack of continuity of care of acutely ill patients and each teams unfamiliarity with the other departments facilities may lead to the clinical care not being optimal. It would seem appropriate to accept that this model has not been ideal and for each Trust in Team East to consider managing their own on-call arrangements.

The amalgamation of the Northern and Western Trust urology teams has been looked at in detail, with external high quality urological assessment of the Team's proposal.

At present the two teams have not combined their on-call rotas and the proposed plans to make the amalgamation possible require significant investment. The two Trusts have reported their continued commitment to the concept of North West Team Urology, although there was little quantifiable evidence to support how the team functioned for acute on-call and sharing waiting lists on an on-going basis.

The Southern Trust urology team in Craigavon Hospital has several peripheral hospitals to serve but the plan did not involve them in amalgamating with another urology team.

C) Identify actions to improve clinical leadership and team dynamics, which may have been hampered by local issues such as junior doctor vacancies, on-call arrangements, sharing resources and governance/risk sharing across the teams.

It is helpful to recognise that the urology consultants have a dual role within their professional responsibilities. Clearly they are responsible for delivering their clinical commitments according to their job plan for their Trust, but in addition they have a responsibility to deliver a regionally coordinated service whereby they are able to share best practice through clinical audits, to review cancer services collectively and support patient-centred care-pathways, and to support the training of the specialist registrars.

Leadership is needed both locally in individual urology directorates to establish suitable job plans to make best use of the trust facilities as well as to encourage innovation and adopt best practice but also regionally to support those with regional responsibilities involving teaching, training, audit, research and cancer services.

The annual appraisal and the subsequent GMC revalidation require evidence that the consultant has contributed to these aspects of the service and have combined reflective practice as well as participation with the audits and meetings.

D) Identify key limiting factors [eg theatre access, equipment] which may be impacting on the delivery of full capacity

Without all the consultants complete job plans it is not possible to give an accurate assessment on any limitations to operating theatre access. However at each of the hospital visits the consultants said that they were limited in their access to theatre and needed more sessions to deliver the surgical work that was required.

Most urology teams seemed to feel that they had a satisfactory supply of theatre kit.

E) Review the expected case mix and activity assumptions of specialist verses core urology consultant posts, including the input of middle grade staff who operate independently

The evidence nationally and from speaking to the urologists in Northern Ireland is that suitable candidates for staff grade jobs are now virtually no longer available. This is the result of fewer subcontinent trainees coming to the UK as a result of EU rules and the changes in training for UK registrars.
For this reason, it would make sense to vire any current funding for unfilled staff grade posts and convert them into consultant posts. This would be in line with the NHS ambition for a consultant orientated service.

There has been a long standing difficulty in finding suitable candidates to appoint to vacant urology consultant posts in Northern Ireland. The training opportunities for urology HSTs are considerable and a short term increase in HST places in NI would act to increase the number of locally trained urologists who may be more likely to consider a consultant post in the Province. This is an area the regional BAUS representative and the Urology Programme Director may consider approaching the Urology Specialist Advisory Committee directly.

The current method of commissioning a service level agreement requires specific numbers of outpatient visits, diagnostic procedures and therapeutic operations. With changes in clinical practice aimed to deliver patient-centred care, the one-stop clinic visits, and the increasingly complex operations being performed. It will be necessary to consider a more sophisticated method of specifying and monitoring what work should be delivered for what budgetary agreement.

Alternatively, the commissioning contract [using historical levels of resources and funding as a guide] could aim to provide funding for a Trust management team so they are responsible for delivering the clinical service within the totality of budget. The measure of success and productivity being determined by achievement of waiting list targets as opposed to delivering of units of activity. In this way each team would be encouraged to develop innovative ways of delivering high quality cost effective clinical care. This has been demonstrated in England where outcome/target based budget contracts allowed hospital chief executives to vire funds towards the areas that are most needed. It was this environment that produced some of the most worthwhile patient-centred service developments during the Action on Urology project.

F) Assess the specialist operating requirements within the region, including increased utilisation of technology, to ensure delivery of the full ranges of urology procedures

One area of urology that benefits from state of the art theatre technology is stone surgery. As each acute centre will have to deal with its own share of acute stone patients having the appropriate kit would ensure high quality clinical care for patients wherever they presented in Northern Ireland. Such kit would include both rigid and flexible uretero-renoscopes and suitable laser technology to break up impacted stones. The specialist technique of percutaneous nephrolithotomy is generally best performed where there is interventional radiology support.

Two other areas that are worth considering:-

Flexible cystoscopies – using video style flexible cystoscopes has the advantage that teaching trainees is much easier, it is possible to make recordings of the examination if needed and there is less strain on the surgeon's neck. This technology would be an appropriate addition to the outpatient diagnostic services.

Robotic surgery – Robot assisted laparoscopic radical prostatectomy [RALP] is becoming the standard of care for surgically curable prostate cancer patients. Conventional laparoscopic surgery is recognised as a challenging procedure to perform and has a long learning curve.

It was little used in USA but with the introduction of RALP this is now standard practice. In the UK we have been slower to develop the use of robotic surgery, but it is clear that each region in the UK will be expected to deliver on this type of surgery.

Most regions have seen an increase in cases of surgically curable prostate cancer due both to PSA testing and following the regular review of all cases at the regional MDT.

In addition to prostatectomy, most robotic centres are using the robot for laparoscopic nephron sparing surgery, and are developing on the Scandinavian and USA experience of robot assisted cystectomy.

Northern Ireland should assess the need for access for its population to robot assisted laparoscopic radical prostatectomy. Recent studies and guidance provides greater clarity on the position in regard to the benefits and cost effectiveness of robotic assisted prostatectomy. The potential for this to be provided locally should be considered. The benefits of such a local service would demonstrate how forward looking the region is and could well result in increasing the quality and number of applicants for consultant posts.

Some urological conditions and procedures are rare or seldom performed. In a region of 1.8 million it is likely that some procedures will not be suitable for the regions skill set. This may include some reconstructive procedures, and some prosthetic devices. Arrangements for such patients to be treated elsewhere would seem appropriate.

G) Review the service delivery to those acute hospitals sites which do not have an on-site urology team

The initial review recommended that arrangements should be in place to proactively manage and provide equitable care to those patients admitted under General Surgery in hospitals without Urology units. The only major acute hospital trusts which have no urological team based on site is Antrim Hospital Trust and SWAH.

The discussion with the general surgeons and the gynaecologists at Antrim clearly showed their need to have urological services based there. Currently the patient care may not be optimal despite acute support from the Causeway urology team and visits from the Belfast urology team.

It would make sense to consider the enhancement of the urology services based at Antrim Hospital. The work would inevitably be mainly acute urology and core urology and initially the operative facilities may be based only at Whiteabbey

Hospital, although in time it is likely sessions would become available at the Antrim site, when the mobile Theatres are provided on the site or earlier if possible [much as was the case when the general surgeon Arthur McMurry was there].

The advantage of such a development is that some of the core urology cases that currently go to BCH would be redirected to Antrim taking some of the pressure off the regions urology Cancer Centre.

In the current stocktake South West Acute Hospital was not visited.

H) Assess the increased demand for urology services, especially the growth in suspect cancer referrals – including the potential impact from implementation of `NICE guidance CG175' [Prostate cancer management].

As stated earlier, reviewing the data over the last 5 years for primary care referral rate, hospital outpatient waiting times and operative procedure waiting lists for the 5 trusts providing urology care the primary referral rate has risen by ~10% year on year with red flag referrals rising by 25% year on year.

The audit headed up by Chris Hagan has shown that red flag referrals do not represent all the suspected cancer cases as demonstrated by reviewing the eventual outcome of the investigations. A more helpful statistic is that about 50% of men who undergo prostate biopsy are found to have a prostate cancer.

The evidence from England [and the USA and Europe] is that the numbers of patients having a localised prostate cancer identified are increasing significantly. This is reflected in the numbers of patients undergoing radical surgery.

The NICE guidance CG175 is a wide ranging series of recommendations for all aspects of referral, investigation and treatment of all stages and complications of prostate cancer. This document offers an excellent blueprint against which the regional cancer audit can compare itself and be able to present at their Peer review in 2015.

Some specific areas that the Cancer group may wish to look at would include information and decision support for men with prostate cancer, their partners and their carers; the management of post radical prostatectomy sexual dysfunction and the investigation and management of hormone therapy induced osteoporosis.

Comments and Conclusions

Many of these points have been made earlier in this narrative.

This section aims to summarise some of these points and add some comments that might be helpful in devising better ways of delivering excellent cost-efficient patient-centred services and to provide opportunities for regional planning.

In discussions at the hospitals with the consultant urologists and the management it was clear that all groups are keen to deliver an excellent clinical service. Most groups describe common types of difficulties including

- insufficient theatre capacity,
- the challenges of shared responsibility for clinical care especially those patients admitted as an emergency;
- increasing referrals from primary care,
- significant difficulties in recruiting suitable candidates to consultant posts

In discussions with those clinicians with regional responsibilities it is clear there is an untapped real opportunity to use the annual regional audit meetings, the annual regional cancer review meeting, and the regional representative report meetings to create regional cohesion amongst the urology teams. Each of these meetings would offer an opportunity to share best practice amongst the teams, provide an occasion for the trainees to present their research or audit projects [possibly with a prize for the best one], and to review the data from the BAUS complex operations audit. It is common practice in many other regions to combine the regional representative meetings with an evening meal giving the chance for consultants and trainees to meet socially.

To generate ideas for suitable patient-centred audit the technique of process mapping a service can be helpful and the work done during the Action on Urology project in England might offer some guidance.[see this pdf with a summary of some of the projects:-]
http://www.qualitasconsortium.com/index.cfm/publications/service-transformation/action-on-guides/action-on-urology-good-practice-guide/

There seem to be significant challenges in delivering the three team arrangement that the 2009 Review recommended. From a clinical governance perspective the Eastern Team has encountered problems and the NW Team development seems to be dependant on a significant financial input that has not yet been agreed. It seems that this three team recommendation should be reconsidered. This would impact on any new on-call arrangements, but would return them to the pre-review on-call arrangements.

It is not possible to form a complete picture of the current arrangements of the consultants job plans as so many were deemed confidential and were not released to the team undertaking the stocktake . Access to job plan information should be a prerequisite if future funding is to be approved. However there are ways of improving service delivery by suitable adjustment of job plans that can

also deliver an improved working practice for the consultant. It is for the Hospital Trusts and the HSCB to review this possibility.

There is a strong recommendation in Transforming Your Care for the best use of technology to improve patient care. Ensuring each urology unit can offer best practice acute renal stone services seems essential.
Video flexible cystoscopes have advantages over the eye-to-lens variety. These instruments would help train specialist nurses who wish to develop these skills as well as junior urologists.

It would seem ideal that the regions specialist urology nurses are encouraged to meet to discuss clinical topics perhaps supported by the consultant urologists. Their membership of either BAUN or IAUN and attendance at the national meetings would seem desirable [contacting a past president of BAUN, Jerome Marley who works at Craigavon and the University of Ulster, might help develop this]. Ensuring that community based nurses can provide both continence catheter care including catheter changes can reduce the numbers of A&E attendances.

There is a detailed commentary within the narrative regarding robotic assisted prostatectomy. It is likely that the colo-rectal surgeons and the gynaecologists would also need to be trained on this equipment if the purchase of the robot was to be a viable option.

A regular observation from both the urological surgeons and the hospital managers was that they did not have sufficient theatre capacity for the use of the surgeons. This is clearly part of a much bigger audit as so many different surgical specialities are dependent on access to theatres with appropriate anaesthetic and theatre staff support.

Although recruitment of suitable candidates for the consultant urology posts has been challenging, a worthwhile addition to the skill set for the regions urologists would be the appointment of an academic urologist. Such an appointee would have the opportunity to initiate audit and research with the trainees and to contribute to the regional leadership. Initially this may have to be a senior lecturer but in due time a chair of urology would add enormously to the development of the urology services in Northern Ireland.

As a long term strategy, aiming to increase the numbers of Higher Surgical Trainees within the Northern Ireland training circuit could bring benefits for locally trained urologists keen to apply for consultant post in Northern Ireland.

A SWOT analysis of the stock-take and ideas for a strategic way forward for urology services in Northern Ireland.

1. **A SWOT analysis**

One strength of a stock-take such as this is that it allows a small team to visit the whole of the regions urology providers and ask about their perceived challenges and what their aims are for delivering an improved and modern urology service. Individual trusts can present their plans allowing the team to draw conclusions about how well the service is integrated regionally and where the different Trusts could share best practice.

Another strength is that the team can critically assess the current commissioning methods that generate the SBA in an attempt to see what role this plays in dealing with waiting times and waiting lists. This includes reviewing the various numerical data and to review the workforce and how it is distributed.

One weakness of this stock-take is that it looks at the urology services over only a short period of time. However we have tried to ensure the narrative is reviewed by all the Trusts to correct any factual errors before it is finally circulated, and the hope is a longer term audit for the Region to assess different Trusts performance will be seen as helpful.

Very few organisations as complex as a Health Care System are perfect requiring no improvements. This stock-take has tried to identify opportunities to improve urology services aimed at a patient-centred guideline unified service. Various ideas have been presented in the text and are summarised in the second half of this section dealing with ideas for a strategic way forward.

Any stock-take or visit to assess a teams work patterns and productivity will represent a potential threat and challenge to the autonomy of the group. However, this stock-take has looked both at the clinical services and at the commissioning methods as well as how Trust management and clinical leadership are working to deliver a patient centred urology service. This has been done to give an overall regional picture and under pins the ideas in the next section.

2. **Ideas for a strategic way forward for urology services in Northern Ireland**

Below are three points of view based on how the challenges of delivering a clinical service are perceived:-

From a patients' perspective the long waiting times for new and review outpatient visits, the waiting times for diagnostic and operative procedures and the current imbalance in regional acute urology services would seem to be a major concern. A longer term patient anxiety would be to have easy access to the local clinical outcomes of treatments and procedures and know they are

satisfactory and that the inevitable occasional complications or adverse outcomes are at least within an acceptable range.

To achieve this level of service needs a constant reassessment of how audited processes are performing, to regularly introduce better diagnostic processes and better clinical methods that can be studied for their efficacy, and to maintain a regularly updated clinical outcome and complications data base that can be presented collectively to a regional meeting.

From a public health perspective, commissioning clinical services needs to be based on a clear understanding of the needs of the patient population, the assessment of the different types of work that are being funded while giving the providers freedom to develop value for money methods of delivering the clinical service without diminishing the service below an acceptable level.

From a providers' point of view the clinicians should have the kit and the access to operating and outpatient time that is needed to efficiently deliver the work during their contracted time. The trust management have the challenge of balancing the hospital's resources by wise deployment and appropriate use of their workforce.

What has this stock-take identified and what ideas might be worth examining to improve the clinical service for patients?

1) The current commissioning method for creating the SBA has within it two consequences that may have influenced the build up of waiting lists and long waiting times. Firstly by defining specific numbers of out patient clinic consultations and specific numbers of operative procedures but without recognising the wide variability of both types of clinical work the current method is guilty of a one-size-fits-all method and gives no allowance for innovative ways of managing patient care.

    a. For example the one stop service where a patient with haematuria will have an initial consultation, an ultrasound scan, a flexible cystoscopy and then a 'follow up' consultation where all the results are discussed and a management plan decided all at the same visit represents much more than a single outpatient attendance.

    b. Similarly a cystoscopy and biopsy under general anaesthetic to exclude a bladder lesion does not compare to a 30 gram bladder tumour resection or a 100 gram prostate resection.

The second inherent consequence is shown by the perceived imbalance between the clinical work commissioned and the actual numbers of patients referred to be investigated and treated. The responsibility to deal with the excess clinical work devolves straight back to the commissioners whose solution is to attempt to commission more clinical work from a urology service which already states itself to be a fully employed workforce and maximally utilising hospital facilities. This seems to also have the potential unintended consequence of removing the

responsibility for the Trust team to look for imaginative cost effective new ways to deliver the service such as those that were developed in the Action on Urology project [see website given earlier]. Many of the smarter ways of working involved better use of specialist urology nurses including stable hormone controlled prostate cancer patient clinics, telephone follow up clinics and pre-investigation consenting clinics for example.

How might this apparent anomaly be address? One method is to provide a historically calculated budget but with the expectation that the Trust will use it imaginatively to achieve the best value for money for the total referral cohort– a sort of 'consume your own smoke' model. This is different from the current commissioning arrangement whereby delivery of SBA units of activity are used as the key measure of productivity.

2) To best engage the whole clinical team in looking proactively for better ways of delivering a clinical service the process mapping technique ['patient journey'] proved very effective during the Action on Urology project. This would only be possible regionally if a project manger was funded to support the different teams in their work. For example:-
    - Different ways of addressing the challenges of processing new referral patients, dealing with review of patients' results, appropriate review clinic protocols and better ways of maximising theatre usage would all be worthwhile areas to investigate.

3) As part of each consultant developing their appraisal portfolio in readiness for their annual appraisal and eventually their reaccreditation, involvement in regional audit meetings, regional cancer outcome meetings and involvement with education and training of BST and HST doctors as well as urology specialist nurses would all pay dividends. There is a responsibility for those clinicians with a regional role to organise worthwhile meetings and for the management to support the urologists attendance.

4) A necessary part of the annual appraisal is reassessing each consultants job plan. This works both for the management who ensure the contractual hours are used efficiently and for the consultant to ensure that the resources necessary for him or her to carry out the work are available. There are several ways of using this job planning review for the benefit of both parties.

5) The idea of negotiating an increase in HST places in NI has been mentioned as a way of training some home grown potential consultants to ensure efficient succession planning.

6) An acute hospital such as Antrim without any urological team based within the hospital is not consistent with the delivery of high quality acute urological care. Ideally Antrim should have its own self contained urology consultants. As there are 6 gynaecologists working there with an

interest in functional urology such an interest would be ideal for urologists appointed there.

7) Northern Ireland urology could look much more attractive to prospective consultant applicants if it shows itself to be innovative and using the most modern technology. This would be one reason to consider supporting the local provision of RALP. Clearly the robot could be used for radical prostatectomy but also the general surgeons and the gynaecologists are increasingly developing its use. However recent studies may suggest that robotic prostatectomy might be a cost-effective alternative to open prostatectomy, if more than 150 cases were treated each year.

8) It is likely that NI urology will not be able to provide all aspects of urological procedures. To what extent reconstructive and prosthesis surgical procedures will need to be exported will depend on how closely the different teams are able to collaborate.

9) Any new consultant appointment could usefully reflect the regions urology skill needs as well as the Trusts needs. A reconstructive surgeon, an academic appointment or a robotically trained urologist would all add significantly to the regions skill base.

10) The recruitment of a regional urology improvement management, on a fixed term basis, could support Trusts develop innovative ways of delivering patient care. This would involve process mapping and identifying new ways of working to improve patient care and productivity within existing resources.

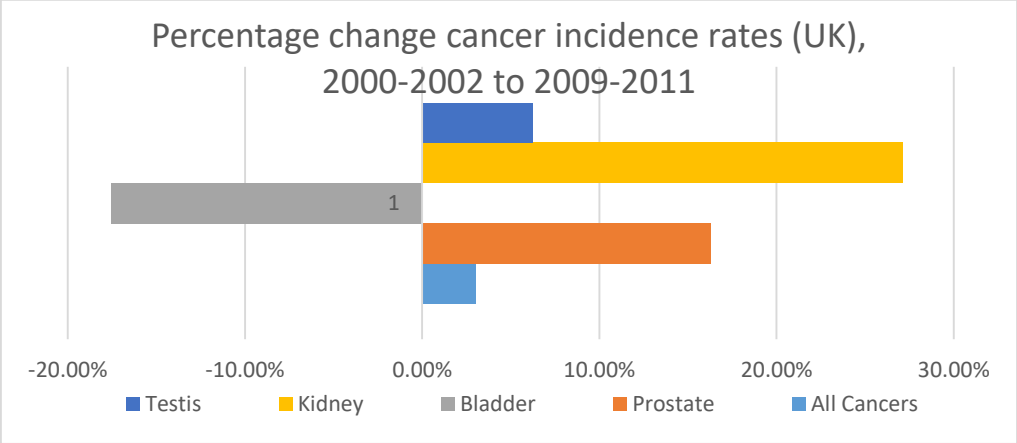
11) Finally, it seems paradoxical that a stock-take with a particular remit to look at operative procedures and waiting lists should find that hospital Trusts claim to have insufficient staffed operating theatre capacity to satisfy the needs of their surgical staff. Theatre usage will have peaks and troughs and some attempt is needed to average out demand to calculate what capacity is needed, however once the capital expenditure for an operating theatre has been paid the main expense is in staffing it. This could suggest that having over-capacity of theatre facilities would be at minimal cost when not in use, but allow immediate use of the facility when required.

The Vision for Urology Services
Southern Health and Social Care Trust

Background

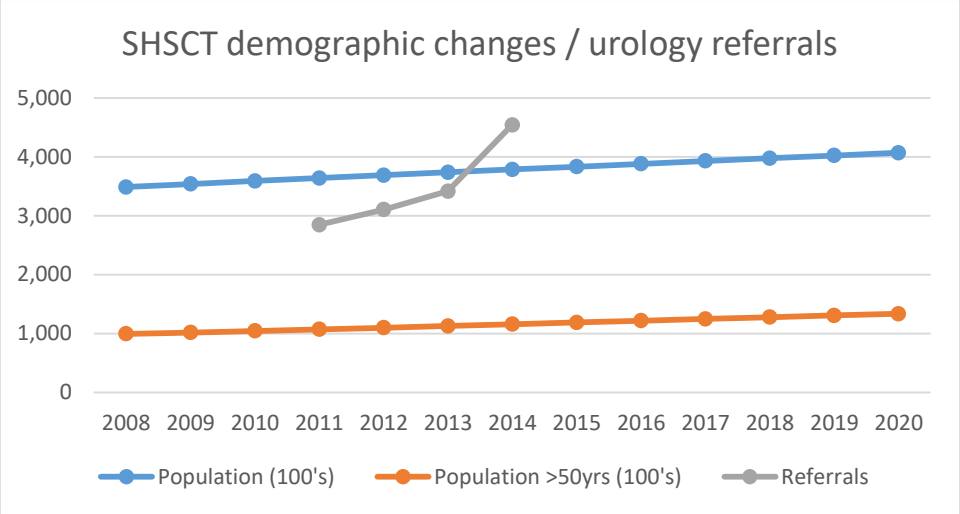
One of the biggest challenges facing the NHS is matching capacity to demand. Demand for secondary and tertiary healthcare services is rising faster than would be expected from population demographic change alone and is driven by a combination of this demographic change, increases in disease incidence, increases in available interventions, increased patient awareness and expectations and capacity constraints of primary care services.

Within urology the incidence rates of disease are rising. Published data is available regarding incidence rates of cancers. The table below shows percentage changes in incidence of the 20 most common cancer in the UK.



Corresponding figures for Northern Ireland are an increase in prostate cancer incidence of 39.9% (UK figure 16%), kidney cancer incidence of 31.4% (UK figure 27%), testes cancer incidence of 6.5% (UK figure 6.2%) and a reduction in bladder cancer incidence of 3.4% (UK figure -18%). These changes in incidence rate equate in increases in case numbers across Northern Ireland of 67.4%, 57.1%, 12.5% and 11.4% for prostate cancer, kidney cancer, bladder cancer and testes cancer respectively over the same time period. A similar pattern would be observed for benign disease but this incidence data is not as readily available as cancer incidence statistics.

Looking specifically at SHSCT, the graph below shows population demographics vs Urology outpatients referrals (nb the demographics information does not include Fermanagh which is part of the SHSCT Urology catchment). The incorporation of Fermanagh (65000 population, 17% rise in population served) into SHSCT urology catchment accounts for some of the big increase seen in 2014, prior to this year on year referral increases were at approximately 10% per year.



The result of this increasing demand for urological services in SHSCT and across the NI Healthcare system is that patients are waiting too long for their care. The SHSCT urology service received 4541 outpatient referrals between 1st July 2013 and 30th June 2014 while over the same time period 2557 of these new referrals were seen. Consultant numbers have now increased which has increased the available clinics to see new patients (to a maximum of 4100) but this does not meet demand or the expected 10% increase in demand in 2014-2015.

Additionally, in order to maximise theatre utilisation above the profiled 41 weeks, SHSCT urology has cross covered theatre lists such that the profile currently being utilised runs at 47 weeks and as a result dropped some outpatient activity. This has meant that while there were 2262 available new outpatient appointments based on a 41 week profile, 1935 were actually delivered (this is based on capacity delivered for the full year and does not include sessions delivered by members of the team who started or left during this 12 month period, 622 new outpatients were seen over this period by these additional members of the team).

For Inpatient / Day Case surgery an average of 140 hours of operating per month over the last twelve months has been listed for theatre within a capacity of 120 hours of operating per week. The result of this demand vs capacity mismatch is a growing waiting list across every aspect of our service, the current waiting lists are;

- New outpatients – 1586 (1250 > 9 weeks, 880 > 15 weeks)
- Follow-up outpatients – 3385 (longest waiter due OP review Feb 2011)
- Inpatient / day case surgery – 973 (115 > 52 weeks)
- Flexible cystoscopy – 185 (includes planned patients)
- Urodynamics – 117 (80 > 9weeks)

In light of this SHSCT urology has worked towards creating a vision for delivery of urological services which;

- Delivers a sustainable service.
- Is based on efficient models of care.
- Maximises available capacity.
- Maintains acceptable, equitable waiting times.
- Incorporates planning for delivery of increasing demand.
- Identifies what additional resource is required to deliver this service.
- Identifies risks which pose a threat to delivery of the vision.

Experience of previous attempts to tackle the demand vs capacity mismatch are that focus on one or two elements has resulted in short term improvement and subsequent return to the previous situation. We agreed therefore that in order to deliver this vision we would re-examine the entire urology service and redesign the entire process. For each aspect of the patient pathway we posed the question 'what can be done differently to reduce our consultant capacity requirement?'. The output from this can be split into three aspects, demand management, capacity planning and management and service delivery which will be discussed in further detail.

1. Demand management

This is a key element in delivering a sustainable service, with the focus being an increase in primary care investigation and management prior to referral into secondary care. To assess the possible impact of managing demand a sample of routine outpatient referrals were reviewed and from these, with expectations for primary care investigation and management prior to urological referral approximately 50% of these referrals could have been avoided. The overall impact of demand management would be expected to be less than 50% as this review did not include urgent or red flag referrals, also some of these patients that did not require referral at that point will require referral after completion of additional investigation / management in primary care. A suggested reasonable expectation for demand management would be a reduction in referrals of 20%.

Existing referral systems that are utilised within NI primary care have been explored. The central vision for referrals into secondary care is to move to all referrals occurring electronically via the CCG. This Gateway currently provides a standardised referral form providing key demographic information and with a free text section for clinical information. From a demand management perspective, key limitations of this gateway is an absence of any mandatory, condition specific requirements for referral with the 'gateway' acting effectively, as an open door; GPs can refer any patient to secondary care without any expectation placed upon them of initial management, investigation or provision of clinical information. A number of different demand management interventions have been utilised in other areas of the NHS. Many of these have been led by primary care and have resulted in an initial fall in referral numbers and this has been followed by a return to previous referral levels – referrals

have been delayed rather than prevented. In order to be successful and sustained we believe demand management systems require;

- To be led by Secondary care.
- Simple safe guidance for primary care management and investigation.
- Timely primary care access to necessary investigations (eg radiology).
- Mandated clinical information at referral specific to each condition.
- Effective policing of referrals and rejection of those that do not meet mandated requirements.

The ideal demand management process would therefore consist of comprehensive guidance for primary care investigation and management of urological conditions which is readily accessible, simple to use and written by the secondary care team. The referral itself needs to include specified mandatory information, specific to the condition being referred for. The referrals need to be reviewed against the mandated requirements and returned to the referrer if they do not meet the requirements. Alongside this there is a requirement for secondary care to provide primary care access to the diagnostic investigations specified in the guidance for primary care management and investigation and a need for access for advice from secondary care without generating a secondary care referral.

All of these requirements could be met by a comprehensive electronic referral process with dynamic forms which mandate provision of specific information and do not allow referral without provision of this information. Design of these forms could be such that they are simple to use (from a primary care perspective) and indeed could cover all specialities from an initial entry point (first question could be ‘what speciality do you wish to refer the patient to?’ which would then lead to subsequent speciality specific questions). Incorporation of secondary care guidance would enable this electronic referral process to categorise the urgency of the referral (e.g. those that meet red flag criteria would be automatically graded as red flag). Most importantly, without completion of all specified mandatory information the electronic form could automatically reject the referral.

These systems are used in other areas of the NHS and to a limited extent in specific conditions within NI (e.g. post-menopausal bleed clinic referral). Unfortunately we are advised that this ideal is a considerable distance from being available within the NI ‘gateway’. Presently referral via the electronic gateway stands at 26%, dynamic protocols are not currently developed within the software (required for dynamic forms).

Having explored the existing / available referral processes available in NI it is clear that presently we cannot move immediately to the ideal mechanism of mandated electronic referral for a number of reasons. Therefore, in order to commence a mechanism of demand management the process will need to be based upon primary care guidance and education, consultant review and triage of all referrals against the agreed primary care guidance and rejection of referrals which do not meet the specified referral criteria. Over time and with training we envisage that some of this work will be performed by clinical nurse specialists. This process will use

considerable consultant time and in order to maximise efficiency of consultant time we would envisage this as a 'stop gap' measure until a suitable electronic referral process is available.

2. Service delivery Model

The service delivery model was divided into elective and emergency care with a separate model of delivery for each. Across both models specific consideration is required with regards infrastructure and staffing requirements.

Elective

The Guys model of new patient outpatient service delivery model has been considered as the preferred model of initial secondary care contact for the patient. This model delivers outpatient care such that at the end of the single visit patients are either discharged back to primary care or listed for a urological intervention. The Guys model is delivered with a capacity of 18 patients seen in a session with medical staffing at 2 consultants and a trainee. In addition to the positive service aspects of this model it also had significant positive impact on training and supervision for the SPRs. It was agreed that this model should be pursued as a basic model of outpatient service delivery. The number of these sessions required will be guided by capacity requirements (see below). There needs to be agreement in planning the patient pathways on;

- Do all patients need to be seen in OP?
  Patients referred for a vasectomy can be placed directly on a waiting list rather than coming to an outpatient clinic first.
  Patients referred from the continence team can be listed directly for urodynamics.
- What will be done before the OP visit?
  Ideally all radiological investigations should be done and available at the time of the OP visit. Each referral pathway will require consideration of how appropriate investigation will be arranged.
- What will be done at the time of the OP visit?
  Ideally all investigations required to make a treatment decision will be performed at this OP visit. For each investigation have considered what will be needed to deliver this at the time of the OP visit (ie infrastructure, equipment, staff).
- Who will be followed up?
  Ideally patients will be either discharged or listed and so follow-up requirements will be minimal. Where follow-up is required does this need to be delivered by a consultant in person? Could it be delivered by a nurse in person or over the phone? Can it be delivered by letter? For example TRUS biopsy patients with cancer on biopsy need an in person follow-up with their pathology results but do patients with negative results? Published data from Guys suggests a follow-up rate of 30%.

Specific consideration of models of care and capacity planning needs to include the requirements of active surveillance TRUS biopsies of prostate (utilise radiology provision of TRUS for this group?), TCC surveillance (protocol guided, nurse delivered?), Urodynamics (direct access following continence team referral for female LUTS?) and the specific needs of the stone service which bridges acute and elective care (ESWL capacity and delivery, stent removal).

In order to deliver the demand there needs to be considerable expansion in delivery of aspects of care by non-consultant staff. Staff grade post recruitment is an issue across Northern Ireland and GPwSI models have been utilised but the experience of the Trust and wider NHS is that whilst they provide additional capacity when posts are filled, once a post is vacated they leave a gap in service delivery and recruitment to fill again is difficult. It was agreed that the delivery of care will be broadly based upon a consultant delivered service with SPR delivery (supervised) and CNS delivery of specific aspects.

In order to deliver a sustainable service there is recognition that the number of Clinical Nurse Specialists and scope of practice needs to increase above that which is currently provided. It is recognised that at inception the model will involve consultant delivery of aspects which over time, following likely recruitment and training will become CNS delivered. This training requirement will mean that at inception the capacity of the service will be reduced but this will increase as competencies are acquired. Some aspects of service will remain consultant delivered while others will be consultant led. Examples of these are below;

Consultant Delivered (provided by medical team)	Consultant Led (provided by CNS and medical staff as a team)
New OP appointments	Flexible cystoscopy
Inpatient / Daycase surgery	Urodynamics
Acute care	Intravesical treatments
	Follow-up OP appointments
	TRUS Biopsy of prostate

Specific deficiencies in the current patient pathway with regards fitness for surgery and assessment of holistic patients' needs were identified. These create specific issues in elective list planning, worsen the waiting list position with patients not fit for anaesthetic being on the waiting list and currently result in significant utilisation of consultant time. It was agreed that for elective surgery the waiting list should only include patients deemed fit for surgery. A model was agreed whereby patients listed for elective surgery will receive an initial pre-admission assessment at the time of their listing. This will include holistic needs assessment (care needs, notice requirements, transport issues, post procedure care requirements etc) in addition to an initial anaesthetic assessment. The anaesthetic assessment will identify two

groups of patient, those with no major comorbidity who are fit and able to be placed directly on the waiting list, and those who require further anaesthetic assessment and will only be placed on the waiting list when deemed fit for their planned elective surgery.

There is agreement to the creation of a pooled waiting list for common urological procedures. This would bring advantages in terms of capacity planning, delivery of equitable waiting times and off site operating (see below). It was accepted that individual patients may wish to 'opt out' of this but should be made aware that this will result in longer waiting times for their procedure and that across the team capacity for delivering procedures from this list will differ.

It was acknowledged that delivery of capacity for operating theatre centred care is a major challenge. On Craigavon Area Hospital site Inpatient theatre capacity is fixed and at a premium while the location of the day surgery unit, availability of day unit recovery beds and timing of the urology allocated sessions constrains what procedures can be delivered through day case theatres. Having calculated capacity requirements for theatres we have increased the available urology theatre sessions from 8 per week to 12 per week. This increase has been achieved with current infrastructure by extending the working day across 3 surgical specialities and anaesthetics / nursing. Theatre productivity will be addressed by working with theatres in order to maximise the efficiency of these sessions, specifically addressing turnaround times, start times and ensuring that the lists finish on time by identifying issues which directly impact on these factors (eg porter availability).

There was discussion around procedures which are currently delivered as inpatient care which could be delivered as day cases. In order to increase our scope of delivery of day unit procedures there is a requirement for infrastructure work on Craigavon Area Hospital site. An alternative that is being explored is delivery of day case urological surgery off site with Daisy Hill Hospital and South West Acute Hospital being identified as potential sites. All consultants would be happy to deliver certain procedures on these sites which would offer significant advantages to the service and bring care closer to home for patients requiring suitable procedures. There are specific requirements in order to deliver off site operating which include;

- Theatre equipment.
- Theatre and ward staff training.
- Junior doctor support both in and out of hours (although intended as day case procedures, a proportion of procedures may require subsequent overnight admission).
- Provision of consultant out of hours cover.

Non-Elective

Non elective care presents specific challenges due to variation in demand and a need for prompt access. Significant numbers of referrals for outpatients originate from accident and emergency attendances. A model of non-elective care was presented and agreed which is consultant delivered. This model would entail;

- Consultant led morning ward rounds Mon-Fri.
- Hot clinic – A&E referrals plus non-elective GP referrals which don't require inpatient admission. This will entail appropriate management and investigation of these patients with some seen in an outpatient setting and others managed remotely.
- Non-elective operating (regular 1 hour morning slot on the emergency theatre list).
- GP advice and triage of referrals (demand management).
- Consultant led afternoon ward rounds Mon-Fri (of patients who had investigations so as to review results and make further plans).

3. Capacity management

The Demand / Capacity calculations described below include a number of assumptions and estimates. As a result of these assumptions / estimates, although we are confident in the accuracy of the data presented, the projected capacity requirements / capacity delivery and backlog reduction may upon delivery of the service be wrong (are based upon an 80% upper confidence level therefore 20% risk of true referral numbers being higher than planned for, equally a risk of numbers being lower than planned for). Staffing numbers have been considered based upon what is required to deliver the service as described but in some cases will require recruitment and training before the full capacity can be delivered.

Demand / capacity for the urology service has been calculated based upon the preceeding 12 months demand information. Projected demand for outpatients activity has been based upon an anticipated impact of demand management of a 20% reduction in referrals alongside an expected 10% annual increase in referrals. The demand projections cover a 3 year period with capacity planned at the same level for all three years (based on current demand minus 20% (demand reduction), plus 10% each year for demand increases). This will allow for some backlog reduction during years one (backlog reduction of 17% of overall capacity) and year two (backlog reduction of 8% of overall capacity) with demand matching capacity in year three. All demand projections are based upon an upper confidence level of 80% (as recommended by the NHS institute). The demand calculations are therefore;

Current demand = 80% upper confidence limit of mean demand for April 2013 – March 2014

Projected demand Year 1 = current demand – 20% (demand management impact)

Projected demand Year 2 = Projected demand year 1 + 10%

Projected demand Year 3 = Projected demand year 2 + 10%

Capacity plan = Projected demand Year 3.

Where projected numbers of sessions are calculated, these are based on delivery over a 41 week profile. It is recognised that as the department has worked to cross cover annual leave in order to maximise inpatient theatre utilisation over the past 12

months (resulting in a 47 week profile of theatres covered) this had meant the cancellation of a number of other sessions, most of which have been outpatients activity. The net impact of this cross cover was a loss of 232 new outpatients appointment slots across the service over a 12 month period.

Regarding inpatient / daycase theatre capacity this is calculated in a similar manner however there is no element of demand management reducing required capacity (as it is anticipated that the same numbers of patients will be listed for surgery as at present). Average theatre times for procedures undertaken over the 12 month period from July 2013 – July 2014 were obtained from TMS with an addition of a turnaround time (time between anaesthetic finishing on one case to starting on the next case). These timings were then applied to all new additions to the waiting list over this period. The capacity calculations include an anticipated 10% increase in referrals each year with capacity being set at the same level for the 3 years to allow for some backlog reduction (21% of available capacity year 1, 10% of available capacity year 2). Additional backlog reduction is expected as a result of theatre productivity / efficiency work but this has not been factored into the capacity planning. Projected capacity requirements are calculated as;

Current demand = 80% upper confidence limit of mean demand for July 2013 – July 2014

Projected demand year 1 = Current demand

Projected demand year 2 = Projected demand year 1 + 10%

Projected demand Year 3 = Projected demand year 2 + 10%

Capacity plan = Projected demand Year 3.

New Referrals

The Data for April 2013 – March 2014 as described above is below. The capacity plan is therefore set at delivering 407 new outpatients slots per month. As described in the service delivery plan the majority of these will be seen in the new patient service modelled on the Guys clinic. A proportion will be managed via the Acute clinic by the consultant of the week. We have estimated this at 5 new referrals per day (25 per week, with the acute clinic running 50 weeks of the year as the only aspect of service running 5 days a week all year round with no service on bank holidays and weekends, resulting in 1250 being managed via this service per year). The New general outpatient clinic will therefore have an annual capacity requirement of 3634 patients per year. Based upon the guys model number of 18 appointments delivered by 2 consultants plus a trainee, modelled at 41 weeks this will require 202 of these clinics to be delivered over the year, equating to 5 clinics per week. This capacity will enable reduction in the current backlog of new referrals by 1291 patients over the first 2 years of delivery of the service.

New referrals 2013 - 2014	
April	410
May	379

June	395
July	426
August	360
September	442
October	459
November	438
December	395
January	380
February	443
March	345
Total referrals	**4872**
Monthly Mean	**406**
80% CI Upper limit	**420**
Projected Monthly Demand Year 1	**336**
Projected Monthly Demand Year 2	**370**
Projected Monthly Demand Year 3	**407**
Projected Backlog reduction (over 3 year period)	**1291**

Inpatient / Daycase Theatres

Theatre time calculations have been collated from twelve months data of waiting list additions and theatre data systems information on theatre case length (time from patient entering theatre to being in recovery), unfortunately information on turnarounds (time between patient being in recovery and next patient being in theatre) was not readily available and has been estimated at 10 min. The table below shows the monthly minutes of theatre listings over a twelve month period July 2013-2014 (including the 10 min turnaround). An additional analysis of cases that could be delivered in a daycase setting has also been performed which has demonstrated that expansion in current capacity for inpatient / daycase theatres is required for inpatient theatres with adequate current capacity within daycase theatres.

As discussed in the service plan, utilisation of offsite theatres is being explored. Theatre capacity will therefore be planned at 2101 hours per year which profiled over a 41 week period equates to 13 theatre lists per week. As discussed previously, work is already underway to enable delivery of this required theatre capacity in the near future. The calculations here do not include the increase in numbers of cases listed that would be expected as a result of the increase in new patient appointments delivered. It is anticipated that this increase in numbers of patients placed on the waiting list will be met to a significant degree by theatre productivity / efficiency work.

We have benchmarked our required operating minutes against theatre time requirements for a large NHS Foundation Trust in England which has been through a number of cycles of theatre productivity / efficiency work. If our theatre timings are brought level with these timings this will result in a further capacity of 6 hours theatre capacity per week (based upon current timings) which we anticipate will meet this

demand. However, it is noted that in order to get to the benchmark timings, the Benchmark Trust had been through 6 year period of multiple cycles of productivity and efficiency work and therefore there is significant risk that this productivity increase does not meet the demand increase and therefore backlog reduction is reduced. Given this significant risk, backlog reduction prediction figures have not been calculated.

	Total minutes operating listed
July	8614
Aug	8845
Sept	6792
Oct	10402
Nov	7998
Dec	7245
Jan	8145
Feb	8416
Mar	7537
Apr	8741
May	8070
June	8971
Total Minutes operating listed	**99776**
Monthly Mean Operating listed	**8315**
80% confidence upper limit	**8682**
Projected Monthly Demand Year 1	**8682**
Projected Monthly Demand Year 2	**9551**
Projected Monthly Demand Year 3	**10506**

Flexible cystoscopy

As part of the 'Guys model' of new outpatient consultations the haematuria and diagnostic / Lower Urinary Tract Symptoms (LUTS) assessment patients will undergo their flexible cystoscopy during their Outpatient attendance. Patients undergoing TCC surveilance flexible cystoscopies and flexible cystoscopy and removal of stent will continue to need this service otside of the 'Guys model'. Between 12 – 16 patients per month undergo a planned flexible cystoscopy (TCC surveilance). We have not got patient numbers for flexible cystoscopy and removal of stent. For planning if we assume that half of all emergency cases get a stent that requires removing (other half have stent and subsequent further procedure) and 2 elective cases per week, this will give an estimate of 16 procedures required each month. This would mean a service need of one flexible cystoscopy list per week. The elective flexible cystoscopy service is planned to be deliverred as a consultant led

service delivered by clinical nurse specialist and occuring alongside elective consultant outpatient activity.

TRUS biopsy of the prostate

As with the flexible cystoscopy service most will be provided at the time of the initial consultation. Long term it is anticipated that this will be provided by clinical nurse specialists within this clinic but this will require CNS training and recruitment. Some will not be suitable for providing through this clinic (patients on anticoagulation, active surveilance as specific examples). These will be provided within the capacity currently provided by radiology consultants. It has not been possible to obtain accurate data on these numbers and the demand / capacity for this service will require close monitoring and possible adjustment during the initial months of introduction of the service.

Urodynamics

This will not be provided as part of the 'Guys model' clinic due to time and space requirements. This investigation is planned to be a consultant led, CNS delivered service with specific consultant delivered sessions for complex clinical conditions (estimated 2 CNS delivered : 1 Consultant delivered). Our initial estimate is that we will require 3 sessions per week (9 patients). However, this is an estimate and the demand / capacity for this service will require close monitoring and adjustment during the initial period.

Extracorporeal shock wave lithotripsy (ESWL- Stones)

Based upon current demand 444 treatments are required per year. The year on year increase for this service is affected by both within Trust referrals and referrals from other NI trusts. We have not obtained information on the last 5 years listing numbers for this tretament in order to estimate the year on year demand increases and as such have not modeled this. We treated 276 patients in the last 12 months. The service will therefore need to deliver additional treatment sessions to meet this unmet demand. Additionally there is a requirement for capacity to utilise this treatment modality in the acute management of ureteric colic which is currently not available. We estimate that this service will require 3/4 sessions per week to deliver the required capacity running 50 weeks per year. Again, this is an estimate and the demand / capacity for this service will require close monitoring and adjustment during the initial period.

Follow-up appointments

Estimating future follow-up capacity is extremely complex and would be based upon large numbers of assumptions / estimates. Follow-up demand for 2013-2014 was 4994 appointments, additionally there would have been further demand if we had seen the patients currently awaiting new appointments. The change in service delivery as described will reduce demand for follow-up appointments. Additionally there is a large current backlog. We anticipate patients only attending outpatients where absolutely necessary. This will be achieved by the triage ensuring that all necessary investigations have been performed prior to the first outpatients

attendance. Where investigations are arranged, writing with results and if required telephone follow-up. Those patients who do need to attend for follow-up will be seen either by CNS or consultant. A significant proportion of this required follow-up will be consultant led and nurse delivered (in particular oncology follow-up), thus reducing the consultant time requirement to deliver the demand. We propose to provide available capacity to meet demand for the past 12 months and this capacity will be delivered in a consultant led service with approximately 50% of the capacity provided by the consultant and 50% provided by the CNS team. Ongoing capacity for follow-up will need close monitoring and adjustment once true demand within the new service is understood.

A separate plan is required for reduction of the follow-up backlog. We propose to manage this as a team working through the 3385 overdue follow-up appointments, initially by case review and discharge as appropriate and then by provision of additional capacity (outside of proposed service) which will require funding. We would be opposed to this work being outsourced to private providers as experience of this is that significant numbers are referred back for ongoing follow-up while our aim in reviewing this backlog is to achieve a very high discharge rate.

Staffing requirements

Staffing requirements in order to deliver the service to meet demand as illustrated have been calculated. In the Thorndale Unit (urology outpatients), in order to provide the services we will require expansion of the team of Clinic Nurse Specialists. There will need to be 4 members of this team 'on the ground' for each half day session plus support workers. In our current service significant amounts of CNS time are utilised managing the outpatients department. To free up this time we propose the creation of new outpatients administrative roles which will enable the clinical staff to spend more time delivering patient care. These staffing requirements are shown below, some of the gap is funded but currently unfilled;

Band	In Post (WTE)	Proposed (WTE)	Gap (WTE)
7	1.86	3.4	1.54
5/6	2.72	4.4	1.68
2/3	0.8	3.4	2.6
4 Admin Support	0	1	1
2 Admin Support	0	1	1

The CNS team is anticipated to provide opportunity for progression and development and as such we would anticipate that as the individuals acquire skills and educational requirements to deliver service at a higher band they will be afforded this opportunity in-house. Without this we would be a significant risk of providing training / development to members of staff who then leave the Trust to progress their careers. Funding and subsequent appointment to these posts is essential in order to deliver the service as described.

At consultant level numbers of PA's have been calculated based upon capacity requirements as above and the following hours calculations;

Session	Consultant Hours per session (including admin time)	Weekly sessions required	Weekly Hours	Weekly PA's
Theatres (Inpatient and daycase)	5	14	70	17.5
Outpatients clinics (New, FU, Off site)	5	17.6	88	22
Urodynamics	5	1	5	1.25
ESWL	1	4	4	1
Multidisciplinary team meetings (oncology and non oncology)	5	6	30	7.5
Acute care	4.75	12.2	57.9	14.5
Unpredictable out of hours work	4	6	24	6
Supporting Professional Activities	6	7	42	10.5
Total			320.9	80.25

In order to deliver the anticipated demand the service will therefore require funding for 7 consultants (11.4 PA's) in addition to the expansion in the outpatients nursing team. Without this we will not be able to meet projected demand as consultant capacity would be reduced.

Summary

We have reviewed the Urology service within Southern Health and Social Care Board and examined every aspect from the perspective of aiming to provide a sustainable service. We believe the plan as described will enable us to provide this while maximising the efficiency of utilisation of consultant time. In order to do this there is a need for expansion of the clinical nurse specialists within the team. This expansion will require training and funding, without this the service cannot be provided in a sustainable manner. However, even with this expansion and maximisal efficiency of consultant time there is no currently sufficient consultant time available to provide capacity for projected demand. Without providing this capacity we will also not be able to deliver any backlog reduction.

Demand reduction will be a major aspect of delivery of the service. This requires support in our engagement with primary care and in the principle of secondary care defining the criteria for referral and rejection of referral which have not followed agreed primary care investigation and management guidance. The currently available mechanisms for this process will require significant consultant input. The proposed electronic mechanism for this process would be preferable and reduce this consultant input but presently we believe this aspiration is some considerable time away.

Southern Health
and Social Care Trust

Quality Care - for you, with you

Chair
Roberta Brownlee

Chief Executive
Mairead McAlinden

Our Ref: MMcC/pc/ew

19 December 2014

Mrs V Watts
Chief Executive
Health & Social Care Board
12 – 22 Linenhall Street
BELFAST
BT2 8BS

Dear Valerie

ELECTIVE CARE – UNDERDELIVERY OF CORE CAPACITY VOLUMES

I refer to your letter dated 24 November 2014, and I very much appreciate the Boards decision in relation to our areas of underperformance. To provide you with assurance of the efforts being made by the Trust to reduce the risk of underperformance, I am providing the following detail at speciality level:

- **Colposcopy (New Out-Patient)**

  The SBA for Colposcopy was established through the HSCB SBA Modelling process. The SBA was and continues to be in excess of the demand for the service. The Trust had accepted this higher level of SBA in anticipation of the demand that was expected from the HPV Screening Programme. However, this demand has not yet materialised.

  As the Trust was not in a position to achieve SBA, due to insufficient demand, we undertook to reduce the waiting times in line with the Colposcopy Standards of 2-weeks for urgent referrals and 4-weeks for routine referrals.

Trust Headquarters, Craigavon Area Hospital site, 68 Lurgan Road, Portadown, Craigavon BT63 5QQ
Tel: Personal Information redacted by the USI Fax: Personal Information redacted by the USI Email: Personal Information redacted by the USI

This had been achieved and unfortunately due to Medical Staff Sick Leave the routine access time has increased to 5-weeks. However, the Trust anticipates that, based on the current service profile, the access time will return to 4-weeks in Quarter 4.

The Trust is currently engaging with the Southern LCG in respect of the recurrent Gynaecology capacity gap with a proposal under discussion for the transfer of capacity from Colposcopy out-patients to Gynaecology out-patients. If this proceeds the SBA will be rebased to a realistic level, however, the access times for Colposcopy will increase.

- **Gynaecology (In-Patient/Day Case)**

Underperformance in SBA during 2014/2015 continues to be affected by Medical Staff Maternity Leave; Medical Staff Sick Leave and Medical Staff absence. Performance against SBA at the end of Quarter 3 is estimated to be –8.5% with a further improvement estimated by the end of Quarter 4.

Whilst the Gynaecology IP/DC SBA is currently underperforming the Trust is undertaking in-depth analysis to understand the performance issues.

- **Urology (New Out-Patient and In-Patient/Day Case)**

New Out-Patient – Underperformance in SBA during 2014/2015 continues to be affected by Medical manpower issues, continuing on from 2013/2014 ie. loss of GPwSI due to ill-health and loss of 3 Middle Grade staff, which effectively lost the Specialty 25% of the total workforce. In light of the lost capacity the Trust has continued to focus on the red flag cancer pathway and the urgent patients as its clinical priority and with this focus a significant improvement in the 62-cancer pathway, for Urology patients, has been demonstrated.

The Trust has been working in partnership with the HSCB Director of Commissioning to develop a 'blue-sky' thinking model for Urology. Partial implementation of the new model has begun in December with a pilot of full implementation scheduled for January 2015.

If this proves to be effective the model will require discussion with HSCB regarding sustainability. On the basis of this model's implementation the Trust estimates that it will achieve a -13% SBA underperformance by the end of Quarter 4, which represents an improvement on the current position.

At 30 September 2014 SBA demonstrated underperformance of -20.59% (-407 NOP). Cumulative performance for October and November demonstrate -5.6% (-37 NOP). Therefore, the majority of the cumulative underperformance estimated by March 2015 is associated with Q1/2. **In-Patient/Day Case** – When reviewing the IP/DC SBA performance for Urology the Out-Patient Procedure activity requires to be counted as these procedures are included in the SBA baseline, which was established utilising the BAUS Guidelines.

Underperformance in SBA during 2014/2015 continues to be affected by the issues identified above.

Performance against SBA at the end of Quarter 3 (inclusive of OPP activity) is estimated to be -5.6% with a further improvement estimated by the end of Quarter 4, -4%.

It should be noted that as part of the 'blue sky' modelling process the Director of Commissioning has advised the Consultant Team that this implementation will take precedence over SBA performance.

- **Breast Surgery (In-Patient/Day Case)**

Whilst there are relatively small volumes in this specialty performance at the end of Quarter 2 demonstrates an underperformance of -4.5% this is an improved position on Quarter 1 of -7%. Performance against SBA at the end of Quarter 3 is estimated to be -2.5% (2 patients) and it is anticipated that this position will be sustained, if not improved, by the end of Quarter 4.

The Trust has engaged with the Southern LCG to consider rebasing of the Breast Surgery SBA to take account of the change in casemix ie. reconstruction. These discussions have not yet concluded.

- **Dermatology (New Out-Patient)**

Underperformance against SBA continues to be associated with Medical Staff maternity/adoption leave; sick leave; and Specialty Doctor vacancies. The lost medical staff capacity accounts for approximately 25% of the total medical staffing complement. The Dermatology situation has been discussed at length with HSCB and SLCG. Steps undertaken by the Trust to rectify the situation are as follows:

- Recruitment has been undertaken on at least 5 occasions for Locum Specialty Doctors – no success.
- Recruitment for a Locum Consultant – no success.
- Retired Consultant approached to undertake sessions – no success.
- In-patient beds closed and monies reconfigured to appoint a 3rd Consultant – offer made to successful candidate, however, candidate declined.
- Vacant monies have been utilised to secure a contract for activity within the Independent Sector. This activity is being counted against core SBA activity, however, due to the cost will only deliver a small volume.

Following the above actions the Trust then undertook to recruit GPwSI for Dermatology. This recruitment process was successful and the Trust has recruited 4 GPwSI, each undertaking a minimum of 2 sessions per week.

Compounding the underperformance against the new SBA for Dermatology was the clinical risk associated with the volume of patients who were in the out-patient review waiting list backlog. In order to reduce the clinical risk associated with these patients the Trust have approved the diversion of new patient capacity to increase review capacity, allowing the Dermatology team to focus on the review backlog.

Performance against the new out-patient SBA at the end of Quarter 3 is estimated to be -35%, with review out-patient SBA at -1%. Further improvement for the new out-patient SBA is estimated by the end of Quarter 4, -25% with the review out-patient SBA sustaining at -1%.

- **Orthopaedic (New Out-Patient)**

  2014/2015 has seen significant trauma pressures within the Trust. These have been two fold – one from increased trauma demand of our current catchment area with the second being associated with the partial retraction of BHSCT staff from their visiting service to the Newry & Mourne population.

  Therefore, to deal with this clinically urgent demand the Trust have had to cancel elective Orthopaedic out-patient clinics in order to redirect clinical capacity to the clinically urgent trauma demand.

  The Trust has sought funding from HSCB on a number of occasions to facilitate the re-provision of the elective orthopaedic activity. Confirmation of the out-patient funding has now been received on 11 December 2015.

  At the HSCB Elective Monitoring meeting on Friday, 7 November 2014 the Trust sought confirmation that it would not be financially penalised for the orthopaedic underperformance, as a consequence of the trauma demand. The Director of Performance confirmed that this impact was recognised and that it would be taken into consideration. As at 4 December 2014 the Trust has undertaken an additional 967 new out-patients within trauma. This volume is in excess of the level of underperformance within Orthopaedics of -322 representing an overperformance in the specialty of Trauma and Orthopaedics.

The Trust would request HSCB consideration of total SBA performance against the full range of specialties within In-Patients / Day Cases; New Out-Patients; and Diagnostics before a final decision is taken on the retraction of funding against those specialties listed above.

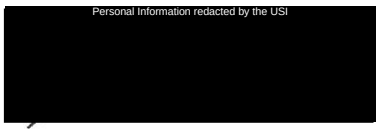
At 4 December 2014 the SBA position, as follows, shows an improved position across all elective areas on the total SBA.

Please note that this relates only to SHSCT elective activity and excludes Visiting Services from BHSCT and SEHSCT):

- In-patients -3.83% (-166)
- Day Cases -4.76% (-981)
- New Out-Patients -2.09% (-1150)

- Review Out-Patients -3.33% (-3166)
- Diagnostics (position at 31 October 2014, including Plain Film) +13.30% (18552)

Yours sincerely



MAIREAD McALINDEN
CHIEF EXECUTIVE

cc: Mrs P Clarke, Director of Performance & Reform – SHSCT
Mrs D Burns, Interim Director of Acute Services – SHSCT
Mrs L Leeman, Assistant Director Performance Improvement - SHSCT
Mr D Sullivan, Director of Commissioning – HSCB
Mr M Bloomfield, Director of Performance & Corporate Services – HSCB
Mrs L Donnelly, Commissioning Lead – Southern LCG

National Peer Review Programme

NHS England

Manual for Cancer Services
Urology Measures
Version 1.0

VERSION CONTROL SHEET

Date	Version	Changes	Update by
Jan 2014	1.0	Initial version	Julia Hill
Mar 2014	1.1	p14 for bladder cancer - remove asterix after neo-adjuvant chemotherapy	Julia Hill

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Section 2 – Clinical Indicators / Lines of Enquiry
TBA

National Cancer Peer Review and The Manual for Cancer Services

1 Introduction

The National Cancer Peer Review Programme provides important information about the quality of clinical teams and a national benchmark of cancer services across the country. It aims to improve care for people with cancer and their families by:

- ensuring services are as safe as possible;
- improving the quality and effectiveness of care;
- improving the patient and carer experience;
- undertaking independent, fair reviews of services;
- providing development and learning for all involved;
- encouraging the dissemination of good practice.

The benefits of peer review have been found to include the following:

- provision of disease specific information across the country together with information about individual teams which has been externally validated;
- provision of a catalyst for change and service improvement;
- identification and resolution of immediate risks to patients and/or staff;
- engagement of a substantial number of front line clinicians in reviews;
- rapid sharing of learning between clinicians, as well as a better understanding of the key recommendations in the NICE guidance.

The Manual for Cancer Services is an integral part of Improving Outcomes: A Strategy for Cancer and aligns with the aims of the Coalition Government: to deliver health outcomes that are among the best in the world. The Manual supports the National Cancer Peer Review quality assurance programme for cancer services and enables quality improvement both in terms of clinical and patient outcomes. The Manual includes national quality measures for site specific cancer services together with cross cutting services such as chemotherapy and radiotherapy.

The Report of Mid Staffordshire NHS Foundation Trust Public Inquiry (Robert Francis Jan 2013) said the creation of a caring culture would be greatly assisted if all those involved in the provision of healthcare are prepared to learn lessons from others and to offer up their own practices for peer review. Whilst peer review will have a specific relevance in cases of practitioners where there may be concerns about substandard performance, it has a far more fundamental role in changing behaviour to ensure a consistent and caring culture throughout the healthcare services. Peer review therefore needs to be a key part of the delivery and monitoring of any service or activity, and those involved need to demonstrate that this element of monitoring and learning is integral to the process of compliance with fundamental standards and of improvement. Among the recommendations made is recommendation 49, Enhancement of monitoring and the importance of inspection, which states;
Routine and risk-related monitoring, as opposed to acceptance of self-declarations of compliance, is essential.
The Care Quality Commission should consider its monitoring in relation to the value to be obtained from:

- The Quality and Risk Profile;
- Quality Accounts;
- Reports from Local Healthwatch;
- New or existing peer review schemes;
- Themed inspections.

1.1 National Cancer Measures

The development of cancer measures is a dynamic process in order to:

- reflect new NICE Quality Standards and clinical guidelines and revisions to existing NICE guidance;
- allow greater influence by users of cancer services and their carers;
- allow greater influence by clinicians;
- take account of possible modifications to measures following peer review visits;
- ensure the scope of measures encompasses the broader implementation of the Improving Outcomes: A Strategy for Cancer;
- reflect new developments and initiatives in treatment and patient care;
- reflect the NHS Commissioning Board specialised service specifications.

1.2 Clinical Indicators/ Outcomes

Peer review is changing its emphasis to focus on both clinical and patient outcomes. In order to achieve this, clinical indicators have been introduced and form part of the review process along with a reduced number of structure and process measures.

2 Interpretation of the National Manual for Cancer Services

2.1 Guidance Compared to Cancer Measures

National guidance is exactly what it says – guidance in general and indeed is excellent for this purpose. Guidance involves giving advice and recommendations on how things should be done now, in the future and sometimes on how things should have been done for sometime already. It may involve describing in effect the “perfect” service, using phrases like “the best possible”, “to all patients at all times”, etc. It may involve all-inclusive, far-ranging objectives and aspirations involving many agencies in long, interlinked chains of events and tasks which all have to be fulfilled before the desired outcome of the guidance is achieved. A particular person’s accountability for each task is often not stated. Without this underlying type of mind-set guidance would not inspire, lead, motivate or guide and would probably be almost unreadable.

The Manual for Cancer Services has to take a different approach. It is written for the specific purpose of being used to assess a service; to aid self assessment and team development; to be fair compared to visits to other services elsewhere and to past and future visits to the same service. Therefore, the measures have to:

- be objective
- be measurable
- be specific, clear and unambiguous
- be verifiable
- state who exactly is responsible for what
- be discriminating
- be achievable
- be developmental – encourage continuous quality improvement and not produce destructive competition or a sense of failure.

2.2 “The Responsibility for Assessment Purposes”

This refers to the fact that someone, or some group, is always held nominally responsible for compliance with each one of the quality measures. This has to be specified or, in terms of organising the peer review and collecting the results, it would be unclear who was being held as compliant or non-compliant or who the results could be attributed to. Where it is unclear who has responsibility there tends to be inertia. This attribution of responsibility does not necessarily commit a given person to actually carrying out a given task

– this can be delegated according to local discretion, unless it is clear that a given task really is limited to a certain group.

2.3 "Agreement"

Where agreement to guidelines, policies etc. is required, this should be stated clearly on the cover sheet of the three key documents including date and version. Similarly, evidence of guidelines, policies etc. requires written evidence unless otherwise specified. The agreement by a person representing a group or team (chair or lead etc.) implies that their agreement is not personal but that they are representing the consensus opinion of that group.

2.4 Confirmation of Compliance

Compliance against certain measures will be the subject of spot checks or further enquiries by peer reviewers when a peer review visit is undertaken. When self assessing against these measures a statement of confirmation of compliance contained within the relevant key evidence document will be sufficient.

2.5 "Quality" Aspects of Cancer Service Delivery

The peer review process recognises the qualitative as well as quantitative aspects of review and in addition to the objective recording of compliance against the measures there is a narrative part to the report that provides an overall summary of a team's performance.

Manual for Cancer Services On-line

An on-line version of the Manual for Cancer Services has been developed. The on-line version allows individuals to identify and extract measures by tumour site, organisation type and subject area in a variety of formats.

The on-line manual can be accessed from the CQuINS web site at http://www.cquins.nhs.uk

UROLOGY SPECIFIC MEASURES

Introduction

The NICE Improving Outcomes Guidance (IOG) for urological cancers outlines a network-wide structure of different MDT types, with instructions on how these teams should relate to each other. For some treatments, the guidance will result in referral of cases between individual networks, and the establishment of supranetwork teams. The specific configuration of teams in a given network may take different forms depending on catchment population of the network. The recommended minimum catchment population for teams delivering the specialist urology care defined below is one million. The minimum catchment population for the specialist treatment of testicular cancer is two million and of penile cancer, four million. These latter two areas of the service are described in the measures as supranetwork care, delivered by supranetwork teams, even though the teams may not, in all cases, deal with more than one network. The size of the catchment populations is estimated to provide at least a minimum viable case number for the respective teams involved. There is also a requirement for a specialist team to carry out a combined total of at least 50 radical prostatectomies and/or total cystectomies per year and an immediate requirement for surgeons performing five or less radical prostatectomies or five or less cystectomies per year to cease (the 'rule of five').

Implications of the IOG Urology Guidance

There are different levels of care; local care, specialist care and supranetwork care.
They are intended to be provided by different types of MDT; local, specialist and supranetwork, with provisions which are outlined below. The different types of teams are characterised by certain criteria and qualifications, also outlined below.

Shape of the Service

(See also, Appendix—Ground Rules for Networking)

1. Local Urology Team

Local urological teams provide local care for their own catchment, referring patients to specialist urology teams for specialist care and to supranetwork teams for certain aspects of care for testicular and penile cancer. Some treatments for penile cancer and testicular cancer may be given by specialist teams with no supranetwork responsibility but all patients with these cancers should be discussed with the supranetwork team.
One important principle underlying the NICE IOG for urological cancers is the principle of the consolidation of services for relatively infrequent procedures. It follows on from this that there should not be more than one local urology team for its cancer site on or covering a given hospital site.

2. Specialist Urology Team

Specialist urological teams provide specialist care for their referring catchment.The principle of consolidation of services requires that there should not be more than one specialist team for its cancer site on or covering a given hospital site or for its specialist referral catchment area.

In order that specialist teams experience the full range of practice for the relevant urological cancers they are required to function as the local urology team for their cancer site, offering local care to their local secondary catchment population.

Another important principle underlying the NICE IOG is the principle of ensuring that the MDT method

of working adds its full potential value to patient care. This requires that for radical surgical aspects of specialist care, the surgical operations and immediate post-op care should all be carried out in the same host hospital of the team.

3. Supranetwork Testicular Team

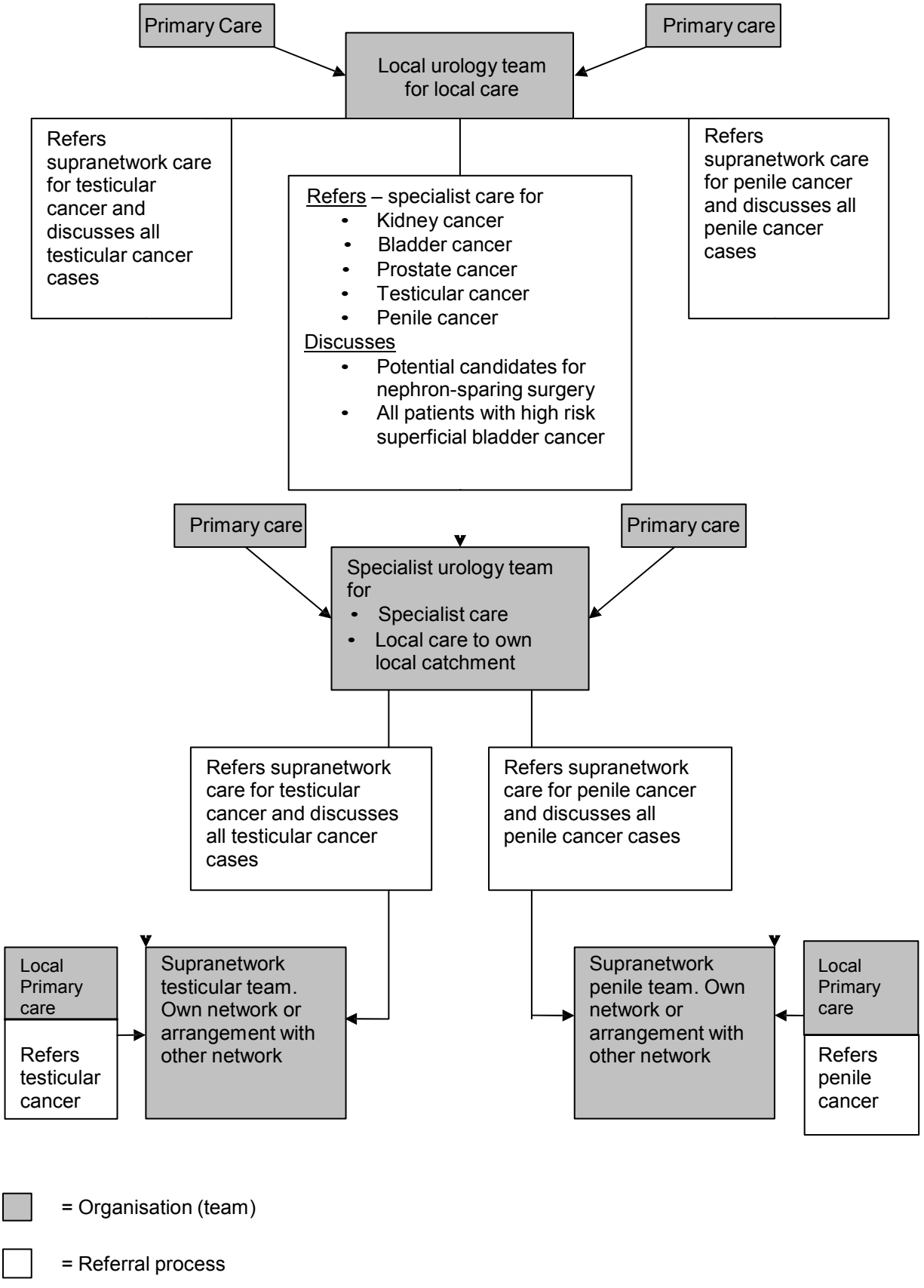
Supranetwork teams for testicular cancer deliver supranetwork care for their referring catchment. In order that supranetwork teams for testicular cancer experience the full range of practice for the disease, they are required to act as the local/specialist MDT, delivering all of the care including local and specialist care for testicular cancer for their own, secondary catchment population.

For testicular teams to add their full potential value to patient care, some surgical procedures and their immediate post-op care are required to be restricted to certain named hospitals.

4. Supranetwork Penile Cancer Team

Supranetwork teams for penile cancer deliver supranetwork care to their referring catchment which should be a minimum of four million. For supranetwork penile cancer teams to experience the full range of practice for the disease, they are required to act as the local/specialist team, delivering all of the care, including local and specialist care, for penile cancer to their own, secondary catchment population. For the team to add their full potential value to patient care, the supranetwork surgical procedures and their immediate post-op care are required to be restricted to certain named hospitals.

Team Relationships in Network Configuration



The team criteria for the network configuration

Local Urology team

- Should not be more than one in any one hospital.

Specialist Urology team

- Should not be more than one in any one hospital.
- Should be the only specialist team for its cancer site for its specialist catchment area
- Should act as the local urology team for its own local secondary catchment population as well as being a specialist team.
- Should have at least one million total catchment population, for specialist care and perform the 50 minimum combined total procedures. (It is estimated that this population will produce well over the 50 minimum combined total for prostatectomies and/or cystectomies.)

Supranetwork team for testicular cancer

- Should not be more than one in any one hospital.
- Should be the only supranetwork team for its cancer site in its supranetwork referral catchment area.
- Should act as the team responsible for all care of testicular cancer for its own secondary catchment population, as well as delivering supranetwork care.
- Should have at least two million total catchment population for supranetwork care.

Supranetwork team for penile cancer

- Should not be more than one in any one hospital.
- Should be the only supranetwork team for its cancer site in its supranetwork referral catchment area.
- Should act as the team responsible for all care for penile cancer for its own secondary catchment population as well as delivering supranetwork care.
- Should have at least four million total catchment population for supranetwork care.

Local Care

Provided it is agreed in the network guidelines, the procedures and treatments classed as local care may be delivered under the care of members of the local urology team. They should also be delivered by a specialist/supranetwork team for their own, secondary - i.e. "local" catchment population. They may also be delivered by the specialist urology team on behalf of referring local teams, with agreement in network guidelines.

The procedures and treatments classed in these measures as local care are:

For kidney cancer:

- The diagnostic process.
- Imaging for tumour extent.
- Nephrectomy, excluding the cases outlined below under "specialist care".
- Palliative chemotherapy and radiotherapy.
- Nephro-ureterectomy.

For bladder cancer:

- The diagnostic process.
- Trans-urethral resection (TUR):
  - For the diagnosis of newly presenting patients with suspected bladder cancer and determining tumour grade and invasion depth.
  - As treatment for those initial cancers found to be low risk superficial i.e. pTa (G1 or G2); T1 (G1or G2).
  - As a follow up procedure for low risk recurrent superficial cancers.

Note:
For high risk superficial bladder cancer: - pTa (G3); T1 (G3); extensive G2; multifocal G2; recurrent G2; and carcinoma insitu - the respective roles of the local team and the relevant specialist team in the ongoing management should be explicitly defined in the agreed network pathways.
The definition of high risk superficial bladder cancer is taken from IOG. It is acknowledged that histological grading of bladder cancer is liable to subjective interpretation and observer variation.

- Intravesical therapy for superficial bladder cancer.
- Palliative chemotherapy and radiotherapy.

For prostate cancer:

- The diagnostic process.
- Active monitoring.
- Orchidectomy.
- Medical hormone therapy.
- Palliative chemotherapy and radiotherapy.

For testicular cancer and penile cancer, see special sections below.

Specialist Care

This should only be delivered under the care of members of the specialist urology team and this is not subject to change by the network's own pathways. There are two categories of specialist procedures:

(i) Procedures which, in addition to being under the care of specialist core team members, should only be carried out in the host hospital of the specialist team:

For kidney cancer

- Resection of primary tumours which have or are suspected to have invaded renal vein, vena cava or heart.
- Resection of metastatic disease.
- Resection of both primary and associated metastatic disease.
- Resection of bilateral primaries.
- Resection of any primary where it is predicted that the patient will subsequently require dialysis.
- Surgical management of patients with von Hippel-Lindau disease or hereditary papillary tumours.
- Resection of urothelial cancers of the upper urology tract.
- Resection by nephron-sparing surgery.
- Resection of non-renal cell kidney cancer, excluding transitional cell carcinoma of the kidney, treated by nephro-ureterectomy.

For bladder cancer
(For the management of high risk superficial cancer see note above)

- Radical surgery (cystectomy).
- Bladder reconstruction.
- Surgery for urinary diversion.
- Resection of urethral cancer.
- Resection of squamous or adenocarcinoma.
- Partial cystectomy (indicated only for adenocarcinoma in the dome of the bladder).

For prostate cancer

- Radical prostatectomy.

For testicular & penile cancer, see special sections below

(ii) Procedures and treatments which should be delivered under the care of specialist team core members, but the site of delivery is determined by agreement in the network's guidelines.

For kidney cancer

- Adjuvant chemotherapy.
- Biological therapy.
- Non-surgical management of non-renal cell kidney cancer.

For bladder cancer

- Radical external beam radiotherapy.
- Adjuvant chemotherapy.
- Neo-adjuvant radiotherapy.*
- Neo-adjuvant chemotherapy.

* Recommended only as part of the clinical trial.

For prostate cancer

- Radical external beam radiotherapy.
- Radical brachytherapy. This is only available in a few networks. Many patients will need referring outside their own network for this therapy.

Supranetwork Care

Testicular cancer

Referral for treatment to another team

Note:Guidelines/pathways on this and on MDT discussion below should be circulated to all urologists in the network not just those who are members of urological cancer MDTs.

Patients being referred for treatment to specialist or supranetwork teams, as outlined below, should be made known to the receiving team within 24-hours of orchidectomy. 'High risk' patients (which should be precisely defined in the network guidelines) should be referred and made known to the supranetwork team pre-operatively, as soon as possible after diagnosis.

MDT Discussion

All cases of testicular cancer should have their case notes presented to and discussed at the next team meeting of the relevant supranetwork testicular team following their diagnosis. This discussion should not delay their management, however.

Local Care

This consists of:

- Diagnosis of all cases and
- Orchidectomy for non-high risk patients

It may be performed under the care of any urologist, not just those who are members of urological cancer MDTs.

Specialist care

This should be defined and agreed by each network as follows:

Patient pathways should be agreed by each urological network group in consultation with their relevant supranetwork testicular cancer team (which for some networks will be in another network). The pathways should determine:

- Regarding radiotherapy for seminoma; which categories of patients may be given radiotherapy under the care of one of a list of agreed specialist teams in the network and which categories of patients should be treated only by the supranetwork team.
- The agreed list of named specialist teams, referred to in the paragraph above.
- Regarding chemotherapy for germ cell cancer; an agreed list of named specialist teams in the network which may treat stage I and 'good prognosis' metastatic cases.
- The specific parameters which define 'good prognosis' as referred to in the paragraph above.

*The network may agree that certain of the treatments outlined above **should not** be delivered by specialist teams for their particular network but should only be delivered by the supranetwork team. Also, the 'specialist care' outlined above, may be given by the supranetwork team if agreed and desired by the patient and relevant consultants.*

Supranetwork care

This should only be given by the relevant supranetwork testicular cancer team and consists of:

- Orchidectomy on high risk patients referred pre-operatively.
- Surgical resection of post-chemotherapy residual masses. (It may be considered appropriate for only a small number of supranetwork teams to offer this in the country).
- Treatment of all post radiotherapy and post chemotherapy recurrences. (Treatment of first recurrences occurring during surveillance should follow the network's agreed guidelines as for newly diagnosed cases, depending on parameters of disease stage and type.)
- All other treatment by any modality, excluding local care and the network's particular arrangements for specialist care.

Surveillance

This is not a form of treatment and is dealt with separately, for clarity. The network urological cancer site-specific group should agree, as part of their referral guidelines, in consultation with the relevant supranetwork testicular team, a list of named specialist teams who may carry out surveillance and for which specific categories of patients. Otherwise it should be carried out by the supranetwork team. The network may agree that surveillance **should only** be carried out by the supranetwork team. Also, surveillance which might otherwise be carried out by an agreed specialist team, may be undertaken by the supranetwork team if desired and agreed by the patient and relevant consultants.

Penile cancer

All penile cancer cases should be discussed with the supranetwork team prior to proposed treatment if not referred directly to that team.

Local care

i) The diagnostic process only.

Local care should be carried out by local teams for their catchment. It should also be carried out by specialist teams and supranetwork teams for their secondary catchment population.

Specialist care

(i) Resection (except in cases needing penile reconstruction or lymph node resection). All resections should be carried out in the host hospital of the team.
(ii) Radiotherapy and chemotherapy. The site(s) where this is carried out should be agreed in the network guideli~~nes~~s.

Specialist care may be delivered by:

- A specialist urological team without a supranetwork interest in penile cancer provided this is agreed in the network guidelines and with the relevant supranetwork team. It should not be delivered by local urological teams.
- A supranetwork team for referring specialist teams provided this is agreed in the network guidelines.
- The supranetwork team for their secondary catchment population.

Supranetwork

Resection in cases needing penile reconstruction or lymph node resection. All resections should be carried out in one of the hospitals named as part of the facilities of the host locality. All such operations should be carried out in the same hospital.

Supranetwork care should be delivered by the *supranetwork team only.* This is not subject to alteration by the network pathways.

Network Group Measures

Introduction
The responsibility for review purposes for the measures dealing with the functions of the network group lies with the chair of the network group.

Key Theme

Structure and Function

Objective
Patients have access to appropriate care supported by best practice guidance.

Measure	Notes	Evidence
14-1C-101g Network Configuration		
The Local Urology MDTs should be named, with their host hospitals and trusts and the named practices that refer to them. (1, 2) The Specialist and Supranetwork MDTs should be named with their host hospitals /trusts and their catchment populations which should be a minimum of one million for specialist teams, two million for testicular cancer teams and four million for penile cancer teams. (3,4) The relationship of the MDTs to their catchments and their hospitals should comply with the team criteria in the 'Shape of the Service' section of the introduction to the urology peer review measures. The specialist teams providing radiotherapy for seminoma patients according to specified categories should be named. (5) The specialist teams providing chemotherapy for stage 1 and 'good prognosis' metastatic germ cell. (5) The specialist teams who may treat penile cancer with surgery without penile reconstruction or lymph node resection should be named. (4) The specialist teams and the sites at which radiotherapy and chemotherapy for penile cancer may be delivered should be named. (4) A single network group should be named for the urology network under review, with its associated urology MDTs. The relationship between the network group with its associated MDTs should comply with the peer review ground rules for networking: (5) • the network group should be the only such network group for the MDTs which are associated with it; • the network group should be associated with more than one MDT. (6)	*(1) This includes specialist teams acting in their capacity as local teams for their own local (secondary) catchment population.* *(2) The principles of a given primary care practice stating that patients will be referred to a given MDT is not intended to restrict patient or GP choice. A rational network of local and specialist MDTs can only be developed if i) there is an agreement on which MDT the patients will normally be referred to and ii) the resulting referral catchment populations are counted once, for planning purposes. It is accepted that individual patients will on occasion be referred to different teams, depending on specific circumstances.* *(3) The population should be estimated in each case from the catchment populations from their referring local teams and their own local population which they serve.* *(4) The list of specialist teams need not include all teams in the network.* *(5) A full version of the ground rules for networking, for all types of MDT, network groups and also cross cutting*	

All the above arrangements, which constitute the configuration of the urology cancer clinical network, should be agreed by the director of the relevant area teams.	*service groups can be found in Appendix 1.* *(6) For cancer sites where there is a division into more than one level of MDT, i.e. into local and specialist/supranetwork MDTs, the network group need only be associated with one specialist/supranetwork MDT as long as it is associated with more than one MDT for the cancer site overall.* *The relevant parts of the ground rules for network groups should be fulfilled for each separate cancer site in measures covering a group of sites, such as for urology.*	
14-1C-102g **Network Group Membership**		
There should be a single network group, having the following membership: (1) • a core member from each of the associated MDTs; • a urology nurse specialist; • a urology surgeon; • representation covering both clinical and medical oncology; • a radiologist; • a histopathologist; • two user representatives; (2) • there should be a named chair who should be a core member of one of the associated MDTs; • one of the NHS employed members of the network group should be nominated as having specific responsibility for users' issues and information for patients and carers; • a member of the network group nominated as responsible for ensuring that recruitment into clinical trials and other well designed studies is integrated into the function of the network group; • named secretarial/administrative support. There should be terms of reference agreed for the network group which include: (3) • the provision of clinical opinion on issues relating to urology cancer for the network; • the development of patient pathways and clinical guidelines; • the co-ordination and consistency across the network for cancer policy, practice guidelines, audit, research and service development; • consulting with the relevant 'cross cutting' network groups where applicable.	*(1) There may be additional agreed members and attendance at an individual meeting need not be limited to the agreed members.* *Any one individual may fulfil more than one of the roles on the list, compatible with their discipline and status.* *(2) If there are no user representatives, there should be an agreed mechanism for obtaining user advice.* *(3) There may be additional points in the agreed terms of reference.*	Constitution. Annual Report including meeting attendance spread sheet. The spread sheet should include names, roles and MDT represented.

14-1C-103g	Network Group Meetings		
The network group should meet regularly and record attendance.		*The attendance of MDT representatives is reviewed as part of the MDT measures.*	Constitution. Annual Report including meeting attendance spread sheet.

14-1C-104g	Work Programme and Annual Report		
The network group should produce an annual work programme in discussion with the strategic clinical network (SCN) and agreed with the medical director of the relevant area team. It should include details of any planned service developments and should specify the personnel responsible and the timescales for implementation. The network group should have produced an annual report for the SCN and relevant area team.			Work Programme. Annual Report including details of any service development.

Key Theme

Co-ordination of Care / Patient Pathways

Objective

All patients receive agreed treatment that is consistent and equitable.

Measure		Notes	Evidence
14-1C-105g	**Clinical Guidelines for Kidney Cancer**		
The network group should produce clinical guidelines for kidney cancer (i.e. how a given patient should be clinically managed) The guidelines should include the following: • protocols for diagnosis and assessment of primary and recurrent disease, including specific indications for CT, MRI and biopsy; • the parameters of disease stage and patient fitness, which determine when each of the treatments and procedures classified as local, and specialist care, in the introduction, are indicated; • the parameters which determine which patients are potential candidates for nephron sparing surgery and resection of primary and metastases.		*Chemotherapy treatment algorithms are dealt with in a separate measure in this section, below. Radiotherapy treatment techniques are dealt with in the Radiotherapy measures.* *Where there are nationally agreed requirements for clinical guidelines it is recommended that these are adopted.*	Clinical Guidelines.
14-1C-106g	**Clinical Guidelines for Bladder Cancer**		
The network group should produce clinical guidelines for bladder cancer (i.e. how a given patient should be clinically managed) The guidelines should include the following: • protocols for diagnosis and assessment of primary and recurrent disease including indications, agreed with a network representative from primary care, for GP referral to the designated haematuria clinic (see topic 2G); • the parameters of disease stage and patient		*Chemotherapy treatment algorithms are dealt with in a separate measure in this section, below. Radiotherapy treatment techniques are dealt with in the Radiotherapy measures.* *Where there are nationally agreed requirements for clinical guidelines it is*	Clinical Guidelines.

fitness which determine when each of the treatments and procedures classified as local and specialist care in the introduction are indicated, including those patients with T2 muscle invasive cancer who are potential candidates for curative surgery and for radiotherapy; • protocols for frequency of cystoscopy during follow up.	*recommended that these are adopted.*	
14-1C-107g	**Clinical Guidelines for Prostate Cancer**	
The network group should produce clinical guidelines for prostate cancer (i.e. how a given patient should be clinically managed) The guidelines should include the following: • Protocols covering diagnosis and assessment of primary and recurrent disease, including indications for MRI and bone scans; • Protocols for GP referral to the designated prostate assessment clinic; (Measure 14-2G-107) • the parameters of disease stage and patient fitness which determine when each of the treatments and procedures classified as local and specialist care in the introduction are indicated, including those patients with organ-confined prostate cancer who are potential candidates for curative surgery or curative radiotherapy.	*Chemotherapy treatment algorithms are dealt with in a separate measure in this section, below. Radiotherapy treatment techniques are dealt with in the Radiotherapy measures.* *Where there are nationally agreed requirements for clinical guidelines it is recommended that these are adopted.*	Clinical Guidelines.
14-1C-108g	**Clinical Guidelines for Testicular Cancer**	
The network group should produce clinical guidelines for testicular cancer (i.e. how a given patient should be clinically managed). The guidelines should include protocols for diagnosis and assessment of primary and recurrent disease which should cover at least the following: • specific indications for biopsy and agreed methods, uniform throughout the network, for the measurement of alpha-F-P, LDH and beta-HCG; • that there should be referral of orchidectomy specimen histology and histology of post-chemotherapy residual masses to a pathologist core member of the supranetwork team for review; • that there should be referral of any imaging of post chemotherapy residual masses to a radiologist core member of the supranetwork team for review.	*Chemotherapy treatment algorithms are dealt with in a separate measure in this section, below. Radiotherapy treatment techniques are dealt with in the Radiotherapy measures.* *Where there are nationally agreed requirements for clinical guidelines it is recommended that these are adopted.*	Clinical Guidelines.
14-1C-109g	**Clinical Guidelines for Penile Cancer**	
The network group should produce clinical guidelines for penile cancer (I.e. how a given patient should be clinically managed). The guidelines should include the following: • protocols for diagnosis and assessment of primary and recurrent disease.	*Chemotherapy treatment algorithms are dealt with in a separate measure in this section, below. Radiotherapy treatment techniques are dealt with in the Radiotherapy measures.*	Clinical Guidelines.

	Where there are nationally agreed requirements for clinical guidelines it is recommended that these are adopted.	
14-1C-110g	**Chemotherapy Treatment Algorithms**	
The network group, in consultation with the relevant chemotherapy cross cutting groups should agree a list of acceptable chemotherapy treatment algorithms. It should be updated bi-annually.	*Please see further details in appendix 3.*	Annual Report. Work Programme. Examples of treatment algorithms should be seen at Internal Validation (IV) and Peer Review Visit (PR).

Objective

All patients receive co-ordinated care.

Measure	Notes	Evidence
14-1C-111g	**Patient Pathways for Kidney Cancer**	
The network group should produce patient pathways (i.e. the named services, hospitals and MDTs which a patient should be referred to according to named indications, during their investigation, treatment, psychological and social support, rehabilitation and follow up). The pathways should include the relevant contact points for the services, hospitals and MDTs (1,2) and include the following: • that patients are referred for local care and category (i) or (ii) specialist care according to the definitions in the introduction to these measures; • that all patients with kidney cancer potentially suitable for nephron sparing surgery should be discussed with a named specialist team, prior to either referral to that team or management by the local team; • that certain patients (as specified in measure 14-1C-105g) are referred for resection of the primary and metastases by a named specialist team; • the follow up arrangements between the specialist/supranetwork teams and the referring local urology team(s); • the network group should agree with the chair of the relevant teenage and young adult cancer network co-ordinating group (TYACNCG), the teenage and young adult (TYA), patient pathways for initial management, follow up on completion of first line treatment and cases involving NHS specialised services; • that any patient with metastatic carcinoma of unknown origin should be referred on for	*(1) This should include, where relevant, any services, hospitals or MDTs outside those associated with the network group.* *(2) Rehabilitation pathways should include reference to the NCAT rehabilitation pathways.*	Constitution.

discussion by the carcinoma of unknown primary MDT.		

14-1C-112g	Patient Pathways for Bladder Cancer	
The network group should produce patient pathways (i.e. the named services, hospitals and MDTs which a patient should be referred to according to named indications, during their investigation, treatment, psychological and social support, rehabilitation and follow up). The pathways should include the relevant contact points for the services, hospitals and MDTs (1,2) and include the following: • that patients are referred for local care and category (i) or (ii) specialist care according to the definitions in the introduction to these measures; • the respective roles of the local and specialist teams in the management of high-risk superficial bladder cancer; • all patients diagnosed with high risk superficial bladder tumours should be discussed with a named specialist team prior to either referral to that team or management by the local team; (3) • for bladder reconstruction and urinary diversion, where they are not being provided by all specialist teams in the network, the specialist teams to which patients should be referred for these treatments; • the follow up arrangements between the specialist/supranetwork teams and the referring local urology team(s); • the network group should agree with the chair of the relevant teenage and young adult cancer network co-ordinating group (TYACNCG), the teenage and young adult (TYA), patient pathways for initial management, follow up on completion of first line treatment and cases involving NHS specialised services. • that any patient with metastatic carcinoma of unknown origin should be referred on for discussion by the carcinoma of unknown primary MDT.	*(1) This should include, where relevant, any services, hospitals or MDTs outside those associated with the network group.* *(2) Rehabilitation pathways should include reference to the NCAT rehabilitation pathways.* *(3) High risk superficial bladder cancer is defined as pTa (G3); T1 (G3); extensive G2,recurrent G2 or multifocal G2; and carcinoma-in-situ.*	Constitution.

14-1C-113g	Patient Pathways for Prostate Cancer	
The network group should produce patient pathways (i.e. the named services, hospitals and MDTs which a patient should be referred to according to named indications, during their investigation, treatment, psychological and social support, rehabilitation and follow up). The pathways should include the relevant contact points for the services, hospitals and MDTs (1,2) and include the following: • that patients are referred for local care and category (i) or (ii) specialist care according to the definitions in the introduction to these measures; • a list of local teams in the network which may	*(1) This should include, where relevant, any services, hospitals or MDTs outside those associated with the network group.* *(2) Rehabilitation pathways should include reference to the NCAT rehabilitation pathways.* *(3) Specialist teams should counsel all patients from their own local catchment*	Constitution.

counsel patients in order for them to select their primary treatment option from curative surgery, curative radiotherapy or other options; (3) • a set of written arrangements governing which core team members, and on which occasions, will present the options and counsel patients (see topic 2G); (4) • for brachytherapy for prostate cancer, the named team in which named network, to whom patients may be referred for this treatment; • the follow up arrangements between the specialist/supranetwork teams and the referring local urology team(s); • that any patient with metastatic carcinoma of unknown origin should be referred on for discussion by the carcinoma of unknown primary MDT.	*population. The list of teams need not include all local teams in the network.* *(4) The network may agree that for certain options, patients should be counselled by the specialist team. Patients who might otherwise be counselled by the local team may be counselled by the specialist team if agreed and desired by the patient and relevant consultants.*	

14-1C-114g	**Patient Pathways for Testicular Cancer**	
The network group should produce patient pathways (i.e. the named services, hospitals and MDTs which a patient should be referred to according to named indications, during their investigation, treatment, psychological and social support, rehabilitation and follow up). The pathways should include the relevant contact points for the services, hospitals and MDTs (1,2) and cover the following: • that patients are referred for local care, specialist care, supranetwork care or surveillance, according to the definitions in the introduction to these measures; • that all cases of testicular cancer should have their case notes presented to and discussed at the next meeting of the relevant supranetwork testicular team following their diagnosis; • which categories of patients with seminoma may be given radiotherapy by named specialist teams and which categories should be treated only by the relevant supranetwork team; (3) • the parameters which define 'good prognosis' metastatic cases for germ cell cancer and in which particular exceptional circumstances (such as geographical considerations) named specialist teams may give chemotherapy for stage I and 'good prognosis' metastatic cases; (3) • those categories of patients and circumstances for which named specialist teams may carry out surveillance; (3) • the follow up arrangements between the specialist/supranetwork teams and the referring local urology team(s); • the parameters which define 'high risk' (see introduction); • the network group should agree with the chair of the relevant teenage and young adult cancer network co-ordinating group (TYACNCG), the	*(1) This should include, where relevant, any services, hospitals or MDTs outside those associated with the network group.* *(2) Rehabilitation pathways should include reference to the NCAT rehabilitation pathways.* *(3) The list of specialist teams need **not** include all those in the network. The network group may agree that certain of the treatments or surveillance should only be carried out by the relevant supranetwork team. Supranetwork teams should carry out specialist care for their own local catchment population.*	Constitution.

teenage and young adult (TYA), patient pathways for initial management, follow up on completion of first line treatment and cases involving NHS specialised services; • that any patient with metastatic carcinoma of unknown origin should be referred on for discussion by the carcinoma of unknown primary MDT.		
14-1C-115g	**Patient Pathways for Penile Cancer**	
The network group should produce patient pathways (i.e. the named services, hospitals and MDTs which a patient should be referred to according to named indications, during their investigation, treatment, psychological and social support, rehabilitation and follow up). The pathways should include the relevant contact points for the services, hospitals and MDTs (1,2) and cover the following: • that patients are referred for local care, category (i) or (ii) specialist care or supranetwork care, according to the definitions in the introduction to these measures; • that all patients diagnosed with penile cancer should have their case notes presented to, and case discussed by, the specialist team which is acting as the relevant supranetwork team at their next weekly meeting after the patient's diagnosis. • a set of written arrangements governing which specialist teams, and which core team members, on which occasions, will present the options and counsel patients in order for them to select their primary treatment option from curative surgery, curative radiotherapy; (3) • the follow up arrangements between the specialist/supranetwork teams and the referring local urology team(s); • a list of specialist teams for the network who may treat penile cancer with surgery without penile reconstruction or lymph node resection; • the named sites at which radiotherapy and chemotherapy may be delivered under the care of which named members of which named teams; • that any patient with metastatic carcinoma of unknown origin should be referred on for discussion by the carcinoma of unknown primary MDT.	*(1) This should include, where relevant, any services, hospitals or MDTs outside those associated with the network group.* *(2) Rehabilitation pathways should include reference to the NCAT rehabilitation pathways.* *The supranetwork team should counsel and treat all patients from their own local catchment population.* *(3) The network group may agree that certain of the treatments outlined above should only be carried out by the supranetwork team.*	Constitution.

Key Theme

Patient Experience

Objective

All patients receive patient centred care with respect and dignity which takes account of their holistic needs.

Measure		Notes	Evidence
14-1C-116g	**Patient Experience**		
In the course of their regular meetings, the network group should annually review patient feedback of their associated MDTs and any actions implemented, and should agree an improvement programme with them.			Annual Report.

Key Theme

Clinical Outcomes / Indicators

Objective

All patients receive treatments intended to provide the best possible outcomes, consistent across the MDTs.

Measure		Notes	Evidence
14-1C-117g	**Clinical Outcomes Indicators and Audits**		
In the course of their regular meetings, the network group should annually review the progress (or discuss the completed results, as relevant), of their associated MDTs' outcome indicators and audits, which should have been carried out, or the data examined across all its associated MDTs: • any urology cancer outcome indicators for hospital practice, required by the Clinical Commissioning Group Outcomes Indicator Set (CCGOIS); • clinical indicators identified in section 2 of the measures; • testicular and penile collaborative audits as detailed in measures 14-2G-318 and 14-2G-415.		*Information from the cancer outcomes and service dataset (COSD) should be used where relevant.* *The compliance for this measure relates to the discussion of the data.*	Annual Report. Work Programme.

Objective

All patients have equitable access to treatments that could potentially improve outcome.

Measure		Notes	Evidence
14-1C-118g	**Discussion of Clinical Trials**		
The network group should discuss the MDT's report on clinical trials, annually with each of its associated MDTs and agree an improvement programme with them.			Annual Report. Work Programme.

Urology Local MDT Measures

Introduction

The MDT is the group of people from different health care disciplines, which meets together at a given time (whether physically in one place, or by video or tele-conferencing) to discuss a given patient and who are each able to contribute independently to the diagnostic and treatment decisions about the patient. The way the MDT meeting itself is organised is left to local discretion such that different professional disciplines may make their contributions at different times, without necessarily being present for the whole meeting in order to prevent wastage of staff time. The key requirement is that each discipline is able to contribute independently to the decisions regarding each relevant patient.

The responsibility for review purposes for the first measure lies with the cancer lead clinician of the host trust of the MDT.

The responsibility for review purposes for the subsequent measures lies with the lead clinician of the MDT.

Key Theme

Structure and Function

Objective

All patients benefit from expert multidisciplinary discussion of their diagnosis and treatment without delay.

Measure		Notes	Evidence
14-2G-101	**Core Membership**		
There should be a single named lead clinician with agreed list of responsibilities for the urology MDT who should then be a core team member. (1) The MDT should provide the names of core team members and their cover for named roles in the team. (2) The core team specific to the urology cancer MDT should include: • at least two urological surgeons; • clinical oncologist who should be a core member of a specialist urology MDT; • medical oncologist (where the responsibility for chemotherapy is not undertaken by the clinical oncology core member). The medical oncologist should be a core member of a urology specialist MDT; • an imaging specialist; (3) • a histopathologist who should be taking part in the specialist EQA for urology cancer; (4) • a urology nurse specialist; • a MDT co-ordinator/secretary; (5) • at least one clinical core member of the team with direct clinical contact, should have completed the training necessary to enable them to practice at level 2 for the psychological support of cancer patients and carers, and should receive a minimum of 1 hours clinical supervision by a level 3 or level 4 practitioner per month; (6) • an NHS-employed member of the core or extended team should be nominated as having specific responsibility for users' issues and information for patients and carers;	*(1) The role of lead clinician of the MDT should not of itself imply chronological seniority, superior experience or superior clinical ability.* *(2) Where a medical specialty is referred to, the core team member should be a consultant. The cover for this member need not be a consultant. Where a medical skill rather than a specialty is referred to, this may be provided by one or more of the core members or by a career grade non-consultant medical staff member.* *All consultants responsible for the delivery of any of the main treatment modalities should be a core member of the MDT.* *(3) The role of the imaging specialist can be met by a group of named specialists.* *(4) The role of the histopathologist can be met by a group of named histopathologists provided each meets the workload and EQA requirements.* *(5) The co-ordinator/secretary*	Operational Policy. Including confirmation of any specific requirements of the roles. Annual Report including meeting attendance spread sheet. *The spread sheet should include the dates of all scheduled meetings and the names and roles of core members.*

• a member of the core team nominated as the person responsible for ensuring that recruitment into clinical trials and other well designed studies is integrated into the function of the MDT.	*role needs different amounts of time depending on team workload.* *(6) For level 2 psychological support, the relevant disciplines include medical, surgical, nursing and allied health professionals. If the MDT has one or more clinical core members who are trained to level 3 or 4, the team is deemed to be automatically compliant with this measure.* *The definition of the levels may be found in appendix 4.*	
14-2G-102	**MDT Quorum**	
The MDT should have treatment planning meetings scheduled every week unless the meeting falls on a public holiday. The attendance at each individual scheduled treatment planning meeting should constitute a quorum, for 95% or more, of the meetings. (1) The quorum for the urology cancer MDT is made up of the following core members, or their cover: (2) • one urology surgeon; • one clinical oncologist. • one medical oncologist (where the responsibility for chemotherapy has not been taken by the clinical oncologist); • one imaging specialist; • one histopathologist; • one urology nurse specialist; • one MDT co-ordinator.	*(1) The % should be calculated over the 12 months prior to the assessment.* *(2) The members counting towards the quorum should be drawn from the list of named core members or their named cover as specified in the core membership measures and are therefore subject to the definition of acceptable core members or their cover.* *This measure does not imply any policy for what to do when an MDT meeting is not quorate. This is left to the MDT members' discretion.*	Annual Report including meeting attendance spread sheet. *The spread sheet should include the dates of all scheduled meetings and the names and roles of core members.*
14-2G-103	**MDT Review**	
There should be an operational policy whereby all new patients should be reviewed by the multidisciplinary team for discussion of their initial treatment plan. (1) The policy should specify that the results of patients' holistic needs should be taken into account in the decision making. There should be a written procedure governing how to deal with referrals which need a treatment planning decision before the next scheduled meeting. (2)	(1) Other occasions when a patient should require MDT discussion should be covered in the agreed patient pathways. It should be understood that any patient may be referred outside the policy, at any stage, at an individual clinician's discretion. (2) e.g. Letters emails or phone calls between certain specified members, retrospective discussion at the next scheduled meeting.	Operational Policy.

Objective
Patients receive treatment from specialists that have the skills and expertise to ensure the best possible outcomes.

Measure		Notes	Evidence
14-2G-104	**Core Members Attendance**		
All core members of the MDT should attend at least two thirds of the number of meetings.		*The intention is that core members of the team should be personally committed to the MDT which is reflected in their personal attendance at a substantial proportion of meetings.*	Annual Report including meeting attendance spread sheet. *The spread sheet should include the dates of all scheduled meetings and the names and roles of core members.*
14-2G-105	**Extended Membership of MDT**		
The MDT should provide the names of members of the extended team for named roles in the team if they are not already offered as core team members. The named extended team for the MDT should include: • stoma nurse; • psychosocial / psychosexual counsellor.			Operational Policy.

Key Theme

Co-ordination of Care / Patient Pathways

Objective
All patients receive agreed treatment that is consistent and equitable.

Measure		Notes	Evidence
14-2G-106	**Clinical Guidelines**		
The MDT should agree the clinical guidelines specified in measure 14-1C-105g to 14-1C-109g.		*Where available, these should reflect national guidelines and policy.*	Operational Policy. Clinical Guidelines should be available for IV and PR visit.

Objective
All patients receive co-ordinated care.

Measure		Notes	Evidence
14-2G-107	**Regular Prostate Clinic**		
The MDT should hold a regular clinic (1) which: i) should be identified on the hospital outpatient department clinic list or timetable as a clinic for new patients potentially having prostate cancer;		*(1) The clinic may be part of an existing clinic or both the prostate and haematuria assessment clinics may run together as long as the*	Operational Policy.

ii) should have the patients to be referred to the clinic defined by the agreed guidelines; iii) should be identified in GP information with a contact point for GP referrals of the above patients; iv) should have bookable, numbered clinic slots identified for the above patients; v) should be run by surgical core member(s) of the MDT; vi) should be part of the work plan or timetable of a nurse specialist member of the MDT.	*conditions in sections 1-6 can be fulfilled independently for each of the two sets of patients.*	
14-2G-108	**Regular Haematuria Clinic**	
The MDT should hold a regular clinic (1) which: i) should be identified on the hospital outpatient department clinic list or timetable as a clinic for new patients having haematuria; ii) should have the patients to be referred to the clinic defined by the agreed guidelines; iii) should be identified in GP information with a contact point for GP referrals of the above patients; iv) should have bookable, numbered clinic slots identified for the above patients; v) should be run by surgical core member(s) of the MDT; vi) should be part of the work plan or timetable of a nurse specialist member of the MDT.	*(1) The clinic may be part of an existing clinic or both the prostate and haematuria assessment clinics may run together as long as the conditions in sections 1-6 can be fulfilled independently for each of the two sets of patients.*	Operational Policy.
14-2G-109	**Agreed Policy for Patient Access to MDT to Discuss Treatment Options**	
The MDT should have agreed a policy whereby patients with the following should be offered a joint meeting with the surgeon, oncologist and specialist nurse to discuss treatment options prior to deciding which modality of treatment to use: • early (organ-confined) prostate cancer; • early (stage I) penile cancer; • high risk superficial bladder cancer as defined in 'local care', bladder cancer, in the introduction to these measures; • muscle invasive bladder cancer.	*(1) The policy may be extended to other patients and circumstances at the MDT's discretion.*	Operational Policy.
14-2G-110	**Patient Pathways**	
The MDT should agree the network-wide patient pathways specified in measure 14-1C-111g to 14-1C-115g.		Operational Policy.
14-2G-111	**Treatment Planning**	
The MDT should agree and record individual patient's treatment plans. The record should include: • the identity of patients discussed; • the multidisciplinary treatment planning decision (i.e. to which modality(s) of treatment - surgery,		Operational Policy. Example of treatment plan to be available for IV and PR visit.

radiotherapy, chemotherapy, hormone therapy or supportive care or combinations of the same, that are to be referred for consideration); • confirmation that the holistic needs has been taken into account.		

14-2G-112	Attendance at the Network Group	
The lead clinician of the MDT or representative should attend at least two thirds of the network group meetings.		Annual Report including meeting attendance spread sheet.

Key Theme

Patient Experience

Objective

All patients receive patient centred care with respect and dignity which takes account of their holistic needs.

Measure		Notes	Evidence
14-2G-113	**Key Worker**		
There should be an operational policy whereby a single named key worker for the patient's care at a given time is identified by the MDT for each individual patient and the name and contact number of the current key worker is recorded in the patient's case notes. The responsibility for ensuring that the key worker is identified should be that of the nurse MDT member(s). The policy should have been implemented.			Operational Policy. Examples of patient notes should be available for IV and PR Visit.
14-2G-114	**Patient Information**		
The MDT should provide written material for patients and carers which includes: • information specific to that MDT about local provision of the services offering the treatment for that cancer site; • information about patient involvement groups and patient self-help groups; • information about the services offering psychological, social and spiritual/cultural support, if available; • information specific to the MDT's cancer site or group of cancers about the disease and its treatment options (including names and functions/roles of the team treating them); • information about services available to support the effects of living with cancer and dealing with its emotional effects.		*Where available, it is recommended that the information and its delivery to patients and carers should be in the format of the NHS Information Prescription.* *It is recommended that the information is available in languages and formats understandable by patients including local ethnic minorities and people with disabilities. This may necessitate the provision of visual and audio material.* *For the purpose of self-assessment the team should confirm the written information which is routinely offered to patients.*	Operational Policy. Examples should be available for IV and PR visit.

14-2G-115	Permanent Record of Consultation	
The MDT should be offering patients the opportunity of a permanent record or summary of at least a consultation between the patient and the doctor when the following are discussed: • diagnosis; • treatment options and plan; • relevant follow up (discharge) arrangements.		Operational Policy.

14-2G-116	Patient Feedback	
The MDT should have undertaken an exercise during the previous two years prior to review or completed self-assessment to obtain feedback on patients' experience of the services offered. The exercise should at least ascertain whether patients were offered: • a key worker; • assessment of their physical, emotional, practical, psychological and spiritual needs (holistic needs assessment); • the MDTs information for patients and carers (written or otherwise); • the opportunity of a permanent record or summary of a consultation at which their treatment options were discussed. The exercise should have been presented and discussed at an MDT meeting and the team should have implemented at least one action point arising from the exercise.	*The exercise may consist of a survey, questionnaire, focus group or other method.* *There may be additional items in the exercise. It is recommended that other aspects of patient experience are covered.* *As an alternative to the measure the relevant local results of the national patient survey may be offered as compliance with this measure.*	Annual Report / Service Profile.

Key Theme

Clinical Outcomes / Indicators

Objective

All patients receive treatment intended to provide the best possible outcomes that is consistent across the network.

Measure		Notes	Evidence
14-2G-117	Clinical Indicators Review / Audit		
The MDT should annually review their data, discuss the progress of their audit or discuss the completed results, as relevant, of the following outcome indicators and/or audits, with the network group, at one of the regular network group meetings: • any urology cancer outcome indicators for hospital practice, required by the Clinical Commissioning Group Outcomes Indicator Set (CCGOIS); • clinical indicators identified in section 2 of the measures; • testicular and penile collaborative audits as detailed in measures 14-2G-318 and 14-2G-415.		*Information from the cancer outcomes and service dataset (COSD) should be used where relevant.* *The compliance for this measure relates to the discussion of the data.*	Annual Report / Service Profile. Work Programme.

Objective

All patients have equitable access to treatments that could potentially improve outcomes

Measure		Notes	Evidence
14-2G-118	**Discussion of Clinical Trials**		
The MDT should produce a report at least annually on clinical trials, for discussion with the network group. The report should include; • details of the MDT's trials portfolio including the extent of local provision of the national portfolio; • the MDT's recruitment to the portfolio, including the extent of delivery against the locally agreed timescales and targets; • the MDT's programme for improvement for the above, as proposed to the network group. The MDT should agree a final programme for improvement at the network group discussion meeting. (1) In addition, applicable only to MDTs dealing with the following cancer sites: • Leukaemia; • Lymphoma; • Germ cell malignancy; • Bone and/or soft tissue sarcoma; • Brain and CNS malignancy; • Malignant melanoma. The MDT should produce a report on clinical trials covering the above points for TYA patients, for discussion at the teenage and young adults' cancer network co-ordinating group (TYA CNCG) (2,3).		*(1) For compliance with this measure the MDT should produce a proposed programme for improvement and at the discussion with the network group, settle on a mutually agreed programme between the participants of the meeting.* *(2) The TYA CNCG's current list of trials and studies suitable for TYAs may not include any of those malignancies dealt with by the MDT under review, in which case this is not applicable for the current assessment in question.* *(3) For compliance with this measure, the MDT should agree a final programme for improvement for TYA clinical trials with the TYA CNCG.*	Annual Report.

Urology Specialist MDT Measures

Introduction

The MDT is the group of people from different health care disciplines, which meets together at a given time (whether physically in one place, or by video or tele-conferencing) to discuss a given patient and who are each able to contribute independently to the diagnostic and treatment decisions about the patient. The way the MDT meeting itself is organised is left to local discretion such that different professional disciplines may make their contributions at different times, without necessarily being present for the whole meeting in order to prevent wastage of staff time. The key requirement is that each discipline is able to contribute independently to the decisions regarding each relevant patient.

The responsibility for review purposes for the first measure lies with the cancer lead clinician of the host trust of the MDT.

The responsibility for review purposes for the subsequent measures lies with the lead clinician of the MDT.

Key Theme

Structure and Function

Objective

All patients benefit from expert multidisciplinary discussion of their diagnosis and treatment without delay.

Measure		Notes	Evidence
14-2G-201	**Core Membership**		
There should be a single named lead clinician with agreed list of responsibilities for the urology MDT who should then be a core team member. (1) The MDT should provide the names of core team members and their cover for named roles in the team. (2) The core team specific to the urology cancer MDT should include: • at least two urological surgeons; • clinical oncologist who should be a core member of a specialist urology MDT; • medical oncologist (where the responsibility for chemotherapy is not undertaken by the clinical oncology core member). The medical oncologist should be a core member of a urology specialist MDT; • an imaging specialist; (3) • a histopathologist who should be taking part in the specialist EQA for urology cancer; (4) • a urology nurse specialist; • MDT co-ordinator/secretary; (5) • at least one clinical core member of the team with direct clinical contact, should have completed the training necessary to enable them to practice at level 2 for the psychological support of cancer patients and carers, and should receive a minimum of 1 hours clinical supervision by a level 3 or level 4 practitioner per month; (6) • an NHS-employed member of the core or extended team should be nominated as having specific responsibility for users' issues and information for patients and carers;	*(1) The role of lead clinician of the MDT should not of itself imply chronological seniority, superior experience or superior clinical ability.* *(2) Where a medical specialty is referred to, the core team member should be a consultant. The cover for this member need not be a consultant. Where a medical skill rather than a specialty is referred to, this may be provided by one or more of the core members or by a career grade non-consultant medical staff member.* *All consultants responsible for the delivery of any of the main treatment modalities should be a core member of the MDT.* *(3) The role of the imaging specialist can be met by a group of named specialists.* *(4) The role of the histopathologist can be met by a group of named histopathologists provided each meets the workload and EQA requirements.* *(5) The co-ordinator/secretary*	Operational Policy. Including confirmation of any specific requirements of the roles. Annual Report including meeting attendance spread sheet *The spread sheet should include the dates of all scheduled meetings and the names and roles of core members.*

• a member of the core team nominated as the person responsible for ensuring that recruitment into clinical trials and other well designed studies is integrated into the function of the MDT.	*role needs different amounts of time depending on team workload.* *(6) For level 2 psychological support, the relevant disciplines include medical, surgical, nursing and allied health professionals. If the MDT has one or more clinical core members who are trained to level 3 or 4, the team is deemed to be automatically compliant with this measure.* *The definition of the levels may be found in appendix 4.*	
14-2G-202	**MDT Quorum**	
The MDT should have treatment planning meetings scheduled every week unless the meeting falls on a public holiday. The attendance at each individual scheduled treatment planning meeting should constitute a quorum, for 95% or more, of the meetings. (1) The quorum for the urology cancer MDT is made up of the following core members, or their cover; (2) • one urology surgeon; • one clinical oncologist; • one medical oncologist (where the responsibility for chemotherapy has not been taken by the clinical oncologist); • one imaging specialist; • one histopathologist; • one urology nurse specialist; • one MDT co-ordinator.	*(1) The % should be calculated over the 12 months prior to the assessment.* *(2) The members counting towards the quorum should be drawn from the list of named core members or their named cover as specified in the core membership measures and are therefore subject to the definition of acceptable core members or their cover.* *This measure does not imply any policy for what to do when an MDT meeting is not quorate. This is left to the MDT members' discretion.*	Annual Report including meeting attendance spread sheet. *The spread sheet should include the dates of all scheduled meetings and the names and roles of core members.*
14-2G-203	**MDT Review**	
There should be an operational policy whereby all new patients should be reviewed by the multidisciplinary team for discussion of their initial treatment plan. (1) The policy should specify that the results of patients' holistic needs should be taken into account in the decision making. There should be a written procedure governing how to deal with referrals which need a treatment planning decision before the next scheduled meeting. (2)	*(1) Other occasions when a patient should require MDT discussion should be covered in the agreed patient pathways.* *It should be understood that any patient may be referred outside the policy, at any stage, at an individual clinician's discretion.* *(2) e.g. Letters emails or phone calls between certain specified members, retrospective discussion at the next scheduled meeting.*	Operational Policy.

Objective

Patients receive treatment from specialists that have the skills and expertise to ensure the best possible outcomes.

Measure		Notes	Evidence
14-2G-204	**Core Members Attendance**		
All core members of the MDT should attend at least two thirds of the number of meetings.		*The intention is that core members of the team should be personally committed to the MDT which is reflected in their personal attendance at a substantial proportion of meetings.*	Annual Report including meeting attendance spread sheet. *The spread sheet should include the dates of all scheduled meetings and the names and roles of core members.*
14-2G-205	**Extended Membership of MDT**		
The MDT should provide the names of members of the extended team for named roles in the team if they are not already offered as core team members. The named extended team for the MDT should include: • stoma nurse; • psychosocial / psychosexual counsellor.			Operational Policy.
14-2G-206	**Single Site Surgery and Post Operative Care**		
The operations and acute post-operative care activities of the MDT, for category (1) specialist care procedures, for kidney, prostate and bladder cancer and operations and acute post-operative care for penile cancer resection (1) should all be carried out in the same hospital.		*(1) Except cases needing penile reconstruction or lymph node resection which should be carried out by the supranetwork MDT.*	Annual Report.
14-2G-207	**Minimum Individual Workload**		
Each surgical core member performing radical prostatectomies should undertake a minimum of 5 a year. Each surgical core member performing total cystectomies should undertake a minimum of 5 a year.		*The number of operative procedures should be calculated as follows:* • *It should be recorded separately for each individual core surgeon.* • *It should be averaged over the two complete calendar years prior to the review.* • *Only those procedures should count where the core surgical team member has scrubbed up, as evidenced by their name appearing on the*	Annual Report.

	operation notes, as a participating surgeon in the procedure. • *Emergency procedures count providing the other criteria are fulfilled.* *Procedures performed in the private sector count, providing the other criteria are fulfilled and the case is discussed at the regular meeting of the MDT under review.* *If only prostatectomies are performed by the individual or only cystectomies - the number performed should still be more than five.*	

14-2G-208	MDT Minimum Workload	
The combined total of radical prostatectomies and/or total cystectomies performed under the care of the MDT should be at least 50 per year.		Annual Report.

Key Theme

Co-ordination of Care / Patient Pathways

Objective

All patients receive agreed treatment that is consistent and equitable.

Measure		Notes	Evidence
14-2G-209	**Clinical Guidelines**		
The MDT should agree the clinical guidelines specified in measure 14-1C-105g to 14-1C-109g.		*Where available, these should reflect national guidelines and policy.*	Operational Policy. Clinical Guidelines should be available for IV and PR visit.

Objective

All patients receive co-ordinated care.

Measure		Notes	Evidence
14-2G-210	**Regular Prostate Clinic**		
The MDT should hold a regular clinic (1) which: i) should be identified on the hospital outpatient department clinic list or timetable as a clinic for new patients potentially having prostate cancer; ii) should have the patients to be referred to the clinic defined by the agreed guidelines; iii) should be identified in GP information with a contact point for GP referrals of the above patients; iv) should have bookable, numbered clinic slots		*(1) The clinic may be part of an existing clinic or both the prostate and haematuria assessment clinics may run together as long as the conditions in sections 1-6 can be fulfilled independently for each of the two sets of patients.*	Operational Policy.

identified for the above patients; v) should be run by surgical core member(s) of the MDT; vi) should be part of the work plan or timetable of a nurse specialist member of the MDT.		
14-2G-211	**Regular Haematuria Clinic**	
The MDT should hold a regular clinic (1) which: i) should be identified on the hospital outpatient department clinic list or timetable as a clinic for new patients having haematuria; ii) should have the patients to be referred to the clinic defined by the agreed guidelines; iii) should be identified in GP information with a contact point for GP referrals of the above patients; iv) should have bookable, numbered clinic slots identified for the above patients; v) should be run by surgical core member(s) of the MDT; vi) should be part of the work plan or timetable of a nurse specialist member of the MDT.	*(1) The clinic may be part of an existing clinic or both the prostate and haematuria assessment clinics may run together as long as the conditions in sections 1-6 can be fulfilled independently for each of the two sets of patients.*	Operational Policy.
14-2G-212	**Agreed Policy for Patient Access to MDT to Discuss Treatment Options**	
The MDT should have agreed a policy whereby patients with the following should be offered a joint meeting with the surgeon, oncologist and specialist nurse to discuss treatment options prior to deciding which modality of treatment to use: • early (organ-confined) prostate cancer; • early (stage I) penile cancer; • high risk superficial bladder cancer as defined in 'local care', bladder cancer, in the introduction to these measures; • muscle invasive bladder cancer.	*(1) The policy may be extended to other patients and circumstances at the MDT's discretion.*	Operational Policy.
14-2G-213	**Patient Pathways**	
The MDT should agree the network-wide patient pathways specified in measure 14-1C-107g to 14-1C-115g.		Operational Policy.
14-2G-214	**Treatment Planning**	
The MDT should agree and record individual patient's treatment plans. The record should include: • the identity of patients discussed; • the multidisciplinary treatment planning decision (i.e. to which modality(s) of treatment - surgery, radiotherapy, chemotherapy, hormone therapy or supportive care or combinations of the same, that are to be referred for consideration); • confirmation that the holistic needs have been taken into account; • in the case of patients referred for supranetwork		Operational Policy. Example of treatment plan to be available for IV and PR visit.

care to another team in the network or a neighbouring network, the team to which they are referred should be named.		

14-2G-215	**Attendance at the Network Group**

The lead clinician of the MDT or representative should attend at least two thirds of the network group meetings.		Annual Report including meeting attendance spread sheet.

Key Theme

Patient Experience

Objective

All patients receive patient centred care with respect and dignity which takes account of their holistic needs.

Measure		Notes	Evidence
14-2G-216	**Key Worker**		
There should be an operational policy whereby a single named key worker for the patient's care at a given time is identified by the MDT for each individual patient and the name and contact number of the current key worker is recorded in the patient's case notes. The responsibility for ensuring that the key worker is identified should be that of the nurse MDT member(s). The policy should have been implemented.			Operational Policy. Examples of patient notes should be available for IV and PR visit.
14-2G-217	**Patient Information**		
The MDT should provide written material for patients and carers which includes: • information specific to that MDT about local provision of the services offering the treatment for that cancer site; • information about patient involvement groups and patient self-help groups; • information about the services offering psychological, social and spiritual/cultural support, if available; • information specific to the MDT's cancer site or group of cancers about the disease and its treatment options (including names and functions/roles of the team treating them); • information about services available to support the effects of living with cancer and dealing with its emotional effects.		*Where available, it is recommended that the information and its delivery to patients and carers should be in the format of the NHS Information Prescription.* *It is recommended that the information is available in languages and formats understandable by patients including local ethnic minorities and people with disabilities. This may necessitate the provision of visual and audio material.* *For the purpose of self-assessment the team should confirm the written information which is routinely offered to patients.*	Operational Policy. Examples should be available for IV and PR visit.

14-2G-218	Permanent Record of Consultation	
The MDT should be offering patients the opportunity of a permanent record or summary of at least a consultation between the patient and the doctor when the following are discussed: • diagnosis; • treatment options and plan; • relevant follow up (discharge) arrangements.		Operational Policy.

14-2G-219	Patient Feedback	
The MDT should have undertaken an exercise during the previous two years prior to review or completed self-assessment to obtain feedback on patients' experience of the services offered. The exercise should at least ascertain whether patients were offered: • a key worker; • assessment of their physical, emotional, practical, psychological and spiritual needs (holistic needs assessment); • the MDTs information for patients and carers (written or otherwise); • the opportunity of a permanent record or summary of a consultation at which their treatment options were discussed. The exercise should have been presented and discussed at an MDT meeting and the team should have implemented at least one action point arising from the exercise.	*The exercise may consist of a survey, questionnaire, focus group or other method.* *There may be additional items in the exercise. It is recommended that other aspects of patient experience are covered.* *As an alternative to the measure the relevant local results of the national patient survey may be offered as compliance with this measure.*	Annual Report / Service Profile.

Key Theme

Clinical Outcomes / Indicators

Objective

All patients receive treatment intended to provide the best possible outcomes that is consistent across the network.

Measure	Notes	Evidence
14-2G-220 **Clinical Indicators Review / Audit**		
The MDT should annually review their data, discuss the progress of their audit or discuss the completed results, as relevant, of the following outcome indicators and/or audits, with the network group, at one of the regular network group meetings: - any urology cancer outcome indicators for hospital practice, required by the Clinical Commissioning Group Outcomes Indicator Set (CCGOIS); - clinical indicators identified in section 2 of the measures; - testicular and penile collaborative audits as detailed in measures 14-2G-318 and 14-2G-415.	*Information from the cancer outcomes and service dataset (COSD) should be used where relevant.* *The compliance for this measure relates to the discussion of the data.*	Annual Report / Service Profile. Work Programme.

Objective

All patients have equitable access to treatments that could potentially improve outcomes.

Measure		Notes	Evidence
14-2G-221	**Discussion of Clinical Trials**		
The MDT should produce a report at least annually on clinical trials, for discussion with the network group. The report should include: • details of the MDT's trials portfolio including the extent of local provision of the national portfolio; • the MDT's recruitment to the portfolio, including the extent of delivery against the locally agreed timescales and targets; • the MDT's programme for improvement for the above, as proposed to the network group. The MDT should agree a final programme for improvement at the network group discussion meeting. (1) In addition, applicable only to MDTs dealing with the following cancer sites: • Leukaemia; • Lymphoma; • Germ cell malignancy; • Bone and/or soft tissue sarcoma; • Brain and CNS malignancy; • Malignant melanoma. The MDT should produce a report on clinical trials covering the above points for TYA patients, for discussion at the teenage and young adults' cancer network co-ordinating group (TYA CNCG). (2,3)		*(1) For compliance with this measure the MDT should produce a proposed programme for improvement and at the discussion with the network group, settle on a mutually agreed programme between the participants of the meeting.* *(2) The TYA CNCG's current list of trials and studies suitable for TYAs may not include any of those malignancies dealt with by the MDT under review, in which case this is not applicable for the current assessment in question.* *(3) For compliance with this measure, the MDT should agree a final programme for improvement for TYA clinical trials with the TYA CNCG.*	Annual Report.

Supranetwork Testicular MDT Measures

Introduction

The MDT is the group of people from different health care disciplines, which meets together at a given time (whether physically in one place, or by video or tele-conferencing) to discuss a given patient and who are each able to contribute independently to the diagnostic and treatment decisions about the patient. The way the MDT meeting itself is organised is left to local discretion such that different professional disciplines may make their contributions at different times, without necessarily being present for the whole meeting in order to prevent wastage of staff time. The key requirement is that each discipline is able to contribute independently to the decisions regarding each relevant patient.

The responsibility for review purposes for the first measure lies with the cancer lead clinician of the host trust of the MDT.

The responsibility for review purposes for the subsequent measures lies with the lead clinician of the MDT.

Key Theme

Structure and Function

Objective

All patients benefit from expert multidisciplinary discussion of their diagnosis and treatment without delay.

Measure		Notes	Evidence
14-2G-301	**Core Membership**		
There should be a single named lead clinician with agreed list of responsibilities for the testicular MDT who should then be a core team member. (1) The MDT should provide the names of core team members and their cover for named roles in the team. (2) The core team specific to the testicular cancer MDT should include: • at least two urological surgeons; • clinical oncologist; • medical oncologist (where the responsibility for chemotherapy is not undertaken by the clinical oncology core member); • oncology representation covering both clinical and medical oncology; • an imaging specialist; (4) • a histopathologist who should be taking part in the specialist EQA for urology cancer (5) a testicular cancer nurse specialist; • MDT co-ordinator/secretary; (6) • at least one clinical core member of the team with direct clinical contact, should have completed the training necessary to enable them to practice at level 2 for the psychological support of cancer patients and carers, and should receive a minimum of 1 hours clinical supervision by a level 3 or level 4 practitioner per month; (7) • an NHS-employed member of the core or extended team should be nominated as having specific responsibility for users' issues and information for patients and carers; • a member of the core team nominated as the	*(1) The role of lead clinician of the MDT should not of itself imply chronological seniority, superior experience or superior clinical ability.* *(2) Where a medical specialty is referred to, the core team member should be a consultant. The cover for this member need not be a consultant. Where a medical skill rather than a specialty is referred to, this may be provided by one or more of the core members or by a career grade non-consultant medical staff member.* *All consultants responsible for the delivery of any of the main treatment modalities should be a core member of the MDT.* *(4) The role of the imaging specialist can be met by a group of named specialists.* *(5) The role of the histopathologist can be met by a group of named histopathologists provided each meets the workload and EQA requirements.* *(6) The co-ordinator/secretary*	Operational Policy. Including confirmation of any specific requirements of the roles. Annual Report including meeting attendance spread sheet. *The spread sheet should include the dates of all scheduled meetings and the names and roles of core members.*

person responsible for ensuring that recruitment into clinical trials and other well designed studies is integrated into the function of the MDT.	*role needs different amounts of time depending on team workload.* *(7) For level 2 psychological support, the relevant disciplines include medical, surgical, nursing and allied health professionals. If the MDT has one or more clinical core members who are trained to level 3 or 4, the team is deemed to be automatically compliant with this measure.* *The definition of the levels may be found in appendix 4.*	
14-2G-302	**MDT Quorum**	
The MDT should meet at an agreed frequency. The attendance at each individual scheduled treatment planning meeting should constitute a quorum, for 95% or more, of the meetings. (1) The quorum for the urology testicular cancer MDT is made up of the following core members, or their cover; (2) • one urology surgeon; • oncology representation covering both clinical and medical oncology; • one clinical oncologist; • one medical oncologist (where the responsibility for chemotherapy has not been taken by the clinical oncologist); • one imaging specialist; • one histopathologist; • one testicular cancer nurse specialist; • one MDT co-ordinator.	*(1) The % should be calculated over the 12 months prior to the assessment.* *(2) The members counting towards the quorum should be drawn from the list of named core members or their named cover as specified in the core membership measures and are therefore subject to the definition of acceptable core members or their cover.* *This measure does not imply any policy for what to do when an MDT meeting is not quorate. This is left to the MDT members' discretion.*	Annual Report including meeting attendance spread sheet. *The spread sheet should include the dates of all scheduled meetings and the names and roles of core members.*
14-2G-303	**MDT Review**	
There should be an operational policy whereby all new patients should be reviewed by the multidisciplinary team for discussion of their initial treatment plan. (1) The policy should specify that the results of patients' holistic needs should be taken into account in the decision making. There should be a written procedure governing how to deal with referrals which need a treatment planning decision before the next scheduled meeting. (2)	*(1) Other occasions when a patient should require MDT discussion should be covered in the agreed patient pathways.* *It should be understood that any patient may be referred outside the policy, at any stage, at an individual clinician's discretion.* *(2) e.g. Letters emails or phone calls between certain specified members, retrospective discussion at the next scheduled meeting.*	Operational Policy.

Objective

Patients receive treatment from specialists that have the skills and expertise to ensure the best possible outcomes.

Measure		Notes	Evidence
14-2G-304	**Core Members Attendance**		
All core members of the MDT should attend at least two thirds of the number of meetings.		*The intention is that core members of the team should be personally committed to the MDT which is reflected in their personal attendance at a substantial proportion of meetings.*	Annual Report including meeting attendance spread sheet. *The spread sheet should include the dates of all scheduled meetings and the names and roles of core members.*
14-2G-305	**Extended Membership of MDT**		
The MDT should provide the names of members of the extended team for named roles in the team if they are not already offered as core team members. The named extended team for the MDT should include: • surgeon with responsibility for resection of post-chemotherapy residual masses.			Operational Policy.
14-2G-306	**Named Hospital and Surgeons for Resection of Residual Mass Post-Chemotherapy**		
Operations to resect residual masses post-chemotherapy for the team's patients should all be carried out in the same named hospital of the host trust. All consultant surgeons responsible for resection of post-chemotherapy residual masses should be either a core member of the testicular cancer team; or a member of the extended team for testicular cancer. Where the MDT is offering resection of post-chemotherapy masses it should provide: i) the total number of such resections performed by the MDT's relevant surgical members during the previous year; ii) the same statistic by individual surgeon. (1)		*(1) Where such cases are referred to another named testicular team in another network, this should be a single named hospital in the host trust of that team.* *Resection of post-chemotherapy residual masses should be a highly specialised procedure and may involve the need for skills in thoraco-abdominal surgery.* *(2) It is strongly recommended that all of these resections are carried out by the same surgeon so that the number of individuals relevant to section 2 is one.*	Annual Report.

Key Theme

Co-ordination of Care / Patient Pathways

Objective

All patients receive agreed treatment that is consistent and equitable.

Measure		Notes	Evidence
14-2G-307	**Clinical Guidelines**		
The MDT should agree the clinical guidelines specified in measure 14-1C-108g.		*Where available, these should reflect national guidelines and policy.*	Operational Policy. Clinical Guidelines should be available for IV and PR visit.

Objective

All patients receive co-ordinated care.

Measure		Notes	Evidence
14-2G-308	**Patient Pathways**		
The MDT should agree the network-wide patient pathways specified in measure 14-1C-110g.			Operational Policy.
14-2G-309	**Patients Offered Sperm Storage**		
The testicular team should offer patients the option of sperm storage prior to chemotherapy or radiotherapy or surgery for residual masses.			Annual Report.
14-2G-310	**Treatment Planning**		
The MDT should agree and record individual patient's treatment plans. The record should include: • the identity of patients discussed; • the diagnosis, including type of testicular cancer; • the multidisciplinary treatment planning decision (i.e. to which modality(s) of treatment - surgery, radiotherapy, chemotherapy, hormone therapy or supportive care or combinations of the same, that are to be referred for consideration); • confirmation that the holistic needs have been taken into account; • in the case of patients referred for resection of post-chemotherapy masses to a team in another network, the team to which they are referred should be named.			Operational Policy. Example of treatment plan to be available for IV and PR visit.
14-2G-311	**Attendance at the Network Group**		
The lead clinician of the MDT or representative should attend at least two thirds of the network group meetings.			Annual Report including meeting attendance spread sheet.

Key Theme

Patient Experience

Objective

All patients receive patient centred care with respect and dignity which takes account of their holistic needs.

Measure		Notes	Evidence
14-2G-312	**Key Worker**		
There should be an operational policy whereby a single named key worker for the patient's care at a given time is identified by the MDT for each individual patient and the name and contact number of the current key worker is recorded in the patient's case notes. The responsibility for ensuring that the key worker is identified should be that of the nurse MDT member(s). The policy should have been implemented.			Operational Policy. Examples of patient notes should be available for IV and PR visit.
14-2G-313	**Patient Information**		

The MDT should provide written material for patients and carers which includes:
• information specific to that MDT about local provision of the services offering the treatment for that cancer site;
• information about patient involvement groups and patient self-help groups;
• information about the services offering psychological, social and spiritual/cultural support, if available;
• information specific to the MDT's cancer site or group of cancers about the disease and its treatment options (including names and functions/roles of the team treating them);
• information about services available to support the effects of living with cancer and dealing with its emotional effects.
• Information that deals with:
  • Sperm storage in general;
  • Information including contact arrangements specific to the sperm storage facilities available to the team's patients
		Where available, it is recommended that the information and its delivery to patients and carers should be in the format of the NHS Information Prescription.
		It is recommended that the information is available in languages and formats understandable by patients including local ethnic minorities and people with disabilities. This may necessitate the provision of visual and audio material.
		For the purpose of self-assessment the team should confirm the written information which is routinely offered to patients.
			Operational Policy.
			Examples should be available for IV and PR visit.

14-2G-314	**Permanent Record of Consultation**		
The MDT should be offering patients the opportunity of a permanent record or summary of at least a consultation between the patient and the doctor when the following are discussed: • diagnosis; • treatment options and plan; • relevant follow up (discharge) arrangements.			Operational Policy.

14-2G-315	Patient Feedback	
The MDT should have undertaken an exercise during the previous two years prior to review or completed self-assessment to obtain feedback on patients' experience of the services offered. The exercise should at least ascertain whether patients were offered: • a key worker; • assessment of their physical, emotional, practical, psychological and spiritual needs (holistic needs assessment); • the MDTs information for patients and carers (written or otherwise); • the opportunity of a permanent record or summary of a consultation at which their treatment options were discussed. The exercise should have been presented and discussed at an MDT meeting and the team should have implemented at least one action point arising from the exercise.	*The exercise may consist of a survey, questionnaire, focus group or other method.* *There may be additional items in the exercise. It is recommended that other aspects of patient experience are covered.* *As an alternative to the measure the relevant local results of the national patient survey may be offered as compliance with this measure.*	Annual Report / Service Profile.

Key Theme

Clinical Outcomes / Indicators

Objective

All patients receive treatment intended to provide the best possible outcomes that is consistent across the network.

Measure		Notes	Evidence
14-2G-316	Clinical Indicators Review / Audit		

The MDT should annually review their data, discuss the progress of their audit or discuss the completed results, as relevant, of the following outcome indicators and/or audits, with the network group, at one of the regular network group meetings. The meeting should include a representative of any teams referring to the supranetwork team in question, whether from within the network or from a neighbouring network:
• any testicular cancer outcome indicators for hospital practice, required by the Clinical Commissioning Group Outcomes Indicator Set (CCGOIS);
• clinical indicators identified in section 2 of the measures;
• a collaborative audit that includes:
  • whether all high risk cases were referred pre-operatively;
  • all other cases referred within 24-hours of orchidectomy;
  • that cases were referred and/or treated by teams according to the network guidelines.
	Information from the cancer outcomes and service dataset (COSD) should be used where relevant.
	The compliance for this measure relates to the discussion of the data.
		Annual Report / Service Profile.
		Work Programme.

Objective

All patients have equitable access to treatments that could potentially improve outcomes.

Measure		Notes	Evidence
14-2G-317	**Discussion of Clinical Trials**		
The MDT should produce a report at least annually on clinical trials, for discussion with the network group. The report should include: • details of the MDT's trials portfolio including the extent of local provision of the national portfolio; • the MDT's recruitment to the portfolio, including the extent of delivery against the locally agreed timescales and targets; • the MDT's programme for improvement for the above, as proposed to the network group. The MDT should agree a final programme for improvement at the network group discussion meeting. (1) In addition, applicable only to MDTs dealing with the following cancer sites: • Leukaemia; • Lymphoma; • Germ cell malignancy; • Bone and/or soft tissue sarcoma; • Brain and CNS malignancy; • Malignant melanoma. The MDT should produce a report on clinical trials covering the above points for TYA patients, for discussion at the teenage and young adults' cancer network co-ordinating group (TYA CNCG). (2,3)		*(1) For compliance with this measure the MDT should produce a proposed programme for improvement and at the discussion with the network group, settle on a mutually agreed programme between the participants of the meeting.* *(2) The TYA CNCG's current list of trials and studies suitable for TYAs may not include any of those malignancies dealt with by the MDT under review, in which case this is not applicable for the current assessment in question.* *(3) For compliance with this measure, the MDT should agree a final programme for improvement for TYA clinical trials with the TYA CNCG.*	Annual Report.

Supranetwork Penile MDT Measures

Introduction

The MDT is the group of people from different health care disciplines, which meets together at a given time (whether physically in one place, or by video or tele-conferencing) to discuss a given patient and who are each able to contribute independently to the diagnostic and treatment decisions about the patient. The way the MDT meeting itself is organised is left to local discretion such that different professional disciplines may make their contributions at different times, without necessarily being present for the whole meeting in order to prevent wastage of staff time. The key requirement is that each discipline is able to contribute independently to the decisions regarding each relevant patient.

The responsibility for review purposes for the first measure lies with the cancer lead clinician of the host trust of the MDT.

The responsibility for review purposes for the subsequent measures lies with the lead clinician of the MDT.

Key Theme

Structure and Function

Objective

All patients benefit from expert multidisciplinary discussion of their diagnosis and treatment without delay.

Measure		Notes	Evidence
14-2G-401	**Core Membership**		
There should be a single named lead clinician with agreed list of responsibilities for the penile MDT who should then be a core team member. (1) The MDT should provide the names of core team members and their cover for named roles in the team. (2) The supranetwork penile cancer team should have at least the following core members: • at least two urological surgeons; (3) • clinical oncologist; • medical oncologist (where the responsibility for chemotherapy is not undertaken by the clinical oncology core member); • an imaging specialist; (4) • a histopathologist who should be taking part in the specialist EQA for urology cancer; (5) • a urology nurse specialist; • MDT co-ordinator/secretary; (6) • any consultant in the supranetwork catchment area of the MDT who is responsible for performing lymph node dissections and/or penile reconstruction should be a core member of the supranetwork penile cancer team; • at least one clinical core member of the team with direct clinical contact, should have completed the training necessary to enable them to practice at level 2 for the psychological support of cancer patients and carers, and should receive a minimum of 1 hours clinical supervision by a level 3 or level 4 practitioner per month; (7) • an NHS-employed member of the core or extended team should be nominated as having	*(1) The role of lead clinician of the MDT should not of itself imply chronological seniority, superior experience or superior clinical ability.* *(2) Where a medical specialty is referred to, the core team member should be a consultant. The cover for this member need not be a consultant. Where a medical skill rather than a specialty is referred to, this may be provided by one or more of the core members or by a career grade non-consultant medical staff member.* *All consultants responsible for the delivery of any of the main treatment modalities should be a core member of the MDT.* *(4) The role of the imaging specialist can be met by a group of named specialists.* *(5) The role of the histopathologist can be met by a group of named histopathologists provided each meets the workload and EQA requirements.* *(6) The co-ordinator/secretary*	Operational Policy. Including confirmation of any specific requirements of the roles. Annual Report including meeting attendance spread sheet. *The spread sheet should include the dates of all scheduled meetings and the names and roles of core members.*

specific responsibility for users' issues and information for patients and carers; • a member of the core team nominated as the person responsible for ensuring that recruitment into clinical trials and other well designed studies is integrated into the function of the MDT.	*role needs different amounts of time depending on team workload.* *(7) For level 2 psychological support, the relevant disciplines include medical, surgical, nursing and allied health professionals. If the MDT has one or more clinical core members who are trained to level 3 or 4, the team is deemed to be automatically compliant with this measure.* *The definition of the levels may be found in appendix 4.*	
14-2G-402	**MDT Quorum**	
The MDT should meet at an agreed frequency. The attendance at each individual scheduled treatment planning meeting should constitute a quorum, for 95% or more, of the meetings. (1) The quorum for the urology cancer MDT is made up of the following core members, or their cover; (2) • one urology surgeon; • one clinical oncologist; • onemedical oncologist (where the responsibility for chemotherapy is not undertaken by the clinical oncology core member). • one imaging specialist; • one histopathologist; • one urology nurse specialist; • one MDT co-ordinator.	*(1) The % should be calculated over the 12 months prior to the assessment.* *(2) The members counting towards the quorum should be drawn from the list of named core members or their named cover as specified in the core membership measures and are therefore subject to the definition of acceptable core members or their cover.* *This measure does not imply any policy for what to do when an MDT meeting is not quorate. This is left to the MDT members' discretion.*	Annual Report including meeting attendance spread sheet. *The spread sheet should include the dates of all scheduled meetings and the names and roles of core members.*
14-2G-403	**MDT Review**	
There should be an operational policy whereby all new patients should be discussed with the supranetwork penile MDT prior to proposed treatment or referred directly to the team. (1) The policy should specify that the results of patients' holistic needs should be taken into account in the decision making. There should be a written procedure governing how to deal with referrals which need a treatment planning decision before the next scheduled meeting. (2)	*(1) Other occasions when a patient should require MDT discussion should be covered in the agreed patient pathways.* *It should be understood that any patient may be referred outside the policy, at any stage, at an individual clinician's discretion.* *(2) e.g. Letters emails or phone calls between certain specified members, retrospective discussion at the next scheduled meeting.*	Operational Policy.

Objective

Patients receive treatment from specialists that have the skills and expertise to ensure the best possible outcomes.

Measure		Notes	Evidence
14-2G-404	**Core Members Attendance**		
All core members of the MDT should attend at least two thirds of the number of meetings.		*The intention is that core members of the team should be personally committed to the MDT which is reflected in their personal attendance at a substantial proportion of meetings.*	Annual Report including meeting attendance spread sheet. *The spread sheet should include the dates of all scheduled meetings and the names and roles of core members.*
14-2G-405	**Individual Surgeon's Workload**		
The MDT should provide the total number of the following procedures performed for penile cancer by the team and by individual surgeons during the previous year. i) penile reconstruction procedures; ii) lymphadenectomies.		*It is strongly recommended that all of these resections are carried out by the same surgeon so that the number of individuals relevant to section 2 is one.*	Annual Report.
14-2G-406	**Named Hospital for Penile Surgical Procedures**		
Operations for penile cancer involving lymphadenectomy and / or penile reconstruction should all be carried out in the same named hospital of the host trust.			Annual Report.

Key Theme

Co-ordination of Care / Patient Pathways

Objective

All patients receive agreed treatment that is consistent and equitable.

Measure		Notes	Evidence
14-2G-407	**Clinical Guidelines**		
The MDT should agree the clinical guidelines specified in measure 14-1C-109g.		*Where available, these should reflect national guidelines and policy.*	Operational Policy. Clinical Guidelines should be available for IV and PR visit.

Objective

All patients receive co-ordinated care.

Measure		Notes	Evidence
14-2G-408	**Patient Pathways**		
The MDT should agree the network-wide patient pathways specified in measure 14-1C-115g.		Th*is should include follow up and referral pathways.*	Operational Policy.
14-2G-409	**Agreed Policy for Patient Access to MDT to Discuss Treatment Options**		
The MDT should have agreed a policy whereby patients with early (stage I) penile cancer should be offered a joint meeting with the surgeon, oncologist and specialist nurse to discuss treatment options prior to deciding which modality of treatment to use. (1)		*(1) The policy may be extended to other patients and circumstances at the MDT's discretion.*	Operational Policy.
14-2G-410	**Treatment Planning**		
The MDT should agree and record individual patient's treatment plans. The record should include: • the identity of patients discussed; • the diagnosis, including type of testicular cancer; • the multidisciplinary treatment planning decision (i.e. to which modality(s) of treatment - surgery, radiotherapy, chemotherapy, hormone therapy or supportive care or combinations of the same, that are to be referred for consideration); • confirmation that the holistic needs have been taken into account.			Operational Policy. Example of treatment plan to be available for IV and PR visit.
14-2G-411	**Attendance at the Network Group**		
The lead clinician of the MDT or representative should attend at least two thirds of the network group meetings.			Annual Report including meeting attendance spread sheet.

Key Theme

Patient Experience

Objective

All patients receive patient centred care with respect and dignity which takes account of their holistic needs.

Measure		Notes	Evidence
14-2G-412	**Key Worker**		
There should be an operational policy whereby a single named key worker for the patient's care at a given time is identified by the MDT for each individual patient and the name and contact number of the current key worker is recorded in the patient's case notes. The responsibility for ensuring that the key worker is identified should be that of the nurse MDT member(s). The policy should have been implemented.			Operational Policy. Examples of patient notes should be available for IV and PR visit.

14-2G-413	Patient Information	
The MDT should provide written material for patients and carers which includes: • information specific to that MDT about local provision of the services offering the treatment for that cancer site; • information about patient involvement groups and patient self-help groups; • information about the services offering psychological, social and spiritual/cultural support, if available; • information specific to the MDT's cancer site or group of cancers about the disease and its treatment options (including names and functions/roles of the team treating them); • information about services available to support the effects of living with cancer and dealing with its emotional effects.	*Where available, it is recommended that the information and its delivery to patients and carers should be in the format of the NHS Information Prescription.* *It is recommended that the information is available in languages and formats understandable by patients including local ethnic minorities and people with disabilities. This may necessitate the provision of visual and audio material.* *For the purpose of self-assessment the team should confirm the written information which is routinely offered to patients.*	Operational Policy. Examples should be available for IV and PR visit.
14-2G-414	**Permanent Record of Consultation**	
The MDT should be offering patients the opportunity of a permanent record or summary of at least a consultation between the patient and the doctor when the following are discussed: • diagnosis; • treatment options and plan; • relevant follow up (discharge) arrangements.		Operational Policy.
14-2G-415	**Patient Feedback**	
The MDT should have undertaken an exercise during the previous two years prior to review or completed self-assessment to obtain feedback on patients' experience of the services offered. The exercise should at least ascertain whether patients were offered: • a key worker; • assessment of their physical, emotional, practical, psychological and spiritual needs (holistic needs assessment); • the MDTs information for patients and carers (written or otherwise); • the opportunity of a permanent record or summary of a consultation at which their treatment options were discussed. The exercise should have been presented and discussed at an MDT meeting and the team should have implemented at least one action point arising from the exercise.	*The exercise may consist of a survey, questionnaire, focus group or other method.* *There may be additional items in the exercise. It is recommended that other aspects of patient experience are covered.* *As an alternative to the measure the relevant local results of the national patient survey may be offered as compliance with this measure.*	Annual Report / Service Profile.

Key Theme

Clinical Outcomes / Indicators

Objective

All patients receive treatment intended to provide the best possible outcomes that is consistent across the network.

Measure		Notes	Evidence
14-2G-416	**Clinical Indicators Review / Audit**		

The MDT should annually review their data, discuss the progress of their audit or discuss the completed results, as relevant, of the following outcome indicators and/or audits, with the network group, at one of the regular network group meetings. The meeting should include a representative of any teams referring to the supranetwork team in question, whether from within the network or from a neighbouring network:
• any penile cancer outcome indicators for hospital practice, required by the Clinical Commissioning Group Outcomes Indicator Set (CCGOIS);
• clinical indicators identified in section 2 of the measures;
• a collaborative audit that includes:
  • whether all cases were discussed with them prior to referral or to proposed specialist care;
  • that cases were referred and/or treated by teams according to the network guidelines.
		Information from the cancer outcomes and service dataset (COSD) should be used where relevant.
		The compliance for this measure relates to the discussion of the data.
			Annual Report / Service Profile.
			Work Programme.

Objective

All patients have equitable access to treatments that could potentially improve outcomes.

Measure		Notes	Evidence
14-2G-417	**Discussion of Clinical Trials**		
The MDT should produce a report at least annually on clinical trials, for discussion with the network group. The report should include; • details of the MDT's trials portfolio including the extent of local provision of the national portfolio; • the MDT's recruitment to the portfolio, including the extent of delivery against the locally agreed timescales and targets; • the MDT's programme for improvement for the above, as proposed to the network group. The MDT should agree a final programme for improvement at the network group discussion meeting. (1)		*(1) For compliance with this measure the MDT should produce a proposed programme for improvement and at the discussion with the network group, settle on a mutually agreed programme between the participants of the meeting.*	Annual Report.

Section 2 Clinical Indicators/Lines of Enquiry

Introduction

The clinical indicators identified in this section have been identified by clinicians within the service as key aspects that reflect the quality of treatment and care provided. These indicators should form the basis of discussion by teams enabling them to identify areas for improvement. The team should comment on these indicators in their self assessment report and any plans for improvement should be included in their work programme.

Clinical Indicators

TBA

Appendix 1 Ground Rules for Networking

Introduction

These ground rules preserve the principles underpinning clinical networking. The principles may be summarized as follows:

- They prevent destructive competition between MDTs for their catchment populations.
- They prevent destructive competition between network groups for their associated MDTs.
- They allow the development of consistent, intra- and inter-team patient pathways which are clinically rational and in only the patients' best interests instead of in the vested interests of professional groups or of NHS statutory institutions.

Network Groups

- The network group should be the only such network group for the MDTs which are associated with it.
- For cancer sites where there is only one level of MDT, the network group should be associated with more than one MDT.
- For cancer sites where there is a division into more than one level of MDT, i.e. into local and specialist/supranetwork MDTs, the network group need only be associated with one specialist/supranetwork MDT as long as it is associated with more than one MDT for the cancer site overall.
    - *Notes: The network group **need** only be associated with one specialist/supranetwork type MDT but **may** be associated with more than one.*

Cross Cutting Groups

These currently include network groups for:

- Chemotherapy
- Radiotherapy
- Acute Oncology

These services are required to have local multiprofessional management teams. These are not equivalent to the site specific groups and are treated differently in the measures. The ground rules for MDTs do not apply to them.

The network group for a given service should be the only such group for that service for all the hospitals/services it is associated with:

- The equivalent reciprocal ground rules to this for hospitals and services would be; any given hospital should be associated with only one network group for any given service, and any service should be associated with only one network service group.
    - *Note: Hospitals and services are mentioned separately because, for the purposes of peer review and data gathering, it has been necessary to clearly define individual services and delineate their boundaries in terms of staff and facilities. Sometimes a declared 'service' may cross more than one hospital.*

MDTs

For MDTs dealing with cancer sites for which the IOG and measures recommend only one level of MDT (i.e. no division into local and specialist or their equivalent. e.g. Breast MDTs):

- The MDT should be the only such MDT for its cancer site, for its catchment area.
    - *Notes: The principle of a given primary care practice agreeing that patients will be referred to a given MDT is not intended to restrict patient or GP choice. A rational network of MDTs, rather than a state of destructive competition can only be developed if i) there is an agreement on which MDT the patients will normally be referred to and ii) the resulting referral catchment populations and /or workload are counted, for planning purposes. It is accepted that individual patients will, on occasion, be referred to different teams, depending on specific circumstances. This ground rule does not apply to the carcinoma of unknown primary (CUP) MDT or the specialist palliative care (SPC) MDT. This is because, for this ground rule to be implementable, it is necessary to define a relevant disease entity in terms of objective diagnostic criteria which governs referral at primary care level. This is not possible for CUP or SPC, by the nature of these practices.*

- The MDT should be the only such MDT for its cancer site on or covering a given hospital site.
    - *Note: This is because for patient safety and service efficiency, there should be no rival individuals or units working to potentially different protocols on the same site. This does not prevent a given MDT working across more than one hospital site. Neither does it prevent trusts which have more than one hospital site, having more than one MDT of the same kind, in the trust. This ground rule does not apply to SPC MDTs, since there may be more than one distinctive setting for the practice of SPC on a single given hospital site.*
- The MDT should be associated with a single named network site specific group (network group) for the purposes of coordination of clinical guidelines and pathways, comparative audits and coordination of clinical trials.
    - *Note: MDTs which are IOG compliant but deal with a group of related cancer sites, rather than a single site, may be associated with more than one network group, but should have only one per cancer site. e.g. A brain and CNS tumours MDT also dealing with one or more of the specialist sites such as skull base, spine and pituitary could be associated with a separate network group for each of its specialty sites.*

For cancer sites for which there is a division into local, specialist and in some cases, supranetwork MDTs, the following apply to the specialist/supranetwork MDTs. The above ground rules still apply to the 'local' type MDTs.

- The specialist/supranetwork MDT should be the only such specialist/supranetwork MDT for its cancer site, for its specialist/supranetwork referral catchment area.
- The specialist/supranetwork MDT should be the only such specialist/supranetwork MDT for its cancer site on or covering a given hospital site.
- The specialist MDT should act as the 'local' type MDT for its own secondary catchment population. If a supranetwork MDT deals with potentially the whole patient pathway for its cancer site, this ground rule applies to the supranetwork MDT. If it deals with just a particular procedure or set of procedures, not potentially the whole patient pathway, it does not apply.
    - *Note: This is in order that the specialist/supranetwork MDT is exposed to the full range of clinical practice for its cancer site.*
- The specialist MDT should be associated with a single named network site specific group (network group), (or possibly one per individual cancer site, as above) for the purposes of coordination of clinical guidelines and pathways, comparative audits and coordination of clinical trials.

Appendix 2 Roles and Responsibilities

Roles and Responsibilities

Introduction

Role of the network group

The network group should be multidisciplinary; with representation from professionals across the care pathway; involve users in their planning and review; and have the active engagement of all MDT leads from the relevant associated organisations.

The network group should:

- agree a set of clinical guidelines and patient pathways to support the delivery of high quality equitable services across the network;
- review the quality and completeness of data, recommending corrective action where necessary;
- produce audit data and participate in open review;
- ensure services are evaluated by patients and carers;
- monitor progress on meeting national cancer measures and ensure actions following peer review are implemented;
- review and discuss identified risks/untoward incidents to ensure learning is spread;
- agree a common approach to research and development, working with the network research team, participating in nationally recognised studies whenever possible.

Responsibilities of the MDT lead clinician

The MDT lead clinician should:

- ensure that designated specialists work effectively together in teams such that decisions regarding all aspects of diagnosis, treatment and care of individual patients and decisions regarding the team's operational policies are multidisciplinary decisions;
- ensure that care is given according to recognised guidelines (including guidelines for onward referrals) with appropriate information being collected to inform clinical decision making and to support clinical governance/audit;
- ensure mechanisms are in place to support entry of eligible patients into clinical trials, subject to patients giving fully informed consent;
- overall responsibility for ensuring that the MDT meetings and team meet peer review quality measures;
- ensure attendance levels of core members are maintained, in line with quality measures;
- provide the link to the network group either by attendance at meetings or by nominating another MDT member to attend;
- ensure MDT's activities are audited and results documented;
- ensure that the outcomes of the meeting are clearly recorded, clinically validated and that appropriate data collection is supported.

Appendix 3 Chemotherapy Treatment Algorithms

Introduction

Introduction; (Definitions). Regimens, Protocols and Algorithms

For the purposes of peer review, a chemotherapy **regimen** is defined by the therapeutic chemotherapy drugs used, often expressed as an acronym e.g. 'FEC'. A change of one or more of these drugs themselves would normally be necessary for it to be classed as a change of regimen. In some cases major changes in the dose or route of administration of one or more of the drugs effectively changes the regimen but these cases are generally known and recognised nationally. A given network is free to choose any further changes which they classify as changing the regimen, as long as it is in accord with the above definition and national exceptions; i.e. they are free to make their definition of a regimen narrower, but not wider. This is relevant to measures in the chemotherapy section (Topic 3S).

For the purposes of peer review, a chemotherapy **treatment protocol** is defined as constituting all the parameters specified in the bullet points in chemotherapy Treatment Protocols. A change in any of these parameters would change the treatment protocol but any change other than the therapeutic drugs themselves (apart from the national and local exceptions specified above) would change only the protocol, not the regimen as well.

For the purposes of peer review a chemotherapy **treatment algorithm** may be described as a guideline which specifies the acceptable range of regimens for each relevant step on the patient pathway. Treatment algorithms are cancer site-specific. They are not specific to individual patients, i.e. they are not individual treatment plans. Thus, a treatment algorithm for breast cancer would include a statement of the range of regimens agreed as acceptable for adjuvant chemotherapy and for first, second and third line palliative chemotherapy etc. Illustrative examples of treatment algorithms in different formats may be found in appendix 1 of the chemotherapy measures. There may be other formats which would be acceptable to the reviewers.

In practice, a change of regimen or order of regimens may no longer comply with a previously agreed treatment algorithm, but a change of one of the minor aspects of a treatment protocol would still comply. The measure for the network group is concerned only with chemotherapy **algorithms**.

Notes: The intention is not to require a single mandatory regimen for each clinical indication. It is to prevent individual practitioners having unorthodox, obsolete and unpredictably varying practice, which is against the opinion of their peers within the network.

The network group should produce the algorithms for its compliance with this measure and the relevant chemotherapy multi-professional teams should produce a compatible list of algorithms for the network group's cancer site for their own service.The relevant chemotherapy multi-professional teams should each agree lists with all the network group relevant to their practice, for compliance with their measure.

The network algorithm for a particular clinical situation may have a number of alternative regimens of which the multi-professional team need only agree those which it intends to use in its service. The multi-professional team need only address those clinical indications which are applicable to the scope of its practice. The key requirement is that all the algorithms on the multi-professional team list are compatible with the network group agreed list.

This exercise should include oral chemotherapy.

This measure is assessed as part of the responsibility of each network group, but from the chemotherapy cross cutting group's point of view regarding the management of this process, the algorithms don't all need to be updated at the same time. It would seem sensible, however, to update all those for a given cancer site, at the same time. Updates require changes only when judged clinically necessary by the network group.

Appendix 4 Psychological Support Levels

Introduction

This appendix gives the definitions, for the purpose of the measures and peer review, of the service levels. The term 'Health Professional' as used in the definitions of levels 1 and 2, implies a professional in a discipline other than the psychiatry/psychology/counselling disciplines themselves, since it is assumed that basic qualification in these disciplines would exempt a practitioner from level 2 training.

Level 1

Is defined as a degree of psychological screening, intervention and support which is deliverable by any qualified health or social care professional, without any further psychological training other than that provided by the basic training in their own discipline.

Note: Level 1 does not feature directly in the measures but it is specified here to set a baseline for comparison with the higher levels and to put them in perspective.

Level 2

Is defined as a degree of psychological screening, intervention and support which requires a practitioner who is a health or social care professional who has received further psychological training, as specified below, in addition to that provided by the basic training in their own discipline.
The additional training is as follows:

I. Attendance on the National Advanced Communications Skills Training course from one of the nationally approved programmes.

PLUS

II. Participation in a network based training programme, relevant to cancer patients and their carers which covers basic psychological screening, psychological assessment and basic psychological intervention skills.

The detailed content of the training programme will be agreed by the network and is not subject to peer review, but for illustration purposes examples of the training in screening are: Jenkins, K. & North, N. (2008) 'Psychological Assessment Skills: A training course for all health and social care staff working in cancer services'. Salisbury NHS Foundation Trust; or, training in the use of a Holistic Needs Assessment tool such as the Distress Thermometer.

For illustration purposes, examples of the training in psychological intervention skills are: Training in Solution Focussed Techniques, or Anxiety Management, or Problem Solving, or Cognitive Behavioural Therapy.

Level 3

Is defined as a degree of psychological screening, intervention and support which requires a practitioner who is one of the following:

- a counsellor, accredited by the one of the national voluntary regulatory bodies for counselling;
- an NHS psychotherapist accredited by one of the national voluntary regulatory bodies for psychotherapy.

Level 4

Is a degree of psychological screening, intervention and support which requires a practitioner who is one of the following:

- a consultant psychiatrist;
- a consultant liaison psychiatrist;
- a clinical or counselling psychologist.

Note: All of the above should have completed an induction at level 3. that meets the British Psychosocial Oncology Society (BPOS) and SIGOPAC requirements.

National Peer Review Programme

NHS

National Peer Review Report:
Northern Ireland 2015

An overview of the findings from the 2015 National Peer Review of Cancer Services in Northern Ireland

Contents

1.0 Introduction

The NHS England Specialised Commissioning Quality Surveillance Team was commissioned by the Northern Ireland Cancer Network (NICaN) to undertake peer review visits in 2015 to trusts in the Province providing services for brain and central nervous system, head and neck, hepatobiliary (HPB), skin and urological cancers. Eleven services were reviewed during June 2015 and this report summarises the findings of those visits.

The peer review programme aims to improve care for people with cancer and their families by:

- ensuring services are as safe as possible;
- improving the quality and effectiveness of care;
- improving the patient and carer experience;
- undertaking independent, fair reviews of services;
- providing development and learning for all involved;
- encouraging the dissemination of good practice.

1.1 Background

There has been a cancer peer review programme in place in England since 2001. Over the years the National Institute for Health and Care Excellence (NICE) has produced research based national Improving Outcome Guidance in order to have consistent structures and processes for cancer care that would improve outcomes. In order to assess how far trusts have implemented this, and subsequent, guidance a series of indicators were developed (the 'measures') and the peer review process assesses compliance with these measures. Each visiting team is made up of a multi-professional team of reviewers and also includes a patient representative. Peer reviewers have a duty to objectively assess the service's compliance with the measures and also, based on their professional training and experience, to raise any other issues about the clinical service that are of concern.

Since the peer review to services in Northern Ireland in 2010 the measures have evolved, with some measures being dropped, some combined and at least one new measure introduced. These measures were examined by NICaN and where necessary, adaptations made or interpretation written to fit in with the healthcare environment in Northern Ireland.

1.2 The Peer Review Process – Northern Ireland

Once again, during 2015 training in the peer review process was provided to trust managers, including the function and use of the web based Cancer Quality Improvement Network System (CQuINS). Each team to be reviewed undertook a self-assessment (SA) against the measures and wrote a self-assessment report that was subsequently made available to the review teams.

Potential peer reviewers were recruited and trained to undertake reviews. Review teams normally consisted of a consultant (surgeon, oncologist etc) and a nurse from the same clinical specialty that was being reviewed, a manger of cancer services and a patient representative. Each team had a balance of reviewers from Northern Ireland and experienced reviewers from cancer services in England. All the patients who participated as reviewers were from Northern Ireland.

At each visit, the reviewers examined the evidence provided by the team delivering the service and had the opportunity to meet with members of that team. The reviewers then agreed a final peer review (PR) compliance, identified good practice and any immediate risks (i.e. where there is a significant risk that patients will come to harm) or serious concerns (i.e. issues that could seriously

affect the quality or outcomes of patient care or affect staff safety), and wrote a report of their findings.

A full description of the process is provided in the handbook for peer review which along with the peer review measures may be found on the resources page of the CQuINS website: http://www.cquins.nhs.uk/?menu=resources .

1.3 Configuration of Services

NICaN is comprised of five integrated hospital and social care (HSC) trusts providing local diagnostic and treatment services to their population and, at Belfast HSC Trust, most of the specialist services for the Province.

Services visited in 2015 are configured as follows:

Brain and central nervous system cancer

All brain and central nervous system services are centralised at Belfast HSC Trust.

Head and neck cancer

Belfast HSC Trust hosts the head and neck MDT for the Province; with the recent appointment of a surgeon at Southern HSC Trust operating now takes place at four different trusts with the Northern HSC Trust offering a diagnostic service.

Hepatobiliary cancer

Hepatobiliary cancer services for Northern Ireland are provided at Belfast HSC Trust.

Skin cancer

The specialist MDT based at Belfast is the only specialist skin MDT in Northern Ireland. It also provides a local MDT service to Belfast Trust's catchment population and also that of the South Eastern HSC Trust. There are local skin MDTs at each of the other trusts.

Urological cancer

The configuration of urological cancer services was reviewed and reorganised in 2009 in order to address long waiting times and to move towards having services in line with the IOG. Three urology cancer MDTs were agreed namely Southern, North West and Belfast. The specialist urological cancer MDT is hosted at Belfast, which also provides local urology services to both its own population and that of the South Eastern HSC From April 2015 it was also agreed that the pathway for eastern catchment population of the Northern HSC Trust would also be to Belfast. The southern part of the Western HSC Trust catchment area was included in the Southern Urology MDT hosted at Southern HSC Trust. The northern population of NHSCT should have been referred into the combined North West MDT hosted by the Western HSC Trust but this has not happened.

Radiotherapy and chemotherapy

The regional oncology service is hosted by Belfast HSC Trust, delivered from the Cancer Centre in Belfast. There are 35 Whole Time Equivalent consultant oncologists providing an oncology service to the local Belfast population and specialist services for patients across Northern Ireland. Systemic anti-cancer therapies (SACT) services for the core tumour sites are delivered at the four other health

trusts using a hub and spoke model with the agreed chemotherapy regimens delivered by the four local trusts' chemotherapy services.

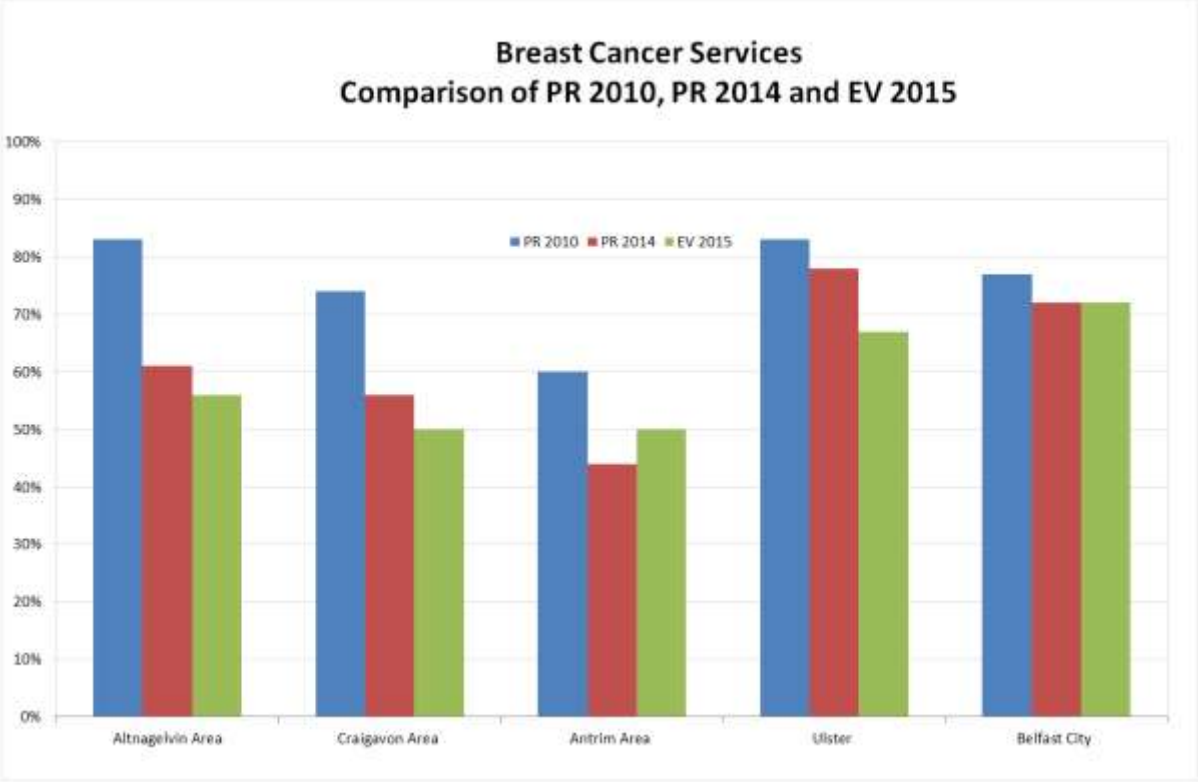
Radiotherapy is delivered solely at the Belfast Cancer Centre with Intensity Modulated Radiotherapy (IMRT) being well established. A second radiotherapy service is planned to open in the Western HSC Trust in 2016.

2.0 Progress of Services reviewed in 2014

In 2014 peer review visits were undertaken to breast, lung, colorectal and gynaecological services. In 2015 trusts undertook a validated self-assessment against the measures and the outcome of those self-assessments were confirmed using a external verification desktop review by a member of the peer review staff.

The table show the compliance with the measures at the peer review visits in 2010 and 2014, and also for the self-assessments and external verification in 2015, for each of the conditions. It should be noted that the reduction in the number of measures, the introduction of a challenging new measure relating to MDT quoracy, and the making of some measures more complex to achieve, affected compliance in Northern Ireland between 2010 and 2014. Also, it is not uncommon for compliance at self-assessment to be higher than that found at peer review or external verification.

2.1 Breast Cancer Services



Key:

SA – Self assessment
EV – External Verification
PR – Peer review

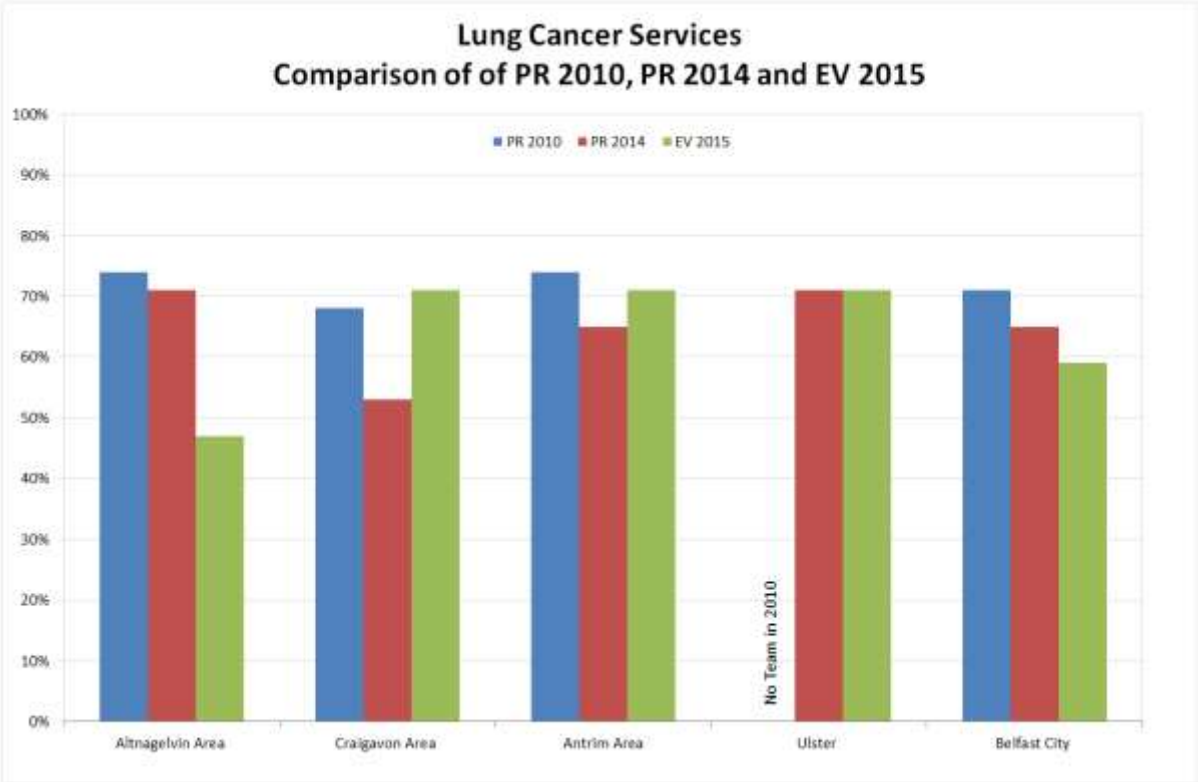
The bar graph above shows the percentage compliance with the peer review measures at self-assessment, peer review and external verification. The table below shows the percentage of teams compliant with each individual measure.

Breast: Compliance with the Measures

Measure	PR 2014	SA 2015	EV 2015
			40%
			0%
			60%
N13-2B-104 - Core Members Attendance			0%
			80%
			100%
			100%
			0%
			100%
			80%
			100%
			100%
			40%
			80%
			100%
			20%
N13-2B-117 - Policy for Communication of Diagnosis to GP			40%
			20%

The compliance found at EV was generally lower than that found at last year's peer review visits, with the exception of the service at the Northern HSC Trust where the compliance reached 50%. Compliance can lower at EV due to it being a desktop exercise with no facility for meeting the team to seek further information or clarification, but equally can reflect a genuine deterioration in compliance.

2.2 Lung Cancer Services



Key:
SA – Self assessment
EV – External Verification
PR – Peer review

The bar chart above shows the percentage compliance with the peer review measures at self-assessment, peer review and external verification. The table below shows the percentage of teams compliant with each individual measure.

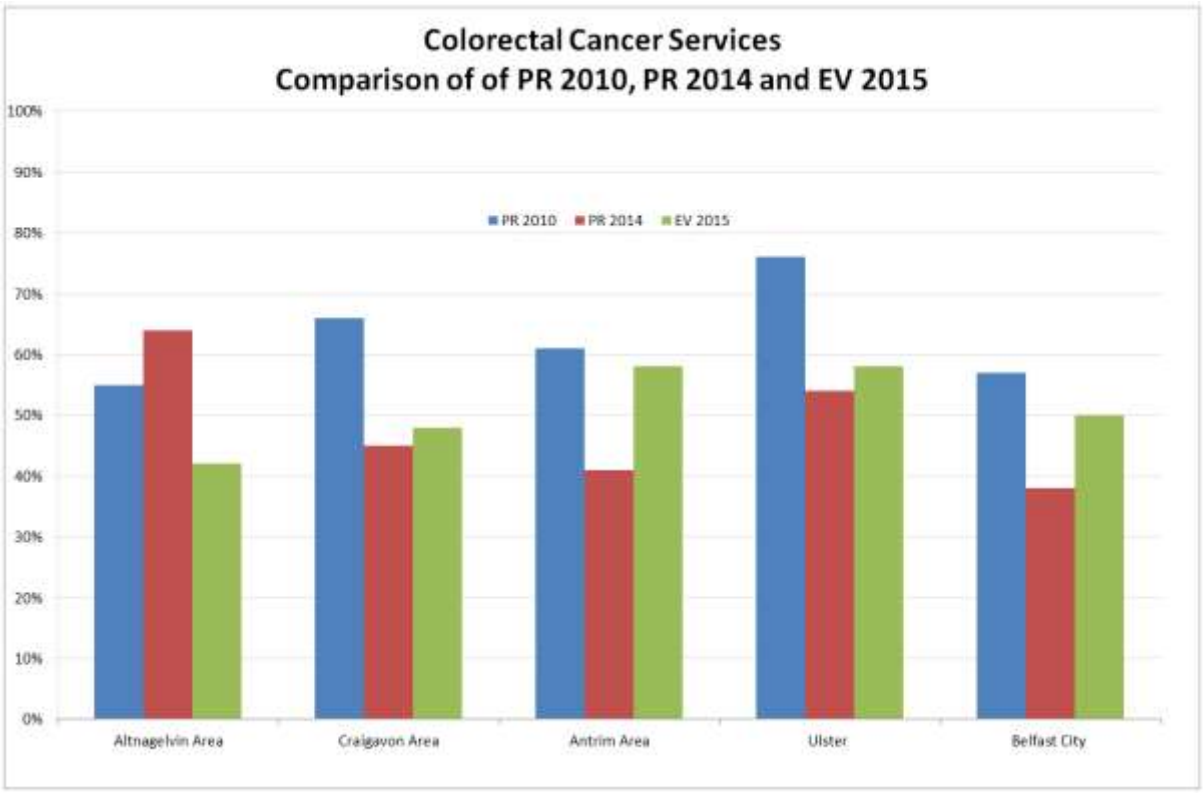
Lung: Compliance with the Measures

Measure	PR 2014	SA 2015	EV 2015
N13-2C-101 - Core Membership	40%	60%	60%
- - -			
N13-2C-103 - MDT Review	100%	100%	100%
- - -			
N13-2C-105 - Extended Membership	40%	100%	100%
- - -			
N13-2C-107 - Patient Pathways	100%	100%	100%
- - -			
N13-2C-109 - Attendance at the Network Site Specific Group	100%	100%	100%
- - -			
N13-2C-111 - Patient Information	60%	80%	80%
- - -			

N13-2C-115 - Discussion of Clinical Trials	80%	80%	80%
N13-2C-117 - Attendance at National Advanced Communication Skills Training Programme	0%	20%	20%

The compliance found at EV showed a significant improvement at Southern HSC Trust and also some improvement at the Northern HSC Trust. The compliance at Belfast has decreased slightly from the peer review visit, whilst at Western HCS Trust it dropped my more than 20%

2.3 Colorectal Cancer Services



Key:
SA – Self assessment
EV – External Verification
PR – Peer review

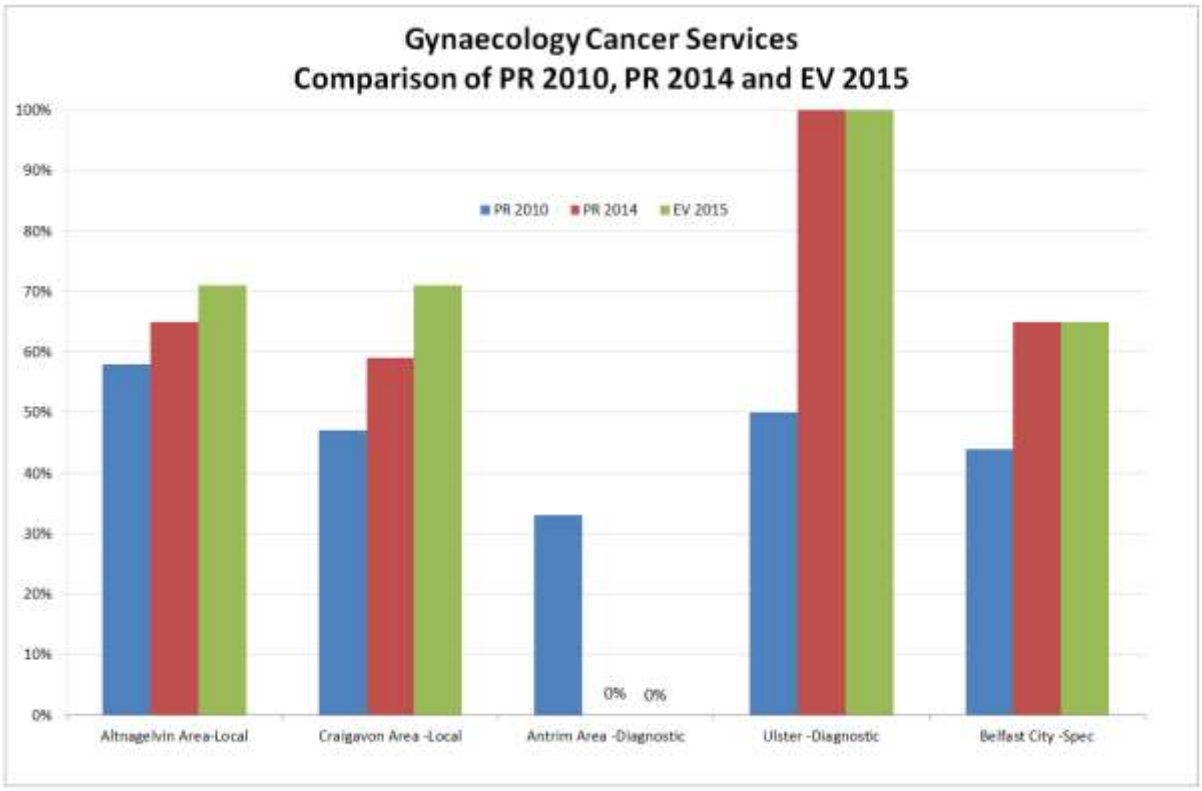
The bar chart above shows the percentage compliance with the peer review measures at self-assessment, peer review and external verification. The table below shows the percentage of teams compliant with each individual measure.

Colorectal: Compliance with the Measures

Measure	PR 2014	SA 2015	EV 2015
			60%
			0%
			0%
			100%
			0%
			60%
			60%
			100%
			0%
			100%
			100%
			0%
N14-2D-113 - Patient Pathways for Colorectal Cancer			100%
			0%
			40%
			80%
			60%
			100%
			20%
			60%
N14-2D-121 - Clinical Indicators Review / Audit			40%
			60%
N14-2D-123 - Policy for Communication of Diagnosis to GP			80%
			0%
			60%

All trusts except Western showed an improvement of compliance with the measures compared to the peer review visit in 2014. At Western, compliance dropped by more than 20%.

2.4 Gynaecological Services



Key:
SA – Self assessment
EV – External Verification
PR – Peer review

The table above bar chart shows the percentage compliance with the peer review measures at self-assessment, peer review and external verification for the specialist, local and diagnostic gynaecological cancer services. Note that there are only two measures that apply to the two diagnostic services. Two of the tables below show the percentage of teams compliant with each individual measure. There is only one specialist MDT and so the table shows whether or not the SMDT was compliant with the measure.

Specialist Gynaecology MDT: Compliance against the Measures

Measure	PR 2014	SA 2015	EV 2015
N14-2E-201 - Core Membership	No	No	No
N14-2E-203 - MDT Review	Yes	Yes	Yes
N14-2E-205 - Extended Membership of MDT	Yes	Yes	Yes
N14-2E-207 - Patient Pathways	Yes	Yes	Yes
N14-2E-209 - Attendance at the Network Group	Yes	Yes	Yes
N14-2E-211 - Patient Information	Yes	Yes	Yes
N14-2E-213 - Patient Feedback	Yes	Yes	Yes
N14-2E-215 - Discussion of Clinical Trials	Yes	Yes	Yes
N14-2E-216 - Policy for Communication of Diagnosis to GP			
N14-2E-217 - Attendance at National Advanced Communication Skills Training Programme	Yes	No	No

Local Gynaecology MDT: Compliance with the Measures

Measure	PR 2014	SA 2015	EV 2015
N14-2E-101 - Core Membership	50%	100%	50%
N14-2E-103 - MDT Review	50%	100%	100%
N14-2E-105 - Extended Membership of MDT	50%	50%	100%
- - -			
N14-2E-107 - Patient Pathways			
- - -			
N14-2E-109 - Attendance at the Network Group			
- - -			
N14-2E-111 - Patient Information			
- - -			
N14-2E-113 - Patient Feedback	Yes	100%	100%
- - -			
N14-2E-115 - Discussion of Clinical Trials	50%	50%	50%
- - -			
N14-2E-117 - Attendance at National Advanced Communication Skills Training Programme	50%	50%	50%

Gynaecology Diagnostic Services: Compliance with the Measures

- - -		

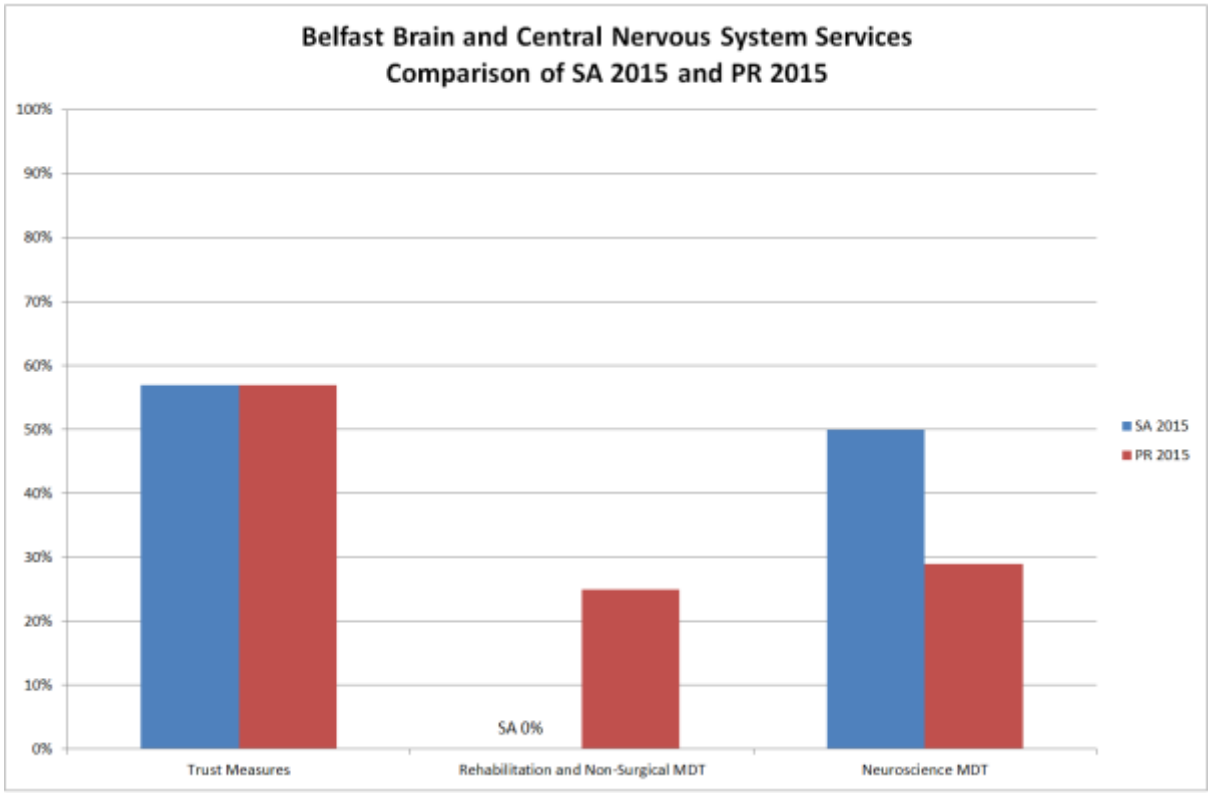
The compliance found at EV for all trusts was either the same as, or a slight improvement on, that found at peer review visits in 2014.

3.0 Services Reviewed in 2015

The sections below summarise the findings of the 2015 reviews for each cancer type. The graphs and tables provide a comparison between the compliance declared by the teams as part of their aelf-assessment, and the compliance found at the peer review visits. It is a regular finding in peer review that self-assessment scores are higher than those found at review, but this disparity is normally in the region of 10%-20%. Anything greater than this may indicate a lack of understanding of the measures, a lack of insight into a service or some other aspect relating to the service or trust.

3.1 Brain and Central Nervous System Cancer Services

There are three sets of measures for brain and central nervous system services. The Trust Measures address the overall leadership, structure, policies and process of the service. The Neuroscience MDT measures pick up all the aspects relating to the functioning opf the MDT, whilst the Rehabilitation and Non-Surgical measures address the parts of the service outside the surgical treatment pathways. Brain and central nervous system cancers are only provided at Belfast HSC Trust.



Key:
SA – Self assessment
EV – External Verification
PR – Peer review

The bar chart above shows the percentage compliance with the peer review measures at self-assessment and peer review. The table below shows the number of immediate risks and serious concerns raised across the service.

Brain and Central Nervous System: Immediate Risks and Serious Concerns

Trust	Team	IR	SC
Belfast HSC Trust	Brain and Central Nervous System	3	2

Brain and Central Nervous System: Good Practice

A number of elements of good practice were identified including:

- Rapid Access Neuro-oncology Clinic (RANOC).
- Good recruitment into clinical trials.
- GP education events.
- 31 day cancer waiting times target achievement.

Brain and Central Nervous System: Measure Compliance

The tables below show whether the service was compliant with each measure at self-assessment and peer review.

Brain and Central Nervous System: Compliance against Trust Measures

Measure	SA	PR
N14-1D-101k - Trust Lead Clinician	Yes	Yes
N14-1D-102k - The Multidisciplinary Specialist Clinic	No	No
N14-1D-103k - Patient Pathways	No	No
N14-1D-104k - Network Communication Framework	Yes	Yes
N14-1D-105k - The Network Emergency Surgical Intervention Protocol	Yes	Yes
N14-1D-106k - Electronic Imaging Transfer	Yes	Yes
N14-1D-107k - Operational Policy for Neuro-Rehabilitation	No	No

Brain and Central Nervous System: Compliance against Neuroscience MDT Measures

Measure	SA	PR
N14-2K-201 - Core Membership	No	No
N14-2K-202 - MDT Quorum	No	No
N14-2K-203 - MDT Review	Yes	No
N14-2K-204 - Core Members Attendance	No	No
N14-2K-205 - Extended Team Membership	No	No
N14-2K-206 - Specified Surgical Programmed Activities for Brain and CNS Tumours	No	No
N14-2K-207 - Specified Surgical Programmed Activities for Pituitary and Skull Base Tumours	Yes	No
N14-2K-208 - Specialist Clinic Attendance by Core Oncologist MDT Members	Yes	No
N14-2K-209 - Specialist Clinic Attendance by Core Nurse MDT Members	Yes	Yes
N14-2K-210 - Specified Radiological Programmed Activities	Yes	No

N14-2K-212 - Clinical Guidelines	No	Yes
N14-2K-213 - Patients Pathways	No	No
N14-2K-214 - Patient Management Planning Decision	Yes	Yes
N14-2K-215 - Network Communication Framework	Yes	Yes
N14-2K-216 - Attendance at the Neuro-oncology Disease Site Group	Yes	Yes
N14-2K-217 - Key Worker	No	No
N14-2K-218 - Patient Information	Yes	No
N14-2K-219 - Permanent Record of Consultation	No	No
N14-2K-220 - Patient Feedback	Yes	No
N14-2K-221 - Clinical Indicators Review / Audit	Yes	Yes
N14-2K-222 - Discussion of Clinical Trials	No	No
N14-2K-223 - Policy for Communication of Diagnosis to GP	No	No
N14-2K-224 - Attendance at National Advanced Communication Skills Training Programme	No	No

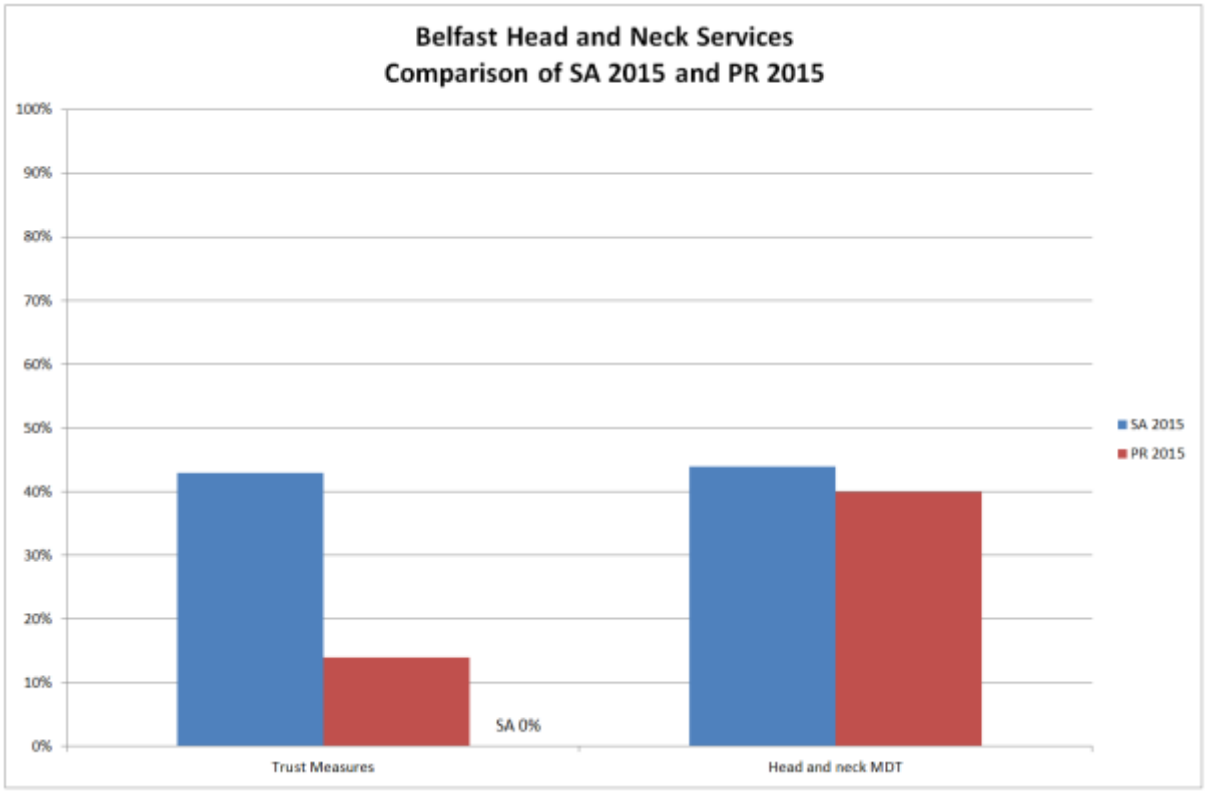
Brain and Central Nervous System: Compliance against Rehabilitation and Non-Surgical Measures

Measure	SA	PR
N14-2K-101 - Core Membership	No	No
N14-2K-105 - Extended Team Membership	No	No
N14-2K-113 - Key Worker	No	No
N14-2K-114 - Patient Information	No	No
N14-2K-115 - Permanent Record of Consultation	No	No
N14-2K-116 - Patient Feedback	No	No
N14-2K-117 - Clinical Indicators Review / Audit	No	Yes
N14-2K-118 - Discussion of Clinical Trials	No	Yes

The service showed good compliance with the trust measures, but between 20 and 30% compliance for the neuroscience and rehabilitation & non-surgical sets of measures. The three immediate risks all related to the functioning of the MDT. Issues identified included the absence of neurology input, the deselecting of some patients for discussion and the preparation time for the MST for the radiologist and histopathologist. Serious concerns related to having different picture archiving (PACS) systems and the lack of allied health professional input to the MDT.

3.2 Head and Neck Cancer Services

There are two sets measure, one addressing the facilities and service available in the hospital, and one the functioning of the MDT. The chart below shows the compliance at Belfast at self-assessment and peer review for both sets of measures.



Key:
SA – Self assessment
EV – External Verification
PR – Peer review

The table below shows the number of immediate risks and serious concerns raised for the service. It should be noted that the table below shows the MDT review at which the issue was identified and raised, but that some of these had implications for, or related to, services in other trusts.

Head and Neck: Immediate Risks and Serious Concerns

Trust	Team	IR	SC
Belfast HSC Trust	Head and Neck	1	8

Head and Neck: Good Practice

Elements of good practice were identified including:

- Patient information checklist.
- Laryngectomy register with the Ambulance Service.
- Patient survey results and implementation of actions.

Head and Neck: Measure Compliance

The tables below show whether the service was compliant with each measure at self-assessment and peer review.

Head and Neck: Compliance with MDT Measures

Measure	SA	PR
N14-2I-101 - Core Membership	No	No
N14-2I-102 - MDT Quorum	No	No
N14-2I-103 - MDT Review	Yes	Yes
N14-2I-104 - Core Members Attendance	No	No
N14-2I-105 - Extended Membership of MDT	Yes	Yes
N14-2I-106 - Pre Treatment Assessment Sessions	No	No
N14-2I-107 - Core Consultant Members Spend 50% of Time on Care of UAT Cancer	No	No
N14-2I-108 - Minimum Individual Workload for Thyroid Surgeons	No	n/a
N14-2I-109 - MDT Minimum Workload	Yes	Yes
N14-2I-110 - Named Surgeons Authorised to Perform Lymph Node Resections	Yes	n/a
N14-2I-111 - Single Named Designated Hospital for Surgical Procedure	No	No
N14-2I-112 - Agreed Service Specification for Rescue of Reconstructive Surgical Flap Failure	Yes	Yes
N14-2I-113 - Clinical Guidelines	Yes	Yes
N14-2I-114 - Patient Pathways	Yes	Yes
N14-2I-115 - Operational Policy Specifying Discharge Criteria	No	No
N14-2I-116 - Treatment Planning	No	No
N14-2I-117 - Attendance at the Network Group	Yes	Yes
N14-2I-118 - Operational Policy for Principal Clinician	Yes	Yes
N14-2I-119 - Key Worker	No	No
N14-2I-120 - Agreed Policy for Patient to Discuss Treatment Options	No	No
N14-2I-121 - Patient Information	Yes	Yes
N14-2I-122 - Permanent Record of Consultation	No	No
N14-2I-123 - Patient Feedback	Yes	No
N14-2I-124 - Clinical Indicators Review / Audit	Yes	Yes
N14-2I-125 - Discussion of Clinical Trials	No	No
N14-2I-126 - Policy for Communication of Diagnosis to GP	No	No
N14-2I-127 - Attendance at National Advanced Communication Skills Training Programme	No	No

Thyroid services were not included in the assessment so those measures were non-applicable at this peer review. As may be seen from the table above, there was generally good agreement between the compliance at self-assessment and at peer review, demonstrating good insight by the team of the areas that need to be addressed to improve the overall compliance, which was low at 40%. The absence of a cross-sectional radiologist from a fifth of the meetings was deemed to be an immediate risk by the reviewers due to the significant risk of inappropriate treatment decisions being made. The Trust has funding to increase the resource but has been unable to recruit a suitable candidate. A number of the serious concerns raised related to the configuration of the service with surgery occurring on several sites, and the logistical and resource challenges that arise from this.

3.3 Hepatobiliary Cancer Services

There is one set of HPB measures, and the service is provided at Belfast HSC Trust. The table below shows the compliance with the measures at self-assessment and peer review.

HPB: Compliance with the Measures

Trust	SA 2015	PR 2015
Belfast HSC Trust	45%	40%

The table below shows the number of immediate risks and serious concerns raised for the service.

HPB: Immediate Risks and Serious Concerns

Trust	Team	IR	SC
Belfast HSC Trust	HPB	5	3

HPB: Good Practice

Elements of good practice were identified including:

- Surgical attendance at the MDT meetings.
- CNS undertaking staff education and clinical supervision for the ward staff.
- Good communication pathways with referring hospitals.
- Good clinically relevant audit.
- Organisation of pancreatic and colorectal wellbeing study day for patients.

HPB: Measure Compliance

The table below show whether the service was compliant with each measure at self-assessment and peer review.

HPB: Compliance with MDT Measures

Measure	SA	PR
N13-2N-101 - Core Membership	No	No
N13-2N-102 - MDT Quorum	No	No
N13-2N-103 - MDT Review	Yes	No
N13-2N-104 - Core Members Attendance	No	No
N13-2N-105 - Extended Membership	Yes	Yes
N13-2N-106 - Specialist Surgical Cover	No	No
N13-2N-107 - Specialist Interventional Radiology Cover	No	No
N13-2N-108 - Single Site Surgery and Post-Operative Care	Yes	Yes
N13-2N-109 - Clinical Guidelines	Yes	Yes
N13-2N-110 - Patient Pathways	Yes	Yes
N13-2N-111 - Treatment Planning	No	No
N13-2N-112 - Attendance at the Network Site Specific Group	Yes	Yes
N13-2N-113 - Key Worker	No	No
N13-2N-114 - Patient Information	Yes	Yes
N13-2N-115 - Permanent Record of Consultation	No	No
N13-2N-116 - Patient Feedback	Yes	Yes
N13-2N-117 - Clinical Indicators Review / Audit	No	No
N13-2N-118 - Discussion of Clinical Trials	Yes	Yes
N13-2N-119 - Policy for Communication of Diagnosis to GP	No	No

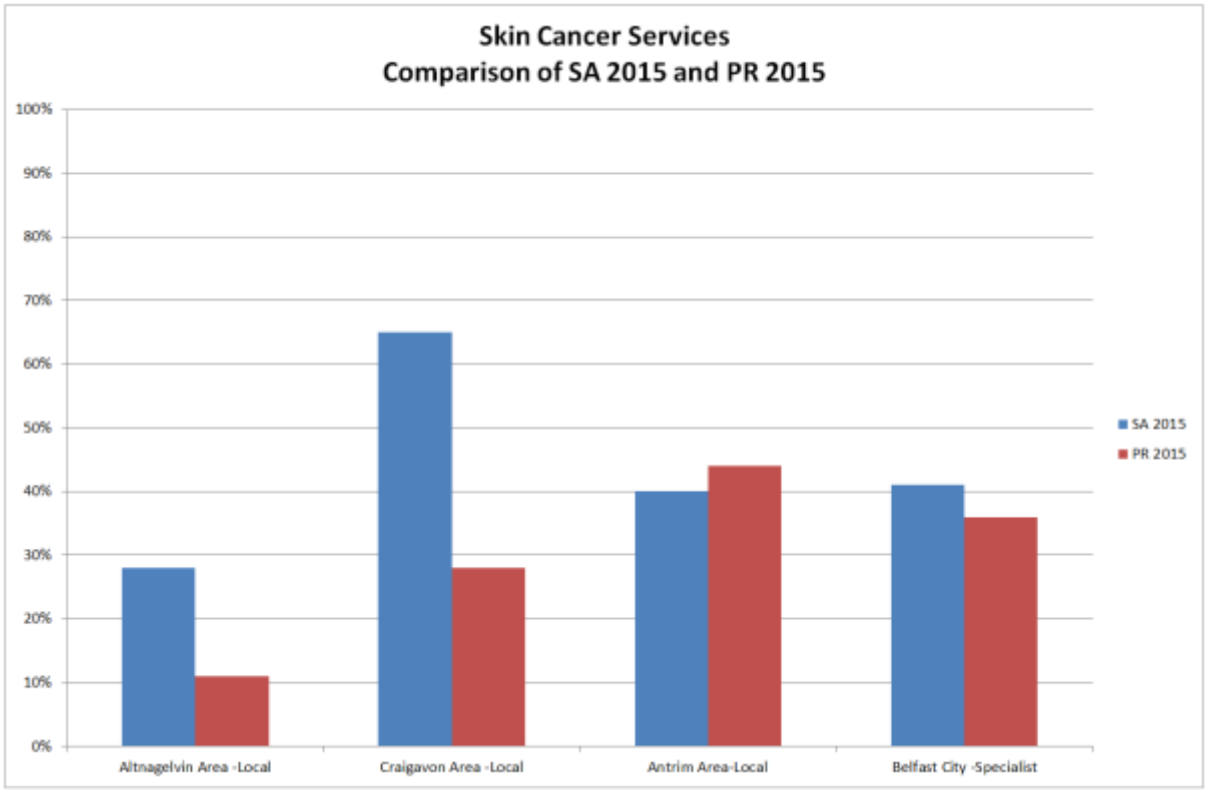
N13-2N-120 - Attendance at National Advanced Communication Skills Training Programme	No	No

Once again, there was good correlation between the compliances at self-assessment and peer review. The overall compliance was low at 40%, with a high number of immediate risks. Areas of significant risk raised as immediate risks by the reviewers included; the support to acutely ill post-operative patients - including reliance on an informal out of hour HPB surgical rota - and the subsequent need to transfer them to another hospital, the lack of histological and nursing support to the service and MDT respectively, and the pre-selection of some patients meaning their case is not discussed at the MDT. The Trust has an action plan to address these issues. Serious concerns included the low percentage of occasions on which the MDT was quorate, the time available for the MDT and the capacity across the service to meet the increasing demand.

3.4 Skin Cancer Services

The specialist skin cancer measures were applied to the MDT at Belfast (which provides the specialist service for the whole of Northern Ireland and the local MDT service for both its own population and that of the South Eastern HSC Trust) whilst the local skin cancer measures were applied to the MDTs at the Northern, Southern and Western HSC Trusts. The single measure relating to the provision of a clinic for immunocompromised patients only related to Belfast.

The chart below shows the compliance at self-assessment and peer review for the sets of measures applied to the service.



Key:
SA – Self assessment
EV – External Verification

PR – Peer review

The table below shows the number of immediate risks and serious concerns raised for the service. It should be noted that the table below shows the MDT review at which the issue was identified and raised, but that some of these had implications for, or related to, services in other trusts.

Skin: Immediate Risks and Serious Concerns

Trust	Team	IR	SC
Belfast HSC Trust	Specialist Skin Cancer	3	7
Northern HSC Trusts	Local Skin Cancer	0	4
Southern HSC Trusts	Local Skin Cancer	0	5
Western HSC Trusts	Local Skin Cancer	1	4

Skin: Good Practice

Elements of good practice were identified across the teams and examples of these include:

- Medical photography triage service (Northern)
- Availability of tele-dermatology services (Southern)
- Dedicated dermatology inpatient and outpatient unit (Western)
- Monthly speciality audit meetings (Belfast)

Skin: Compliance with the Local Skin Cancer Measures

The table below show the percentage compliance with each measure at self-assessment and peer review for the local skin cancer measures.

Measure	SA	PR
N14-2J-101 - Core Membership	33%	0%
N14-2J-102 - MDT Quorum	0%	0%
N14-2J-103 - MDT Review	67%	33%
N14-2J-104 - Core Members Attendance	0%	0%
N14-2J-105 - Extended Membership of MDT	33%	33%
N14-2J-106 - MDT Agreement to Clinical Governance Arrangements for Community Practitioners	50%	-
N14-2J-107 - Training for Model 2 Community Practitioners	0%	-
N14-2J-108 - Clinical Guidelines	100%	67%
N14-2J-109 - Patient Pathways	67%	67%
N14-2J-110 - Treatment Planning	67%	33%
N14-2J-111 - Attendance at the Network Group	67%	0%
N14-2J-112 - Key Worker	33%	0%
N14-2J-113 - Patient Information	67%	67%
N14-2J-114 - Permanent Record of Consultation	0%	0%
N14-2J-115 - Patient Feedback	100%	100%
N14-2J-116 - Clinical Indicators Review / Audit	100%	67%
N14-2J-117 - Discussion of Clinical Trials	0%	0%
N14-2J-118 - Bi-annual Educational / Audit Meetings	67%	33%
N14-2J-119 - Policy for Communication of Diagnosis to GP	33%	0%
N14-2J-120 - Attendance at National Advanced Communication Skills Training Programme	0%	0%

Skin: Compliance with the Specialist Skin Cancer Measures

The table below show whether the specialist service at Belfast was compliant with each measure at self-assessment and peer review.

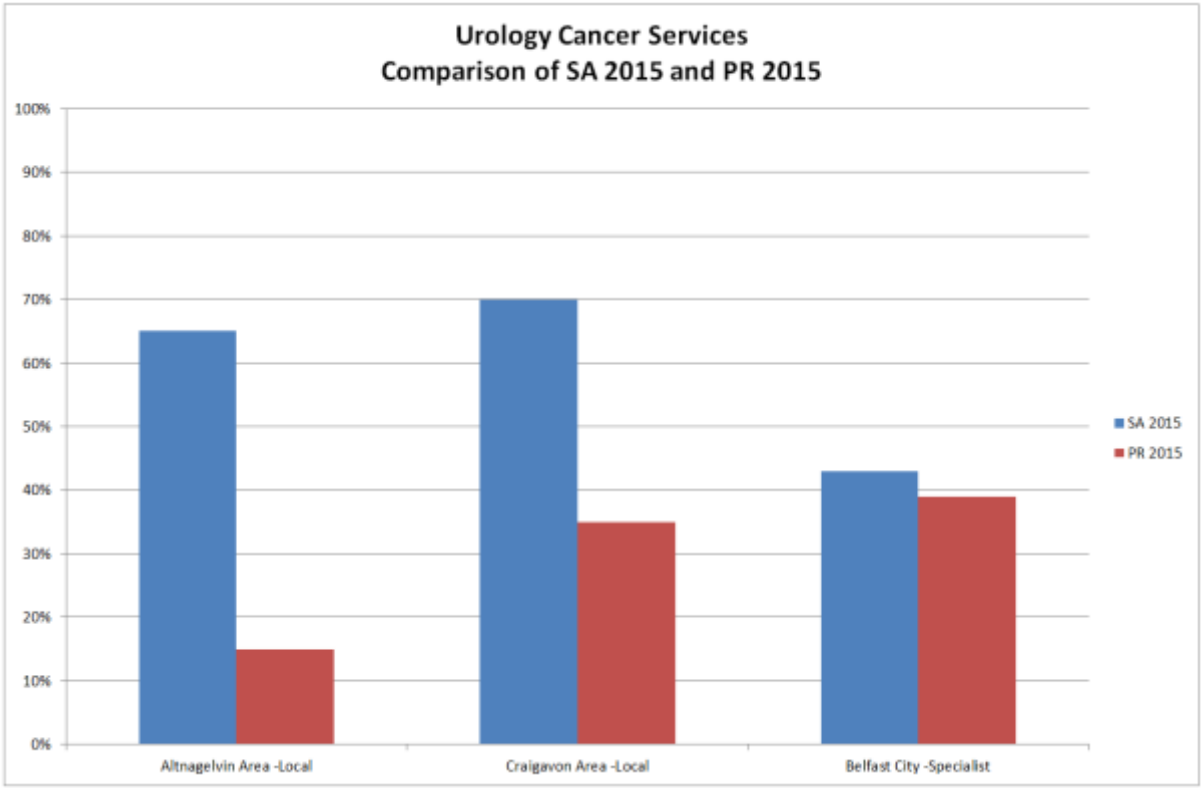
Measure	SA	PR
N14-2J-201 - Core Membership	No	No
N14-2J-202 - MDT Quorum	No	No
N14-2J-203 - MDT Review	Yes	No
N14-2J-204 - Core Members Attendance	No	No
N14-2J-205 - Extended Membership of MDT	Yes	Yes
N14-2J-206 - MDT Agreement to Clinical Governance Arrangements for Community Practitioners	No	No
N14-2J-207 - Training for Model 2 Community Practitioners	No	No
N14-2J-208 - Specific Procedures Carried Out in Same Named Hospital	No	No
N14-2J-209 - Individual Surgical Member Inguinal or Axillary Dissections Workload	No	No
N14-2J-210 - Clinical Guidelines	Yes	Yes
N14-2J-211 - Patient Pathways	Yes	Yes
N14-2J-212 - Treatment Planning	No	No
N14-2J-213 - Attendance at the Network Group	Yes	Yes
N14-2J-214 - Key Worker	No	No
N14-2J-215 - Patient Information	Yes	Yes
N14-2J-216 - Permanent Record of Consultation	No	No
N14-2J-217 - Patient Feedback	Yes	Yes
N14-2J-218 - Clinical Indicators Review / Audit	Yes	Yes
N14-2J-219 - Discussion of Clinical Trials	Yes	Yes
N14-2J-220 - Bi-annual Educational / Audit Meetings	No	No
N14-2J-119 - Policy for Communication of Diagnosis to GP	No	No
N14-2J-120 - Attendance at National Advanced Communication Skills Training Programme	No	No
N14-1D-101j - Provision of Clinics for Immunocompromised Patients with Skin Cancer	No	No

No team achieved more than 45% compliance with the measures with the service at Western meeting only 11%. At both Belfast and Western, immediate risks were raised in relation to the numbers of surgeons carrying out specialist procedures, whether they are core members of an MDT and whether all patients are being discussed at the MDT prior to treatment, or in some cases, discussed there at all. A separate immediate risk was raised at Belfast relating to significant delays in red flag patients being seen by plastic surgeons. The trusts have developed plans to address these issues. There were a number of themes in the 20 serious concerns raised by the reviewers. These included: absence or shortage of CNS support to the MDTs or services, delays for Mohs surgery, shortages of consultants for the population served and reliance on locums, and significant delays in seeing routine referrals.

3.5 Urological Cancer Services

The specialist urological cancer measures were applied to the MDT at Belfast (which provides the specialist service for the whole of Northern Ireland and the local skin cancer measures were applied to the MDTs at the Southern and Western HSC Trusts.

The chart below shows the compliance at self-assessment and peer review for the sets of measures applied to the service.



Key:
SA – Self assessment
EV – External Verification
PR – Peer review

The table below shows the number of immediate risks and serious concerns raised for the service. It should be noted that the table below shows the MDT review at which the issue was identified and raised, but that some of these had implications for, or related to, services in other trusts.

Urology: Immediate Risks and Serious Concerns

Trust	Team	IR	SC
Belfast HSC Trust	Specialist Urological Cancer	1	4
Southern HSC Trusts	Local Urological Cancer	0	4
Western HSC Trusts	Local Urological Cancer	1	5

Urology: Good Practice

Elements of good practice were identified across the teams and examples of these include:

- Research nurses are core members of the MDT and have good attendance, and associated Good recruitment to clinical trials. (Belfast)
- Very clear and comprehensive patient information (Belfast)
- The implementation of the Single Visit Clinic (Southern)
- Secured slots in clinic following MDT meeting for patient discussion (Southern)
- CNS review at Western Trust.
- Comprehensive patient information at Western Trust.
- Survivorship and the Health and Well-Being activities at Northern Trust.

Urology: Compliance with the Local Urology Cancer Measures

The table below show the percentage compliance with each measure at self-assessment and peer review for the local urology cancer measures.

Measure	SA	PR
N14-2G-101 - Core Membership	100%	50%
N14-2G-102 - MDT Quorum	0%	0%
N14-2G-103 - MDT Review	100%	50%
N14-2G-104 - Core Members Attendance	50%	0%
N14-2G-105 - Extended Membership of MDT	100%	50%
N14-2G-106 - Clinical Guidelines	50%	0%
N14-2G-107 - Regular Prostate Clinic	100%	50%
N14-2G-108 - Regular Haematuria Clinic	50%	50%
N14-2G-109 - Agreed Policy for Patient Access to MDT to Discuss Treatment Options	100%	0%
N14-2G-110 - Patient Pathways	100%	0%
N14-2G-111 - Treatment Planning	100%	0%
N14-2G-112 - Attendance at the Network Group	100%	100%
N14-2G-113 - Key Worker	50%	0%
N14-2G-114 - Patient Information	100%	0%
N14-2G-115 - Permanent Record of Consultation	0%	0%
N14-2G-116 - Patient Feedback	100%	50%
N14-2G-117 - Clinical Indicators Review / Audit	0%	0%
N14-2G-118 - Discussion of Clinical Trials	50%	50%
N14-2G-119 - Policy for Communication of Diagnosis to GP	50%	50%
N14-2G-120 - Attendance at National Advanced Communication Skills Training Programme	50%	0%

Urology: Compliance with the Specialist Urology Cancer Measures

The table below show whether the specialist service at Belfast was compliant with each measure at self-assessment and peer review.

Measure	SA	PR
N14-2G-201 - Core Membership	No	Yes
N14-2G-202 - MDT Quorum	No	No
N14-2G-203 - MDT Review	Yes	No
N14-2G-204 - Core Members Attendance	No	No
N14-2G-205 - Extended Membership of MDT	Yes	Yes
N14-2G-206 - Single Site Surgery and Post Operative Care	No	No
N14-2G-207 - Minimum Individual Workload	No	Yes
N14-2G-208 - MDT Minimum Workload	Yes	Yes
N14-2G-209 - Clinical Guidelines	Yes	No
N14-2G-210 - Regular Prostate Clinic	No	No
N14-2G-211 - Regular Haematuria Clinic	No	No
N14-2G-212 - Agreed Policy for Patient Access to MDT to Discuss Treatment Options	No	No
N14-2G-213 - Patient Pathways	Yes	No
N14-2G-214 - Treatment Planning	No	No
N14-2G-215 - Attendance at the Network Group	Yes	Yes
N14-2G-216 - Key Worker	No	No
N14-2G-217 - Patient Information	Yes	Yes
N14-2G-218 - Permanent Record of Consultation	No	No
N14-2G-219 - Patient Feedback	Yes	Yes
N14-2G-220 - Clinical Indicators Review / Audit	Yes	Yes
N14-2G-221 - Discussion of Clinical Trials	Yes	Yes
N14-2G-222 - Policy for Communication of Diagnosis to GP	No	No
N14-2G-223 - Attendance at National Advanced Communication Skills Training Programme	No	No

None of the teams achieved a compliance of over 50%, with Belfast the highest at 39% and Western the lowest at 15%. The immediate risk at Belfast related to the management of penile surgery with some patients being treated locally outside of the MDT whilst others had treatment before their case had been discussed. At Western, it was found that some surgeons who were not members of, and did not attend, the MDT were treating urological cancers and this too was raised as an immediate risk. Of the 13 serious concerns raised, three related to nephron sparing surgery being carried out by all three services, whilst others included lack of CNSs and significant delays in the patient pathway. At Western, the differences between the services on different site also prompted serious concerns.

4.0 Immediate Risks and Serious concerns – Themes in Network/Trusts

The summaries above draw out themes for each specialty. It is, however, also worthwhile to consider themes across trusts and the network as a whole.

The table below shows the incidence of the common issues raised as immediate risks and serious concerns across the trusts. It should be noted that the table shows the trust review at which the issue was identified and raised, but that some of these had implications for, or related directly to, other trusts.

Frequently occurring SCs and IRs	Western	Northern	Southern	Belfast	
	3		2	4	
	2	1	1	3	
		2	2	2	
	2	1	1	2	
			1	4	
			1	4	
				4	
				3	
				2	
				2	
				2	

The teams that were reviewed in 2015 have models based on either local and specialist servicers (eg urological cancers) or centralisation to specialist teams only (eg brain and central nervous system). This has led to a clear difference between the 2014 and 2015 reviews with a large number of immediate risks and serious concerns relating to the configuration of services, and procedures being carried out outside of specialist centres.

Similar to last year, significant delays for both routine and urgent referrals were noted, with this being raised for routine cases at most of the trusts. Staffing was also a common issue with CNS provision once again being raised as a significant risk across all trusts reviewed. However, unlike last year, there were also a large number of gaps in the provision of medical staff, with an over reliance on locums in some areas.

The table also highlights the pressures Belfast has been experiencing across many MDTs relating to time and facilities to run MDTs, the input available from radiology and histopathology and the consequent effect this has had, among other things, on the quoracy of MDT meetings.

5.0 Conclusions

This report describes two main areas. Firstly, teams reviewed in 2014 undertook self-assessments that were validated as being accurate by the trusts. A process of external verification was undertaken and compared to both this year's self-assessment and the outcomes of the previous year's reviews. This exercise showed a mixture of some teams having improved, particularly in gynaecological cancer, and some having stayed the same. It is of concern that in some cases there was a noticeable decline in compliance.

The second part of this report describes the outcomes of the reviews to five types of cancer. None of these had been reviewed in 2010 so comparisons have been made with the trust's own self assessments prior to the visits. As is usual, the compliances found at peer review were lower than at self-assessment. It is of concern that overall the compliances were low, with the majority below 50%. The immediate risks found at these visits have been considered, and themes drawn out both within speciality, but also within and across trusts.

For the network, the reviews have demonstrated considerable challenges relating to the configuration of services to ensure specialist teams, which may be made up from clinicians from more than one trust, act as and provide the advantages to patients of working as a single team. For this model to work it is necessary for all other trusts to refer patients to the agreed pathways and ensure procedures are not carried out locally that should be undertaken at a specialist centre. Work also needs to be undertaken across the board to improve compliance, improve waiting times for routine and urgent referrals, and to address staffing issues in medicine and nursing.

SELF ASSESSMENT REPORT

(MULTI-DISCIPLINARY TEAM)

Network	NICaN
Organisation	Southern
Team	Craigavon Area Hospital Urology Local MDT Measures (N14-2G-1) - 2016
Date of Validated Self Assessment	30th September 2016
MDT Lead Clinician	Mr Aidan O'Brien
Compliance	
UROLOGY LOCAL MDT MEASURES	**Self Assessment** 55.0% (11/20)
Key Themes	
Structure and function of the service	

Southern Health and Social Care Trust has provided a Urology service for patients living in the Southern area of Northern Ireland since 1992. At that time, there was one Consultant Urologist appointed. A second consultant urologist was appointed by Craigavon Area Hospital Group Trust in 1996. Since then, the service has increased incrementally in size and capacity, with a sixth consultant urologist appointed in 2014. Particular features of the service have been the provision of Extracorporeal Shock Wave Lithotripsy at the Stone Treatment Centre at Craigavon Area Hospital since 1998, and the provision of all outpatient services at a dedicated unit, the Thorndale Unit, since 2007. This unit moved to a new location within the hospital in 2013, with increased capacity, to enable all outpatient consultations to be conducted there, in addition to ultrasound scanning, prostatic biopsies, flexible cystoscopy, urodynamic studies and intravesical chemotherapy. The Unit is staffed by Clinical Nurse Specialists, Staff Nurses and Health Care workers, in addition to visiting Radiographers and Radiologists.
A review of urological service provision in Northern Ireland was conducted in 2008/09, resulting in a reconfiguration of responsibilities for services to be provided to changed geographical areas and by three separate teams of urologists. Team South, based at Southern Health and Social Care Trust (SHSCT), took on responsibility for the provision of services to the population of County Fermanagh, with effect from 1st January 2013. County Fermanagh has a population of 61,175. More recently, SHSCT has agreed to provide urological services to the population of and surrounding Cookstown, County Tyrone, bringing the entire catchment population to 427,000.
Since their commencement in 1992, urological services have been based in the Department of Urology at Craigavon Area Hospital. When the future configuration of all cancer services was advised in the Campbell Report of 1996, Craigavon Area Hospital was designated a Cancer

Unit in 1997. In addition to all of the urological services provided at Craigavon Area Hospital,

some core services have been provided at Daisy Hill Hospital in Newry since 1992 by a consultant general surgeon with an interest in urology. That consultant has recently retired, but it is hoped that he will be replaced by a consultant urologist in the near future. As the number of consultant urologists has increased in recent years, it has also been possible to provide endoscopic and day case surgery at South Tyrone Hospital in Dungannon, in addition to outpatient clinics at Banbridge Polyclinic, Armagh Community Hospital and South West Acute Hospital in Enniskillen, County Fermanagh.
The Urology MDT is a well structured and attended MDT which is fully constituted with core and extended members. Whilst the attendance by urologists and pathologists, palliative care and clinical nurse specialists has been very good, that of radiologists and by clinical oncologists has been unsatisfactory. The MDT has made every attempt during 2016 to have this issue addressed and resolved.
The Urology MDT is held every Thursday from 2.15pm, with the exception of public holidays and other exceptional occasions when Virtual MDM is conducted. Video conferencing facilities are used to enable discussion of cases and inter-trust transfer. Mr. Aidan O'Brien, Consultant Urologist, is the Lead Clinician. With increasing numbers of consultant urologists, the functions of Lead Clinician and of Chair of MDM have been separated to enhance active participation in and responsibility for MDM. Since August 2014, a rota has been established for chairing MDM by Mr. O'Brien and two colleagues, Mr. Anthony Glackin and Mr. Mark Haynes.
The Chair of each MDM will have been decided when scheduling takes place at least one month previously. Scheduling has also ensured that time is allocated to the appointed Chair to preview in detail each Wednesday all of the cases to be discussed at MDM the following day. All of the required clinical summaries, results and reports of investigations will have been provided to the appointed Chair for preview. It also enables all multidisciplinary participants to preview cases and to prepare their contributions to the discussion of cases. This provision has greatly enhanced the quality of scrutiny and preparation for discussion of each case.

Coordination of care/patient pathways

The MDT is cognisant of the Clinical Management Guidelines agreed by the Northern Ireland Cancer Network's Clinical Reference Group in Urology. All patients are discussed at MDM, an agreed outcome is recorded and arrangements are made to ensure that patients are reviewed in a timely manner to be advised of the diagnosis and of investigative or management recommendations of the MDT.

Patient experience

Patient feedback and experience is very important in planning service development. Patients' views are taken on board through compliments and complaints and this is fed back to the MDT to see where there can be areas for improvement.
A regional cancer patient experience survey (NICPES) was carried out during 2015. 17% of the Southern Trust respondents were from Urology cancer patients. The majority of patients (90%) rated their care as excellent/very good.
A local patient survey was also undertaken of those patients that were diagnosed in 2015. Response rates were overall complimentary of the service provided. Staff were said to be caring towards patients giving sensitive but clear explanations of diagnosis and treatment. Verbal

information was reinforced by written materials and patients were given adequate time and

opportunity to ask questions. Results of the survey have been reviewed and discussed at an operational meeting and an action plan developed to address areas of weakness. An MDT patient leaflet has been developed as a result and feedback from the Trust service user group is awaited.

Clinical outcomes/indicators

The Urology MDT holds an annual business meeting to discuss the MDT workload over the previous 12 months. The figures are presented.
At this meeting audit activity is reviewed and suggestions made for future audit activity. Audit activity for the past year has been limited. Data was submitted to the British Association of Urological Surgeons (BAUS) Data and Audit database in 2015.

Communication

Communication out to primary care usually takes place within 24-48 hours following discussion and agreement at MDT as GPs are able to view patient letters on the NI Electronic Care Record (NIECR). An audit of the timeliness of communication to GPs was carried out. 70% of letters were typed the same day or following day.
Six core members of the Urology MDT have attended the Advanced Communication training programme to date. The Trust is planning internal training during 2016 and a waiting list of those in the Urology MDT who require training has been compiled and when places become available they will be trained.

Good Practice

Good Practice/Significant Achievements

Trust Excellence Award to the Thorndale unit

Increased consultant capacity to meet 31 and 62 day targets

Regular MDT business meetings to consider findings from peer review and agree actions

Four new clinics per week to provide equitable access to all Red flag referrals

Appointment of two additional nurses and clerical staff to the unit

Allocation of named key worker to all newly diagnosed patients

Implementation of holistic needs assessment for all newly diagnosed patients

Development of permanent record of patient management

New MDT patient leaflet developed

Concerns

Immediate Risks Identified?

Not Identified

Immediate Risks

Immediate Risks Resolved?

Not Applicable

Immediate Risks Resolution

Serious Concerns Identified?

Not Identified

Serious Concerns

Serious Concerns Resolved?

Not Applicable

Serious Concerns Resolution

Concerns

Availability of the clinical oncologist and radiologist at all of the MDT meetings

Highest percentage increase in red flag referrals across the region

Operating theatre capacity and operator time

General Comments

The Urology MDT is a well structured and attended MDT which is fully constituted with core and extended members. Whilst the attendance by urologists and pathologists, palliative care and clinical nurse specialists has been very good, that of radiologists and by clinical oncologists has been unsatisfactory. The MDT has made every attempt to have this issue addressed and resolved.

This has been a difficult and challenging year for the team due to the competing pressures of achieving targets with increasing referrals.
A work programme has been developed which outlines the work for the incoming year, however this is viewed positively as it includes many aspects to improve the quality of the service provided to our patients.

Summary of validation process

A working group was established to examine documentation. The group consisted of Urology Clinical Lead, Clinical Nurse Specialist, Urology Head of Service, Head of Cancer Services & Service Improvement Lead. At regular intervals the documentation was circulated to MDT members for review and comments. Feedback was received and documents were adjusted accordingly. The Self-assessment was carried out by the Clinical Lead for Colorectal MDT, the Colorectal Nurse Specialist, the Head of Service and a Lay reviewer. The Lay Reviewer also reviewed the patient information evidence folder.

Organisational Statement

I, Aidan O'Brien *(Lead Clinician)* on behalf of Southern agree this is an honest and accurate assessment of the Urology Local MDT Measures.

Agreed by Francis Rice *(Chief Executive)* on 28th Sep 2016.

Belfast Health and Social Care Trust
Urology Multidisciplinary Team Meeting Restructuring Options

1. *Overview*

This paper outlines the need to allocate additional recurrent funding to the Belfast Health and Social Care Trust (BHSCT) in order to extend and reconfigure its Specialist Urology Cancer Multidisciplinary Team meeting (MDM).

This change is necessitated due to the fact that the current length of the MDM is insufficient to meet the demand for case discussions at the meeting and this was highlighted as a **serious concern** in a June 2015 NHS Peer Review Report of the MDM.

Several options are described in this paper which could be progressed to address the issues and a preferred option is put forward for consideration.

2. *Background: Current scope and configuration of BHSCT Specialist Urology MDM*

The BHSCT Specialist Urology MDM is based at the Belfast City Hospital and it serves as the Regional MDM for the discussion of urological cancer patients who are to undergo specialist treatment including:

- Patients with Kidney Cancer who are to receive surgery or chemotherapy
- Patients with invasive Bladder Cancer
- Patients with Prostate Cancer who go on to have surgery, radiotherapy or brachytherapy
- Patients with Penile or Testicular Cancer

The MDM also serves as the local MDM for the BHSCT and South Eastern Health and Social Care Trust (SEHSCT): all new patients with a urological cancer diagnosis from these areas are discussed at the meeting.

The meeting is scheduled to take place every Thursday from 2pm-4pm. The following staff are core members of the MDM (attendees cross-cover each other within their respective teams):

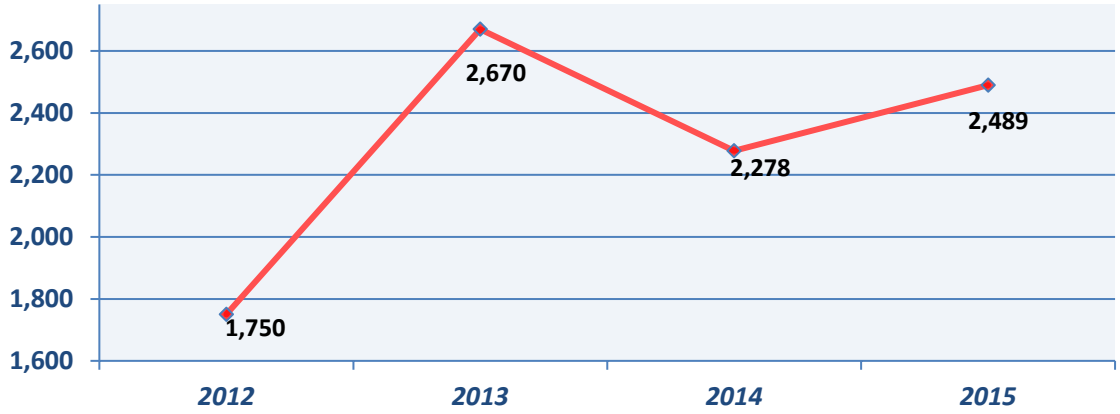
- 7 Consultant Oncologists
- 8 Consultant Uro-Oncology Surgeons
- 4 Consultant Uro-Radiologists
- 2 Consultant Pathologists
- 1 Research Radiographer
- 2 Uro-oncology Clinical Nurse Specialists (CNSs) (BHSCT)
- 2 Uro-oncology CNSs (SEHSCT-attend on alternate weeks)
- 1 Research Nurse
- 1 MDM Co-ordinator

3. *Drivers for change*

The below paragraphs outline the drivers for the proposal to extend and restructure the BHSCT Specialist Urology MDM:

(1) MDM Discussion Cap and insufficient discussion time due to increasing demand

The graph below illustrates the number of discussions at the BHSCT Specialist Urology MDM over the past four years:



This data demonstrates that there has been a 42% increase in the number of discussions at the BHSCT Specialist Urology MDM between 2012 and 2015.

Due to the increasing number of referrals to the MDM, the average number of discussions per meeting has risen from approximately 35 in 2012 to 48 in 2015. However, the number of patients registered for discussion at the meeting has been as high as 70.

The Trust MDM has received no additional resource to cope with the rise in activity seen over the past number of years – in order to help manage demand and ensure that the meeting does not overrun, the service introduced a **cap of 50 patient discussions per meeting in 2015**. This means that some case discussions are now deferred which can lead to delays in making treatment decisions for patients.

Further, because of the large volume of case referrals and the limited meeting time, the Team must discuss the issues in each case quickly in order to ensure that all cases are covered – the average discussion time at the BHSCT Urology MDM is just over 2 minutes. This is insufficient to consider all of the issues carefully and to review the details of each case in depth.

(2) Peer Review Report Concerns

In June 2015 the BHSCT's Specialist Urology MDM was assessed as part of the NHS Peer Review Visit programme. The Review identified a number of shortcomings with the current length of the MDM including:

1. The time allocated for the meeting is not sufficient for the workload undertaken
2. The meeting regularly overruns due to the volume of patients for discussion
3. Each patient is nominally allocated a 2 minute discussion time
4. Some patient discussions are deferred (due to the cap) and therefore all patients that should be discussed at the MDM are not actually being discussed

The Peer Review report concluded that there is a serious concern in relation to the current MDM capacity:

"The MDT is scheduled to last for one hour and 45 minutes and this is inadequate to discuss the 50 patients listed in sufficient detail and means that some patients are delayed until the following meeting. The cap at 50 patients also means that not all patients with cancer are being discussed at the SMDT eg. low risk bladder cancer and penile cancer."

The report also highlighted a serious concern in relation to the fact that all penile and nephron sparing surgery cases are not being discussed by the MDM. The Regional Urology Group is addressing this issue which could potentially increase the workload of the BHSCT MDM in the future.

(3) Benchmarking against NHS Sites

The BHSCT Cancer Services Team has undertaken an exercise to benchmark the activity and running order of the BHSCT Urology MDM against comparable sites in England. This exercise identified that of the 6 sites with a similar workload to the BHSCT MDM (2,127-2,654 discussions per annum):

- **83%** have a longer funded meeting time than the BHSCT (5 out of 6 sites)
- The average funded meeting time is **135 minutes (2 hours 15 minutes)**-the BHSCT MDM is funded for just 2 hours (120 minutes)
- The approximate average case discussion time is **3 minutes** compared to just over 2 minutes in BHSCT

This information highlights that the BHSCT Specialist Urology MDM is significantly out with peer sites in England and underlines the need to extend the meeting's capacity.

Further, the benchmarking exercise identified that some peer sites structure the running order of their Specialist Urology MDMs specifically to maximise clinician attendance. For example the University Hospital Southampton NHS Foundation Trust divides its meeting into 3 sections:

Section 1: Newly diagnosed cases of prostate cancer and non-muscle invasive bladder cancer for which imaging studies are not required

Section 2: Localised prostate cancer, renal cancer and muscle invasive bladder cancer cases for which imaging review is required before further management can be decided

Section 3: Testicular cancer, penile cancer and other cases requiring urgent attention

The BHSCT Urology MDM has recently introduced a new running order for its case discussions which follows this approach, as opposed to discussing cases by referring Consultant.

Summary: Drivers for Change

There is a clear need to extend the running time of the BHSCT Specialist Urology MDM in order to:

- Address the concerns highlighted by the Peer Review Report
- Accommodate the growing demand for case discussions at the meeting
- Ensure the meeting has sufficient capacity to manage all cases which require discussion and therefore avoid the need for a cap
- Ensure that there is adequate time to discuss the details of each case carefully
- Bring the BHSCT MDM in line with peer sites in England in terms of total running time and average discussion time

4. Options

Four options are outlined below which could be considered to address the issues with the BHSCT Specialist Urology MDM. The advantages and disadvantages of the options are described and a high-level indication of the cost of each option is provided.

Option 1 – Do Nothing

This option will maintain the current BHSCT Urology Specialist MDM meeting from 2.00pm-4.00pm with no change to its running time.

Advantages

- No additional costs will be incurred

Disadvantages

- The service will have to maintain the 50 discussions per meeting cap resulting in the continued deferral of some cases (on average 15-20 cases per week)
- The MDM will continue to have insufficient time to discuss each case carefully and safely
- The MDM will have insufficient capacity to cope with the rising demand for case discussions
- The serious concerns highlighted by the Peer Review visit will not be addressed

Estimated cost of Option 1: £129,016 (Baseline funding of time currently allocated for Urology MDM - no additional cost)

The rationale for each of the option costs is outlined at Appendix 1. More detailed costing information is provided in the attached template and a summary of the gross and net costs of the options is provided at Appendix 3.

Option 2– Extend MDM meeting time to 3 hours

Option 2 proposes that the Specialist Urology MDM should be extended to have a total running time of 3 hours- an additional 1 hour to the current running time.

This will facilitate an average discussion time of 3 minutes per case and will provide sufficient capacity to accommodate approximately 61 case discussions per meeting which is the projected future demand that will manifest over the next five years.

The approach taken to calculate the MDM activity and meeting running time for Option 2 is outlined at Appendix 2.

Option 2 also proposes that the MDM will maintain the following the running order:

1. **Part 1: Bladder and Prostate Cases**
    - Non-invasive bladder discussions (No Imaging required)
    - New Prostate Biopsies (No Imaging required)
    - Any other Bladder and Prostate discussions

2. **Part 2: Renal and Other Discussions**
    - Renal Cancer discussions
    - Penile/Testicular discussions

The other HSC Trusts will "dial-in" to the MDM towards the end of Part 1 to discuss their Regional case referrals.

Advantages

- The MDM will have sufficient capacity to discuss all cases, thereby avoiding any case deferrals
- There will be adequate time to discuss cases in detail (in line with peer average)
- The MDM will have sufficient capacity to manage the increasing demand on the service
- The Peer Review concerns will be effectively addressed
- The proposed running order will provide the opportunity to achieve greater case throughput

Disadvantages

- A core of MDM members would be required for the full 3 hour session which could be mentally demanding and resource intensive
- This option does not provide room for further expansion as growth continues
- Additional resources will be required to facilitate Option 2

Estimated cost of Option 2: £219,050 – net additional cost of **£90,034** per annum

Option 3- Extend overall MDM meeting time to 3 hours and split meeting over 2 days

Option 3 is similar to Option 2 in that it plans to extend the total MDM time to 3 hours. However, Option 3 also proposes that the MDM should be split over two separate days to include a 2 hour meeting slot on a Thursday afternoon and another hour-long meeting at some other point during the week. This would avoid a very lengthy meeting and the associated issue of mental fatigue, consequently helping to improve the quality of discussions.

However, there would be significant logistical challenges to accommodate two meetings including trying to co-ordinate and change the Consultant team's job-plans to facilitate separate sessions. There could also be duplication of resources to arrange, set-up and administer two meetings.

Advantages

- The MDM will have sufficient capacity to discuss all cases, thereby avoiding any case deferrals
- There will be adequate time to discuss cases in detail (in line with peer average)

- The MDM will have sufficient capacity to manage the increasing demand on the service
- The Peer Review concerns will be effectively addressed
- The proposed running order will provide the opportunity to achieve greater case throughput
- Avoidance of mental fatigue for core members of the MDM which could improve the quality of discussions
- Capacity to cater for growing demand via two separate meetings

Disadvantages

- There would be significant logistical problems to job-plan the Consultant team to attend two meetings
- Organising dial-in calls from other HSC Trusts to two meetings could prove challenging with knock-on effect for their local service
- Additional resources will be required to facilitate Option 3
- Possible duplication of resource to facilitate two weekly meetings

Estimated cost of Option 3: £219,050 – net additional cost of **£90,034** per annum

Option 4– Transfer of SEHSCT local MDM discussions to the SEHSCT and extension of MDM meeting time

Option 4 proposes that the SEHSCT local MDM discussions should transfer from the remit of the BHSCT meeting to a local MDM in the SEHSCT. It has been calculated that approximately 480 SEHSCT local cases are discussed at the BHSCT MDM per annum which could transfer to an SEHSCT local Urology MDM. The SEHSCT would continue to refer cases for consideration of specialist treatment to the BHSCT meeting.

The rationale for the proposed transfer is that it would maximise BHSCT clinician time to focus on Regional case discussions, it would enable the SEHSCT to consider local cases independently and it would avoid mental fatigue associated with a very long MDM meeting.

Under Option 4 the running order of the BHSCT MDM would be as described for Option 2. However, the total meeting running time would be 2 hours 30 minutes – an extension of 30 minutes to the current meeting. It is anticipated that this would enable the MDM to facilitate approximately 50 case discussions per meeting at a 3 minute average discussion time. (The methodology used to calculate this is outlined in the appendices). The SEHSCT has projected that its standalone MDM should be planned to run for 1.5 hours (1 hour for local discussions and 30 minutes to dial-in to BHSCT Regional meeting).

Advantages

- The MDM will have sufficient capacity to discuss all cases, thereby avoiding any case deferrals
- There will be adequate time to discuss cases in detail (in line with peer average)
- The MDM will have sufficient capacity to manage the increasing demand on the service
- The Peer Review concerns will be effectively addressed
- The transfer of SEHSCT local discussions will maximise BHSCT clinician time
- The proposed running order will provide the opportunity to achieve greater case throughput
- This option helps future proof the MDM as it provides room for further potential expansion

Disadvantages

- Additional resources will be required to facilitate Option 4
- The SEHSCT may have difficulty achieving quorum for pathology and oncology in a local MDM
- Reduction of multi-disciplinary team input into SEHSCT decision making

Estimated cost of Option 4: £243,861– net additional cost of **£114,845** per annum

5. Preferred Option

Option 1 is rejected because it will not address any of the issues outlined and because if it is chosen the current problems with the running of the BHSCT Specialist Urology MDM will continue to be manifest.

Option 2 has also been rejected on the basis that it will not make the best use of resources by continuing to facilitate SEHSCT local case discussions at the BHSCT MDM.

Option 3 is also rejected. While Option 3 will help to overcome the issues highlighted by increasing the meeting capacity, the difficulties associated with trying to facilitate two separate meetings during the working week mean that this option would be unworkable.

Option 4 is the preferred option because it will help to address the current capacity issues with the BHSCT Urology MDM and because it will establish a separate MDM in the SEHSCT for their local case discussions. This will lead to a number of improvements, including:

1. The BHSCT MDM will have sufficient time to discuss all cases and therefore there will be no need for a discussion cap

2. There will be sufficient capacity to meet the growing demand for case discussions at the MDM

3. The MDM attendees will have adequate time to discuss the detail of each case fully

4. The scope of the BHSCT MDM to focus on Regional cases and BHSCT local discussions will maximise clinician time and will be more efficient

5. The SEHSCT will have the capacity to facilitate local discussions independently

Option 4 will incur the highest costs of the outlined options, associated with the establishment of a separate meeting in the SEHSCT. However, Option 4 will help to resolve the challenges currently facing the BHSCT Urology MDM and will overcome the issues highlighted in the recent Peer Review Report by significantly increasing capacity. This will support improvements in both the quality and efficiency of the BHSCT Urology MDM.

The BHSCT acknowledges that a significant amount of planning and organisation time will be required to set up a local Urology MDM in the SEHSCT and recognises that it could take over a year to facilitate this.

Appendix 1 –Rationale for option costs

Staff	Option 1 – Baseline Costs	Options 2 and 3	Net Additional Resource for Options 2 and 3	Option 4	Net Additional Resource for Option 4
Consultant Oncologists	2.25 PAs	3.75 PAs	1.5 PAs	3.58 PAs	1.33 PAs
Consultant Surgeons	3 PAs	4.5 PAs	1.5 PAs	4.63 PAs	1.63 PA
Consultant Pathologists	2 PAs	3 PAs	1.0 PA	4.7 PAs	2.7 PAs
Consultant Radiologists	2 PAs	4.5 PAs	2.5 PAs	4 PAs	2 PAs
Consultant Team Total	**9.25 PAs**	**15.75 PAs**	**6.5 PAs**	**16.91 PAs**	**7.66 PAs**
Trials Nurse (Band 6)	/	/	/	0.05 WTE	0.05 WTE
MDM Co-ordinator (Band 4)	0.6 WTE	1.0 WTE	0.4 WTE	1.3 WTE	0.7 WTE

Calculation Notes-

Consultant Oncologists:

- Team of 7 Oncologists to be job planned to attend MDM with 2 pairs cross-covering each other on alternate weeks

- Options 2 and 3 include resource to facilitate 3 hour attendance for Consultant Oncology team- effectively 5 Consultants attending every week (3 hours or 0.75 PAs x 5 = 3.75 PAs)

- Option 4 includes resource to facilitate 2.5 hour attendance for BHSCT Consultant team (2.5 hours or 0.625 PAs x 4 = 2.5 PAs) plus Consultant time for attendance at SEHSCT MDM which will equate to 1.075 PAs, calculated as follows:
  - 1 x BHSCT Consultant attending 1.5 hour SEHSCT MDM (1.5 hours = 0.375 PAs)
  - Travel time for BHSCT Consultant to and from BHSCT (0.33 PAs)
  - SEHSCT Acute Oncology Consultant attending 1.5 hour SEHSCT MDM (0.375 PAs)
  - Total Consultant Oncologist resource need for SEHSCT MDM: 1.08 PAs

Consultant Surgeons

- Team of 5 BHSCT surgeons currently job-planned to attend 2 hour MDM (2 hours or 0.5 PAs x 5 =2.5 PAs) and SEHSCT have funding for 1 surgeon to attend per week (0.5 PAs) = 3 PAs in total

- Options 2 and 3 include resource to facilitate 3 hour attendance for BHSCT surgeon team (5 x 0.75 PAs = 3.75) plus an additional hour for SEHSCT surgeon (0.5 PAs + 1 hour or 0.25 PAs = 0.75 PAs) = 4.5 PAs in total

- Option 4 includes resource for BHSCT surgeon team to attend MDM for 30 additional minutes (2.5 hours or 0.625 PAs x 5 = 3.125 PAs) plus surgical resource for SEHSCT MDM (1.5 PAs), calculated as follows:
  - 4 x SEHSCT surgeons attending 1.5 hour SEHSCT MDM (1.5 hours or 0.375 PAs x 4= 1.5 PAs)

Consultant Pathologists

- 2 x Consultant Pathologists job planned to attend MDM with 1 PA allocated each (this includes 2 hour attendance time + 2 hours preparation time)= 2 PAs

- Options 2 and 3 include resource to facilitate attendance at MDM for an additional hour plus an additional hour of preparation time per Consultant (3 hours attendance + 3 hours preparation = 6 hours or 1.5 PAs x 2 = 3 PAs)

- Option 4 includes an extra 30 minutes attendance time and an additional 30 minutes preparation time for the two BHSCT Consultant Pathologists, equating to a total of 2.5 PAs (2.5 hours attendance +2.5 hours preparation = 5 hours or 1.25 PAs x 2 Consultants = 2.5 PAs)

  Option 4 also includes the resource required to support a SEHSCT MDM (2.2 PAs), calculated as follows:
  - 2 x Pathologists attending 1.5 hour SEHSCT MDM (1.5 hours or 0.375 PAs x 2 = 0.75 PAs)
  - 2 x Pathologists 1.5 hour preparation time (1.5 hours or 0.375 PAs x 2 = 0.75 PAs)
  - 2 x Travel time (0.33 PAs x 2 = 0.66 PAs)
  - Total Consultant Pathologist resource need for SEHSCT local MDM: 2.2 PAs

Consultant Radiologists

- 2 x BHSCT Consultant Radiologists are job planned to attend MDM for 2 hours with corresponding preparation time (2 hours) which equates to a total of 2 PAs (2 hours attendance + 2 hours preparation = 4 hours or 1 PA x 2 Consultants).

  The SEHSCT has no funding for a radiologist to attend the MDM

- Options 2 and 3 include the resource needed to facilitate a 3 hour MDM attendance plus 3 hours preparation time for both of the BHSCT Radiologists – (6 hours or 1.5 PAs, x 2 Consultants = 3 PAs).

  It also includes the time required for 1 x SEHSCT Radiologist to attend the meeting and have their preparation time, i.e. an additional 1.5 PAs.

- Option 4 includes the resource for the BHSCT Radiology team to attend the MDM for 2.5 hours and the same amount of preparation time which equates to a total of 2.5 PAs (5 hours or 1.25 PAs x 2 Consultants). It also includes provision for Radiology cover for the SEHSCT standalone MDM which equates to 1.5 PAs, calculated as follows:
  - 2 x Radiologists attendance at 1.5 hour SEHSCT MDM (0.375 PAs x2 = 0.75 PAs)
  - 2 x Radiologist 1.5 hour preparation time (0.375 PAs x2 = 0.75 PAs)

Trials Nurse

- The SEHSCT requires funding to support Trials Nurse attendance at its standalone MDM, calculated as follows:

- 1.5 hour SEHSCT MDM x approx. 50 meetings per annum = 75 hours per annum
- 1 WTE Nurse equates to 37.5 hours per week x 42 weeks per year = 1,575 hours
- WTE needed to support SEHSCT MDM = 75/1,575 = 0.05 WTE

MDM Co-ordinator

- MDM co-ordinator time will be required to facilitate extension of the MDM as outlined under Options 2 and 3, equating to 1 WTE worth of work (an additional 0.4 WTE)

- It is anticipated that an additional 0.2 WTE BHSCT MDM co-ordinator time will be needed to facilitate Option 4 and the SEHSCT will also require co-ordinator resource (0.5 WTE) to support its standalone meeting

Appendix 2 – Methodology to calculate MDM running time

Number of SEHSCT local MDT discussions

1. Total BHSCT Urology MDT discussions in calendar year 2014: **2,278**

2. Total SEHSCT discussions at BHSCT Urology MDT in 2014: **665**

3. Estimated SEHSCT Specialist Discussions in 2014: **186**

4. Approximate number of discussions which could transfer to local SEHSCT MDT *(665-186)*: **479**

Remaining Activity in BHSCT MDT

5. Number of discussions at BHSCT Urology MDT in 2015: **2,489**

6. Less approximate number of discussions which could transfer to local SEHSCT MDT *(2,489-479)*: **2,010**

7. Approx. average number of discussions at BHSCT MDT following transfer of SEHSCT local discussions *(2,010 discussions per year/50 meetings)*: **40**

Growing demand

8. There is projected to be a 5%-10% year-on-year increase in meeting discussions at the BHSCT Urology MDT (based on increase in discussions between 2014 (2,278) and 2015 (2,489)). This will result in the following average discussions per meeting over the next five years :

Year	Avg. meeting discussions: SEHSCT local retained	Average meeting discussions: SEHSCT local transferred
2016	50	40
2017	53	42
2018	56	44
2019	58	46
2020	61	48

9. In order to future-proof service, meeting capacity will be calculated based on Year 5 (2020) average discussions per meeting: **61 (if SEHSCT local discussions are retained)**
48 (if SEHSCT local discussions are transferred)

MDM running time

10. The table below shows the required total meeting time for the BHSCT Urology MDT to manage anticipated demand based on an average discussion time of 3 minutes:

Activity	Average Number of Discussions	Meeting Time (3 mins. per discussion)
SEHSCT local retained	61	3 Hours
SEHSCT local transferred	48	2 Hours 30 minutes

*Please note- times have been rounded to nearest 10 minute marker

Appendix 3 – Summary gross and net option costs

Option	Annual Gross Cost	Annual Net Additional Cost
Option 1	£129,016	/
Options 2 and 3	£219,050	£90,034
Option 4	£243,861	£114,845

Health and Social Care Board

Directorate of Commissioning

HSC Board Headquarters
12-22 Linenhall Street
Belfast
BT2 8BS

Tel : 0300 555 0115

Our Ref: DS/LETTERS/Allocations

Date: 11 October 2017

Mr Seamus McGoran
Director of Hospital Services
South Eastern HSC Trust
Trust Headquarters
Ulster Hospital
Upper Newtownards Road
Belfast

Dear Seamus

ESTABLISHMENT OF LOCAL UROLOGY CANCER MDT

As you are aware the Specialist MDT in Belfast currently discusses specialist urological cancer cases for the region as well as Belfast and SET local patients. Following an increase in patient numbers, pressure on the specialist team means that there is no longer adequate time to allow timely discussion of patients and this is starting to impact on the patient pathway.

In order to release capacity within the Specialist MDT and to allow the timely discussion of both specialist and local cases, we are confirming a recurrent allocation of £62,433 to allow SET to establish a weekly meeting of 1.5hrs duration. Based on an anticipated start date of 1 November we are making available an in year allocation of £26,014.

I would be grateful if you could complete the attached IPT and return to Personal Information redacted by the USI no later than Friday 27 October. Please note this investment will be subject to Post Project Evaluation one year from the date of the allocation.

Yours sincerely,

Personal Information redacted by the USI

Paul Cummings
Interim Director of Commissioning

cc. Cara Anderson
Miriam McCarthy
Lisa McWilliams
Karen McKay
Diane Keown
Caroline Leonard
Gillian Traub
Sinead McAteer

Health and Social Care Board

Directorate of Performance Management and Service Improvement

HSC Board Headquarters
12-22 Linenhall Street
Belfast
BT2 8BS

Tel : 0300 555 0115
Web Site : www.hscboard.hscni.net

Our Ref: LMcW044

Date: 18 September 2019

Aldrina Magwood
Director of Performance and Reform
Southern HSC Trust
Trust Headquarters
Craigavon Area Hospital
68 Lurgan Road
Portadown
BT63 5QQ

Dear Aldrina

Urology Expansion

I can confirm that the HSCB will provide £122,382 recurrently from 1 April 2020 and £61,191 CYE to support the expansion of urology capacity in the Southern Trust.

This investment will be used to make the urology service more sustainable by expanding the Urology Clinical Nurse Specialist Workforce.

The IPT will allow the development of 8.5 clinical sessions for urodynamics and LUTS service and a further 8.5 clinical sessions for prostate biopsies and nurse-led PSA follow-up service.

May I take this opportunity to thank Trust colleagues for your cooperation in taking forward this important initiative. Should you require further advice, please contact David McCormick ([redacted]) in the first instance or telephone [redacted].

Yours Sincerely

[redacted]

Lisa McWilliams
Acting Director of Performance Management and Service Improvement

Health and Social Care Board

Performance Management and Service Improvement Directorate

HSC Board Headquarters
12-22 Linenhall Street
Belfast
BT2 8BS

Tel : Personal Information redacted by the USI
Email: Personal Information redacted by the USI

Our Ref: LMCW121
Date: 7 August 2020

Teresa Molloy
Director of Performance and Service Improvement
WHSCT
MDEC Building
Trust HQs
Altnagelvin Hospital Site
Glenshane Road
Londonderry
BT47 6SB

Dear Teresa

UROLOGY EXPANSION

I am writing to confirm HSCB support for the proposed expansion of the urology service in the Western Trust.

The HSCB will provide £1.153m recurrently from 1 April 2020 and £576k CYE. The in-year funding will cover the current consultant costs, allow for the recruitment of support staff and ensure full implementation of the business case from 1 January 2021.

This investment will help expand the catchment area of Team North West to include the County Fermanagh population, provide the regional penile cancer service and the regional andrology implant service. This funding will also support the transfer of 2 day case urology lists from Causeway to Altnagelvin which will be delivered 50 weeks of the year from April 2020.

The HSCB has carried out a full benchmarking exercise of costs in the business case against current speciality costs, and have considered costs in the IPT that would be assumed outside speciality costs. HSCB are satisfied that the investment is appropriate and represents VFM.

To address the immediate capacity pressures, the Trust should take steps to ensure that the recruitment process is expedited and where possible make locum appointments to help maximise in-house capacity

and negate the need for IS provision. Allocation of funding will be subject to confirmation that all the posts are in place and the full costs are being incurred.

The table below details the quantity and associated costs of those procedures which the HSCB would wish to commission.

Workforce Requirements	**WTE**	**Activity** *(currency as agreed in SBA)*	**New SBA**
2.0 Urology Consultants and associated support staff	2.0	492 News 738 Reviews 1030 DC procedures 271 IP procedures (which includes 25 penile cancer cases) MRI – 435 CT – 870 Plain Film – 2610 Ultrasound – 1160	5722 News 8178 Reviews 5992 DC procedures 2155 IP procedures

The Trust will be expected to complete a review of the impact of investment (Post Project Evaluation), and this should be submitted to the HSCB by **end of March 2021**.

If you have any queries, please contact David McCormick in the first instance or telephone Personal Information redacted by the USI

Yours sincerely

Personal Information redacted by the USI

Lisa McWilliams
Interim Director of Performance Management and Service Improvement

Cc Paul Cavanagh
Brian McAleer
David McCormick
Karen McKay

EXTERNAL VERIFICATION REPORT NICaN 2017

Organisation	Southern HSCT	
Team	Urology MDT	
Self-Assessment Compliance	70%	
Report Completed By	Clare Langslow	
Job Title	Interim Senior Quality Manager	
Date Completed	03 October 2017	
EV RAG rating (and EV % compliance)	**Red**	65%
Recommended Action for 2018	Repeat SA	

Structure and Function

EV comments

Core membership is complete although the named clinical oncologist is a locum. There is no cover for the oncologist or the radiologist.

Individual attendance of the surgeons, histopathologist and CNS is good. The greatest challenge for the MDT during the past year remains the inability to have a clinical oncologist and or radiologist at the MDT meetings. This is due to the inability to recruit adequate numbers of clinical oncologists and radiologists to the posts where they are required both in the Trust and regionally. This has been escalated to trust senior management team and is being addressed with the appointment authorities.

With radiologists missing from 23 meetings and oncology from 35 meetings, only five MDT meetings were quorate in 2016 and this is a discernible deterioration from previous year's attendance. This raises concerns over the multidisciplinary discussion and decision making process at the MDT and by implication discussion and decisions must take place outside of the MDT meetings.

SA not agreed

Co-ordination of Care/Patient Pathways

EV comments

Network guidelines and pathways being followed. Nephron sparing surgery is no longer being undertaken locally as one of the SHSCT surgeons is providing support and undertakes nephron sparing surgery at Belfast City Hospital.

SA Agreed

Patient Experience

EV comments

As well as acting on the results of the national survey in 2015, a local patient survey was undertaken in 2016. Response rates were overall complimentary of the service provided. Results have been reviewed and discussed at an operational meeting and an action plan developed to address areas of weakness.

SA Agreed

Clinical Outcomes/Indicators

EV comments

Audit activity has been reviewed and two audits were presented in 2016; Audit on Bladder Cancer Access Standards for non-superficial disease and an Audit of Nurse Provided TRUS Biopsy Service in 2016.

Data was also submitted to the British Association of Urological Surgeons (BAUS) Data and Audit database.

Urology clinical research activity is limited due to limited attendance of the clinical oncologist at the MDT meetings. 16 patients were recruited to trials in 2016.

Trust performance on the 62 day cancer waiting times targets was below the 95% required. The table in the annual report contained formatting errors in the total number of patient on the pathway. Verification showed that 81% of patients were treated within the target.

SA Agreed

Communications

EV comments

The consultant radiologist needs to undertake Advanced Communications Skills training as must be undertaking interventional procedures.

SA Agreed

Concerns raised at SA 2017

Immediate Risk at SA

None identified

Serious Concerns at SA

Identified: Yes

Updates on previous SCs raised, see below.

Not all Resolved

Risks raised at Peer Review Visit 2015 Resolved?

Immediate Risk

None identified.

Serious Concerns

1. There is now a single handed radiologist supporting the Urology MDT with no cover arrangements in place. Attendance at the MDT during 2015 is not consistent due to clinical commitments in order to deliver timely waits for patients. This could adversely affect the treatment planning decisions for patients.

This remains a problem as radiology cover is a regional issue.

Not Resolved

2. Due to low clinical oncology and radiology attendance at the MDT meetings in the reported period only 25% of meetings were quorate. This means that a large proportion of patients are not benefitting from the knowledge and expertise of a full multidisciplinary team when decisions are being made about their diagnosis and care. As a result this could lead to delays in the decision making processes and treatment.

   Arrangements have been made with Belfast Trust to ensure clinical oncology representation at MDT meetings.

   Not Resolved

3. The reviewers were informed by a member of the cancer management team that routine referrals can wait up to 52 weeks for their initial clinic appointment. Patients who have a diagnosis of urological cancer following routine referral have a significant delay in diagnosis and this could impact on the treatment pathways and significantly affect outcomes for patients.

   All urology referrals to the Trust are triaged by the consultants, affording the opportunity for routine referrals to be processed more expeditiously, whether by upgrading to Red Flag status or Urgent, thereby minimising the risk to patients. Data provided shows waits have reduced.

   Resolved

4. Nephron sparing surgery is being undertaken locally and this should all be undertaken by the specialist MDT as indicated in the draft NICaN clinical guidelines.

   This no longer happens as one of the SHSCT surgeons is providing support to undertake nephron sparing surgery at Belfast City Hospital.

   Resolved

Overall Outcome

SA not agreed - Red

Recommended Action for 2018

An accurate assessment completed, whilst compliance is 65%, SCs have not all been resolved and there are concerns over true multidisciplinary discussions at MDT. Therefore recommend Red rating and further SA in 2018 to check

- cover for oncology and radiology core members
- individual attendance
- quoracy of the MDT meetings
- full resolution of SCs.

Health and Social Care Board

Directorate of Commissioning

HSC Board Headquarters
12-22 Linenhall Street
Belfast
BT2 8BS

Tel Irrelevant information redacted by the USI
Web Site : www.hscboard.hscni.net

To: GPs
Trust Medical Directors
Trust Directors of Acute Services
Trust Directors of Planning & Performance

Our Ref: MMC/LETTERS/TrustAll

Date: 26 September 2019

Dear Colleague

REVISION TO NORTHERN IRELAND REFERRAL GUIDANCE FOR SUSPECTED CANCER – RED FLAG CRITERIA

I am writing to confirm that *Northern Ireland Referral Guidance for Suspected Cancer – Red Flag Criteria (NICaN 2014)* has been revised for prostate cancer (see attached) effective from 1 October 2019. As you will be aware the waiting times for patients with prostate cancer continue to present a significant challenge. Work is ongoing regionally to try to improve this position, with additional investment in urology staffing and diagnostics planned during 2019/20.

NICaN Urology Clinical Reference Group (CRG) has, in collaboration with NIGPC, agreed that the provision of some additional decision support and information at the point of referral would support more appropriate referral, allow more effective triage of patients and contribute to a reduction in waiting times.

The revised guidance is based on other pathways across the UK and Ireland.

GPs should continue to refer men on the suspect cancer pathway if the prostate feels malignant on digital rectal examination.

The main change to the guidance relates to referral on the basis of abnormal PSA results. Under the new guideline, *men should be referred using a suspected cancer referral pathway for prostate cancer on the basis of a single PSA result only where the level is >20*

µg /ml. For all other men with a raised age-specific PSA, a second PSA test should be performed within 2-4weeks; a red flag referral should be made only where the second result also sits above the age specific referral range.

A PSA may be raised in the presence of urinary infection, prostatitis or benign prostatic hypertrophy, and may also be elevated following vigorous exercise, ejaculation or prostate stimulation (e.g. prostate biopsy, digital rectal examination, anal intercourse). It is therefore recommended that the PSA test is repeated within 2-4 weeks (except where the level is > 20ug/ml). Please wait six weeks to do a PSA test if a patient has had an active urinary infection, prostate biopsy, TURP, or prostatitis. In order to support practices in the implementation of the guidance, NICaN CRG has worked with primary care colleagues to develop an information leaflet for patients (enclosed). PSA testing should only be carried out after the provision of advice and provision of information.

The updated guidance will be available on the Clinical Communication Gateway and at https://nican.hscni.net/ from the 1st October 2019.

Should you have any queries, please do not hesitate to contact Cara Anderson, Assistant Director of Commissioning (Personal Information redacted by the USI) in the first instance.

Yours sincerely

Personal Information redacted by the USI

Dr Miriam McCarthy
DIRECTOR OF COMMISSIONING

Personal Information redacted by the USI

Mr Mark Haynes
CHAIR NICAN UROLOGY CRG

Personal Information redacted by the USI

Dr Graeme Crawford
MACMILLAN GP FACILITATOR

Cc Ms Cara Anderson
Dr Sloan Harper
Dr Margaret O'Brien
Dr Donagh MacDonagh

From :*Dr Kathryn Boyd ,*
Medical Director, NICaN

Strategic Planning and Performance Group
HSC Board Headquarters
12-22 Linenhall Street
Belfast
BT2 8BS

Tel : Irrelevant information redacted by the USI
Email : Irrelevant information redacted by the USI

By email
Primary Care Practice managers

Date: 10 August 2022

Dear Practice Manager

We would be grateful if you could bring this letter and attached guideline to the attention of your practice GPs and colleagues.

Revised Northern Ireland Referral Guidance for Suspected Cancer – Red Flag Criteria Aug 2022

Please find attached updated NI Referral Guidance for Suspected Cancer- Red Flag Criteria. Changes have been made to two sections to align with NICE guidance (Overview | Suspected cancer: recognition and referral | Guidance | NICE); these are for suspect breast cancer and suspect prostate cancer only. No other changes have been made at this time.

- **Breast** – All breast criteria have been updated in line with NICE Suspected cancer: recognition and referral guidelines (NG12). The main change from previous NICaN guidance is for those aged under 30 with unexplained lump.
- **Urology- Prostate** – there has been a change to PSA thresholds by age group: updated in line with NICE NG12- 1.6.3.

These changes are effective immediately however recognising summer leave; secondary care will not return any referrals that do not meet referral criteria until 1st September 2022.

The Northern Ireland Referral Guidance for Suspected Cancer – Red Flag Criteria can be viewed on an ongoing basis along with other supporting resources at Primary Care – resources and education | Northern Ireland Cancer Network (hscni.net).

Yours sincerely

Personal Information redacted by the USI

p.p. Dr Louise Herron

Dr H Kathryn Boyd
Medical Director, NICaN

cc Dr Louise Herron (PHA)

From: Johnston, Jackie (DoH)
To: Paul Cavanagh; Olive MacLeod
Cc: Michael McBride's email address Ryan Wilson (DoH)
Subject: FW: HPRM: MM/0121/2020 - Email from Maria O"Kane - CONFIDENTIAL EARLY ALERT - Urology
Date: 21 August 2020 16:06:55
Attachments: image001.png
EA 182 20.pdf

Paul and Olive
I'm unsighted as to the extent to which the Southern Trust has involved HSCB and PHA colleagues in this matter. I've attached the EA notification. Ryan is on leave so I've replied that I could meet at 2pm on Monday. HSCB and PHA would need to be involved as the Department will look to you to provide advice on assessing the need for a recall/lookback and if required submit this to the Minister for approval. We would also look to HSCB/PHA to oversee the governance and process if a lookback/recall is required.
Regards
Jackie

From: Wallace, Stephen Personal Information redacted by the USI
Sent: 21 August 2020 15:29
To: Wilson, Ryan (DoH) Personal Information redacted by the USI
Cc: Johnston, Jackie (DoH) Personal Information redacted by the USI; OKane, Maria Personal Information redacted by the USI Geoghegan, Lourda Personal Information redacted by the Chada, Naresh Personal Information redacted by the USI Greenwood, Victoria Personal Information redacted by the USI Campbell, Emma Personal Information redacted by the USI OKane, Maria Personal Information redacted by the USI
Subject: RE: HPRM: MM/0121/2020 - Email from Maria O'Kane - CONFIDENTIAL EARLY ALERT - Urology
Dear Ryan,
Further to the CMO's email below can you advise if you are available to take a call / zoom meeting on Monday (24th) anytime between 1pm-3pm with Dr O'Kane in the first instance.
To date discussions have been held to date with Dr Chada, Dr Brid Farrell and Professor Von Woerden, NHS Resolution, the GMC and we have had a number of discussions with the Royal College of Surgeons. Following on from the early alert notification and further to these discussions on behalf of the Trust we require advice on how to proceed in relation to any potential lookback required. This is in keeping with the 2007 DOH lookback guidance which highlights the key role of the DOH in this process.
The Trust is processing SAIs in relation to these concerns and the discussions are being held locally with patients and families. If you wish to discuss further you can reach me on Personal Information Personal Information
Best Regards
Stephen
Stephen Wallace
Interim Assistant Director of Clinical and Social Care Governance
Mob: Personal Information redacted by the USI

From: Gordon, Lesley Personal Information redacted by the USI
Sent: 21 August 2020 08:46
To: OKane, Maria
Cc: Johnston, Jackie (DoH); Wilson, Ryan (DoH); OKane, Maria; Geoghegan, Lourda; Chada, Naresh; Wallace, Stephen; Greenwood, Victoria
Subject: FW: HPRM: MM/0121/2020 - Email from Maria O'Kane - CONFIDENTIAL EARLY ALERT -

Urology
Maria
As Trust Medical Director grateful if you could liaise/discuss with PHA/HSCB in the first instance and thereafter the relevant Departmental Policy Lead. CMO group will provide all necessary professional advice.
Many thanks.

Lesley
Lesley Gordon
Personal Secretary to:
Dr Naresh Chada (DCMO) &
Dr Lourda Geoghegan (DCMO)
Department of Health
Room C5.21
Castle Buildings
Stormont
BELFAST BT4 3SQ
Tel: Personal Information redacted by the USI

Stay Home Stay Safe

From: OKane, Maria Personal Information redacted by the USI
Sent: 20 August 2020 23:46
To: Lesley Gordon's email address
Cc: Wallace, Stephen Personal Information redacted by the USI
Subject: FW: HPRM: MM/0121/2020 - Email from Maria O'Kane - CONFIDENTIAL EARLY ALERT - Urology

Dear Michael,
I wonder would it be possible to have a phonecall to discuss please?
I would welcome your thought about whether the Department of Health wishes to consider a Patient Service Review / Look Back Exercise in keeping with the DOH 2007 or other guidance please and the extent of this potentially?
Finally Dr Dermot Hughes previously MD Western Trust has agreed to independently chair the 3 initial SAIs that have come to the Trust's attention since June 2020. He has recommended including an expert service user which I would welcome but your thoughts on this would be very helpful please.
Kindest regards, Maria

From: McBride, Michael Personal Information redacted by the USI
Sent: 19 August 2020 11:09
To: OKane, Maria; Wilson, Ryan (DoH)
Cc: Johnston, Jackie (DoH); Geoghegan, Lourda; Chada, Naresh; DoH Early Alert
Subject: FW: HPRM: MM/0121/2020 - Email from Maria O'Kane - CONFIDENTIAL EARLY ALERT - Urology

Maria,
Thank you for forwarding
I write to acknowledge receipt and to advise that I forwarded to the relevant policy lead Ryan Wilson.
Please keep Ryan and secondary care colleagues updated.
Michael
Sent with BlackBerry Work
(www.blackberry.com)

From: Gordon, Lesley [redacted]
Date: Wednesday, 19 Aug 2020, 8:40 am
To: McBride, Michael [redacted], Geoghegan, Lourda [redacted], Chada, Naresh [redacted]
Subject: FW: HPRM: MM/0121/2020 - Email from Maria O'Kane - CONFIDENTIAL EARLY ALERT - Urology

Please see update below received from Mara's O'Kane.

Many thanks

Lesley

Lesley Gordon
Personal Secretary to:
Dr Naresh Chada (DCMO) &
Dr Lourda Geoghegan (DCMO)
Department of Health
Room C5.21
Castle Buildings
Stormont
BELFAST BT4 3SQ
Tel: [redacted]

Stay Home Stay Safe

From: Wallace, Stephen [redacted] **On Behalf Of** OKane, Maria
Sent: 18 August 2020 22:23
To: Gordon, Lesley [redacted]
Subject: HPRM: MM/0121/2020 - Email from Maria O'Kane - CONFIDENTIAL EARLY ALERT - Urology

Dear Michael,

I hope you have had a well-earned break, further to the attached I would like to update you on some aspects of this early alert. The doctor involved has now retired and we are in contact with him through his legal representative. Following on from the advice of NHS Resolutions and the GMC he has agreed not to see private patients. I do not have an oversight of his previous private patients. To the best of my local knowledge he is not working for another Trust and is not registered with the Medical Council of Ireland. We are concerned about patients who were under the doctor's care.

I spoke to Dr Naresh Chada when you were on leave and Dr Brid Farrell and have made contact with Professor Hugo Van Woerden regarding the HSCB / PHA role. We are continuing to liaise with the GMC regarding professional matters and in tandem have continued to consider any potential quality of care issues. We have spoken to the IRS of the RCS to engage with BAUS to consider the import and extent of our findings and to access subject matter experts in relation to SAIs.

Given our information to date I feel we are at a point where we need to make a decision on the requirement for a formal look back exercise and what the nature and scope of such a process would look like. You are familiar with the Department of Health 2007 Guidance *'Conducting Patient Service Reviews / Lookback Exercises'* which states that any decision to progress with a lookback exercise will be taken jointly by the HSCB and Department of Health (Introduction -

Section 1.4).

I would appreciate guidance on the following:

- The information required by the Department of Health to allow for a determination to be made on the requirement for a look back
- If there is a requirement by the Department of Health to issue an Alert letter regarding the clinician
- Any other actions the Trust should be taking currently

Though clinical necessity and in the spirit of openness and candour, one of the consultants has met with a patient and his relatives recently to explain that the patient's care has been impacted by clinician delays.

We are preparing to contact the service users impacted as part of the SAI process, we are keen to ensure that our initial contact provides the service users with full information regarding the circumstances of the identified incidents therefore a determination on the scope of this work will help inform our discussions.

I am happy to discuss the details of this case via phone call if this would be suitable

Kindest Regards Maria

Personal Information redacted by the USI

From: Gordon, Lesley Personal Information redacted by the USI
Sent: 17 August 2020 10:53
To: Wallace, Stephen
Subject: RE: CONFIDENTIAL EARLY ALERT

Stephen

I have spoken to Dr McBride and he has asked if Mara could email him with an update.

Many thanks

Lesley

Lesley Gordon
Personal Secretary to:
Dr Naresh Chada (DCMO) &
Dr Lourda Geoghegan (DCMO)
Department of Health
Room C5.21
Castle Buildings
Stormont
BELFAST BT4 3SQ
Tel: Personal Information redacted by the USI

Stay Home Stay Safe

From: Wallace, Stephen Personal Information redacted by the USI
Sent: 17 August 2020 09:57
To: Gordon, Lesley Personal Information redacted by the USI
Subject: CONFIDENTIAL EARLY ALERT

Lesley, please find attached as discussed

Thanks

Stephen

Stephen Wallace
Assistant Director of Clinical and Social Care Governance
Mob: Personal Information redacted by the USI

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Southern Health & Social Care Trust IT Department Personal Information redacted by the USI

From: Johnston, Jackie (DoH)
To: Olive MacLeod; Paul Cavanagh
Cc: [redacted] Ryan Wilson (DoH)
Subject: RE: HPRM: MM/0121/2020 - Email from Maria O"Kane - CONFIDENTIAL EARLY ALERT - Urology
Date: 24 August 2020 15:54:29
Attachments: image001.png

Olive and Paul

I took part in a Zoom call with Maria and Stephen this afternoon. There are four issues to address:

(1) Finalising a decision on requesting the Royal College of Surgeons to carry out a lookback exercise. I advised that central to this decision would be agreeing the TOR for the exercise including whether this should cover an initial representative sample or a larger group of patients. I further advised that Southern Trust colleagues should seek advice from the HSCB and PHA on drafting the TOR. I understand that Maria has had a preliminary conversation with Brid Farrell and Hugo but not specifically on drafting TOR;

(2) Consideration to be given to an appropriate process for investigating the conduct of the Doctor concerned. I will consider and revert to Trust colleagues on our next call;

(3) Consideration to be given to inviting an expert patient to sit on the panel to be established to review the three SAI cases. Could HSCB/PHA provide advice to the Trust on this proposal? and,

(4) The timing of external communications given the need to finalise decisions on the various strands and informing the patient families of the SAI review.

A further Zoom call has been arranged for Friday 28th August at 12.30pm.

Regards

Jackie Johnston

From: Olive MacLeod [redacted]
Sent: 21 August 2020 18:05
To: Paul Cavanagh [redacted]; Johnston, Jackie (DoH) [redacted]
Cc: McBride, Michael [redacted] Wilson, Ryan (DoH) [redacted]
Subject: RE: HPRM: MM/0121/2020 - Email from Maria O'Kane - CONFIDENTIAL EARLY ALERT - Urology

---

I could also meet after 4pm
Olive

-------- Original message --------
From: Paul Cavanagh [redacted]
Date: 21/08/2020 17:11 (GMT+00:00)
To: "Johnston, Jackie (DoH)" [redacted] Olive MacLeod [redacted]
Cc: [redacted] "Wilson, Ryan (DoH)" [redacted]
Subject: RE: HPRM: MM/0121/2020 - Email from Maria O'Kane - CONFIDENTIAL EARLY ALERT - Urology

Jackie

I have spoken to a number of colleagues and it is clear that while the Board had not been

formally notified of this lookback exercise, we were aware that the Southern Trust urology service was under additional strain. We had sought to address this by meeting with Western Trust colleagues to ask that they bring forward plans to repatriate Fermanagh patients (planned for next year) currently referred to Southern Trust. We had no insight as to a lookback exercise. I am not available on Monday at 2pm but could do later in the day (after 4pm). I will also contact Southern Trust to get some further insight on the matter.

Regards

Paul

From: Johnston, Jackie (DoH) [redacted]
Sent: 21 August 2020 16:07
To: Paul Cavanagh; Olive MacLeod
Cc: [redacted] Wilson, Ryan (DoH)
Subject: FW: HPRM: MM/0121/2020 - Email from Maria O'Kane - CONFIDENTIAL EARLY ALERT - Urology

Paul and Olive

I'm unsighted as to the extent to which the Southern Trust has involved HSCB and PHA colleagues in this matter. I've attached the EA notification. Ryan is on leave so I've replied that I could meet at 2pm on Monday. HSCB and PHA would need to be involved as the Department will look to you to provide advice on assessing the need for a recall/lookback and if required submit this to the Minister for approval. We would also look to HSCB/PHA to oversee the governance and process if a lookback/recall is required.

Regards

Jackie

From: Wallace, Stephen [redacted]
Sent: 21 August 2020 15:29
To: Wilson, Ryan (DoH) [redacted]
Cc: Johnston, Jackie (DoH) [redacted] OKane, Maria [redacted] Geoghegan, Lourda [redacted] [redacted] Chada, Naresh [redacted] Greenwood, Victoria [redacted] Campbell, Emma [redacted]>; OKane, Maria [redacted]>
Subject: RE: HPRM: MM/0121/2020 - Email from Maria O'Kane - CONFIDENTIAL EARLY ALERT - Urology

Dear Ryan,

Further to the CMO's email below can you advise if you are available to take a call / zoom meeting on Monday (24th) anytime between 1pm-3pm with Dr O'Kane in the first instance.

To date discussions have been held to date with Dr Chada, Dr Brid Farrell and Professor Von Woerden, NHS Resolution, the GMC and we have had a number of discussions with the Royal College of Surgeons. Following on from the early alert notification and further to these discussions on behalf of the Trust we require advice on how to proceed in relation to any potential lookback required. This is in keeping with the 2007 DOH lookback guidance which highlights the key role of the DOH in this process.

The Trust is processing SAIs in relation to these concerns and the discussions are being held locally with patients and families. If you wish to discuss further you can reach me on [redacted]

Best Regards

Stephen

Stephen Wallace

Interim Assistant Director of Clinical and Social Care Governance
Mob: Personal Information redacted by the USI

From: Gordon, Lesley Personal Information redacted by the USI
Sent: 21 August 2020 08:46
To: OKane, Maria
Cc: Johnston, Jackie (DoH); Wilson, Ryan (DoH); OKane, Maria; Geoghegan, Lourda; Chada, Naresh; Wallace, Stephen; Greenwood, Victoria
Subject: FW: HPRM: MM/0121/2020 - Email from Maria O'Kane - CONFIDENTIAL EARLY ALERT - Urology

Maria
As Trust Medical Director grateful if you could liaise/discuss with PHA/HSCB in the first instance and thereafter the relevant Departmental Policy Lead. CMO group will provide all necessary professional advice.
Many thanks.

Lesley
Lesley Gordon
Personal Secretary to:
Dr Naresh Chada (DCMO) &
Dr Lourda Geoghegan (DCMO)
Department of Health
Room C5.21
Castle Buildings
Stormont
BELFAST BT4 3SQ
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Stephen Wallace

Assistant Director of Clinical and Social Care Governance

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Southern Health & Social Care Trust IT Department [redacted]

ST UROLOGY 27/8/20
melone, Stephen Wallace, Martina Corrigan, Ronan Cornell, Maria

- TOR & scope of lookback
- Expert patient

Fri 28th @ 12.30

Personal Information redacted by the USI

Investigated under 'Maintaining profl standards' in 2018
Further pats identified - 30% of pats problematic
- Dermot Hughes to chair
- BAUS input to panel
- expert patient from NICaN

5 yr lookback - Royal College suggested 5yrs
IS could do recall reviews - Hillsborough
Seeing private patients at home!
Communications to IS ~~XXX~~
80 charts in first instance

- Board / Agency to approve mbrship of Panel for lvl 3 SAI ~~XXX~~

- Lvl 3 ~~SAI~~ SAI review
- Service review (invited)
- Cancer pat review

Bigger case note review
- 4625 pats in 5 yrs seen by cons
- 884 in review backlog
  - 213 oncology
- 1174 pats operated in 5 yrs

ST UROLOGY 28/8/20

Jackie, Brid, Stephen Wallace, Martina Corrigan, Ronan Carroll, Mona O'Kane

- Dr referred to GMC
- Evidence base for investigation beyond GMC
- Communication with other Trusts & IS providers
  - Jackie to check if this is approp
- ST communicated he should not seek to access shared info

- 3 SAIs & 4 others being screened
- Conditions of concern?
  Largely his work is cancer
  Not responding to results
  Use BAUS then invited service to select 80 cases to review

- Assure DoH around TOR for formal review
- No expert pat reqd
- Going public?

- Internal Review on how consultant bypassed protocols - include in TOR
- Private patients?

26
202·5
150
485
450

- Risk stratify
  - oncology → review pats of concern
  - stents

SURGE/WINTER
Final draft to RMB & stakeholders

- Template for Trusts ~~XXX~~

Smooth flow as a system
Protection of day surgery

- Trigger points
- How service will be different this winter?
  - uncertainty this winter
- Working as a system
  Decisions at short notice

Unsched activity disappeared in 1st surge

Triggers & escalation ~~XXX~~

ST UROLOGY 24/9/20

- Actioning avoidable harm
- Trust Board content to delay invited review

Releasing clinical time
- 3 groups + review backlog

Helplines ready
Need to complete Phase 1 by 12 Oct

~~300 cystology~~
1711 in total to be reviewed - ~~Jan~~ 19 - ~~April~~ 20

RYAN & ALASDAIR 25/9/20 EMA

Agree a monitoring mechanism with HRC
Les has met Trusts
Counselling services have not been resumed ~~***~~
Awaiting Min decision on EMA
2pm on Tuesday
Les' suggestions on monitoring system

Informing Choices Service
- referring to and Trust doc
Clinicians interested in delivering service

ST UROLOGY 8/10/20

9 SAIs confirmed
- 3 from MDM, 3 path, 2 elect, 1 review

Emergency Stent – 147 pats → 3 with concerns now sorted
\ 137 pats being looked at
Elective pats – 334 pats → 18 concerns
- 2 SAIs + 4 poss
- others sorted
\ 233 pats
Results – path & rpt – 168 pats
- 50 clinical rev
- 3 confirmed SAIs + 5 poss once seen by Mark
- radiology – 1600 pats ongoing
- underway review
MDM – 271 pats – 2 confirmed SAIs + 2 poss
- 193 pats
Review – 235 pats being seen in IS by retired consultant to confirm mgt plan
backlog
Drug – colchicine – prostate cancer pats
- pats should be counselled
SAIs are those who have come to harm

Expert Panel has met & is doing ToR

- Trust looking at systems & processes
- 2018 MHPS
ToR with Board & PHA
Martina full-time released with admin support
2 helplines in place

Belfast — 6, 7, 8B, 8B, 8D un post / permanent
South — 4, 6, 6.

Personal information redacted by USI

- Feel you meet essential criteria
- Outline post reqmts — West, ambul, dtles TBD
- Outline duration
- Confirm apptmt — start date

- Personal Information redacted by the USI — FIT testing
- Committed to testing
- Don't want to let it go

ST URO

- Comms plan
- SAI families being contacted
  — no media interest
- Contacting GPs in due course
  — ge thru MOB
  Charities should be advance briefed

- Don't name doc initially
- Date for Min statement ~~next week~~ or week after
  — week 19 Oct
- Be clear on number of SAIs when goes public
- Need comprehensive report to Board ~~ASAP~~
- Communicate with previous SAI families
  — 5 or 6 cases
- Considering counselling services

- Personal Information redacted by the USI

ST URO – DOH 22/10/20

10 SAIs – 9 confirmed – TOR provided
Emergency stents – 147 pats, 3 concerns + 137 to be reviewed
Elective – 334 pats, 18 concerns – 2 SAIs + 4 poss
Path & cysto results – 168
Radio results – 1600
Review backlog – 235 pats
Prostate drug (~~clotamide~~) – pats should have been counselled
(bicalutamide)

Need an independent process – supervision
Just inquiries on other issues

Looks like this has been mismanaged
– should have been dealt with in 2009

Assurance Group similar to neuro recall

Maintaining High Profl Standards
– need to review guidance

- Ext Panel/TOR
- Not reg'l
- Private practice

Convene urgent mtg of Assurance Gp
– DoH, Board, PHA
– ongoing mgt & care of pats
– process for investigation
– MHPS – is this framework adequate?

Letter to Shane to set up assurance group
– Shane, Melanie, Mara
– first mtg next week

Have engaged with some fams

2016 SAI report ~~XXX~~

- Speak to Shane re Craigavon & SWAH ~~XXX~~
- NMS to start with covid but is unsustainable long-term

NEIL RE IMAGING
Must include NIPACS ~~XXX~~
Could we set aside dedicate diagnostics contract ~~XXX~~

Priority
This year funded
Previous year funding

STEPHENS RE CRG

- following process
- 4007 OP records, 1427 IP records - further checks - Nov 3rd ~~XXX~~

- Workforce Trng
- SWAH/CAH
- NMS

- ST concern about mgg covid ~~XXX~~
  - request to meet CMO, CNO
  - outside process → should go thru Trust CX

ST UROLOGY

- Helpline – 135 calls since Monday
- Letter GP practice went at lunchtime
- IS? – send out pts – 191 sent out – cancer pts
- Med prescribing
- Tennamgh pts !!!
- SAI process not designed for multiple cases
- GPs knew about him & thought he was being investigated

Personal Information redacted by the USI

- Concern about staffing
- Routine surgery ongoing in SWAH & Omagh
- Ortho still happening in Alt
- may need to stand down surgery
  - Omagh would be stood down
- Taking on staff to come in by Agency
- Looking at recentuising staff as BT
- Some nurses coming back from isolation tomorrow
- Trying to get 15 ICU beds by weekend

- Urgent Care Centre – trying to put in place
  - looking to dev in Omagh
  - can't fit in Alt

NMS 30/10/20

16/11
- BT redirecting pt to ret to UCC – low acuity
- Ambul offload area being identified in RVH
- SET – red zone offload – remodelling to increase capacity
- Concerns about staffing in ED
- WT – amb handover zone – Bus Case progressing & interim works underway
  - modular build in place late Dec to provide amb zone

Safety, Quality & Standards Directorate

Department of
Health, Social Services and Public Safety

An Roinn
Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí

www.dhsspsni.gov.uk

Castle Buildings
Stormont Estate
Belfast BT4 3SQ
Tel: Personal Information redacted by the USI
Fax: Personal Information redacted by the USI
Email: Personal Information redacted by the USI

Your Ref:
Our Ref: HSS(SQSD) 18/2007
Date: 08 March 2007

Chief Executives, HSS Boards:
For cascade to –
- Directors of Public Health
- Chief Nursing Officers
- Directors of Social Services
- Directors of Pharmaceutical Services
- Directors of Primary Care
- Directors of Dental Services

Chief Executives, HSS Trusts (existing & new):
For cascade to –
- Medical Directors
- Directors of Nursing
- Directors of Pharmacy
- Directors of Social Care

Chief Executive Designate, Health & Social Services Authority
Chief Executives, HSS Agencies
General Medical, Community Pharmacy
General Dental & Ophthalmic Practices

Dear Colleagues

Conducting Patient Service Reviews/Lookback Exercises

A number of Patient Service Reviews have had to be conducted in recent years, most notably the review of endoscopes in 2004 and the review of breast screening in 2005.

Following these events the HPSS Regional Governance Network recognised the need to share the learning from these exercises and established a subgroup to develop guidance based on the experience of members.

The subgroup has now produced *A Practical Guide to Conducting Patient Service Reviews or Look Back Exercises*.

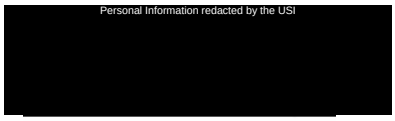
The subgroup members have harnessed their collective experience to advise on:

- Initiating a service review;
- Initial planning;
- Establishing patient helplines (staffing, training, record keeping and location);
- Establishing a patient database;

- The role of the Service Review Team; and
- The process of the Review (including sample documentation).

This is a fine example of the HPSS sharing best practice and I commend the Guide to you as an extremely useful source of reference material should the need for such an exercise occur in the future.

I would also like to thank the HPSS Regional Governance Network and, particularly the subgroup members, for their efforts and commitment in producing this Practical Guide.



Maura Briscoe
Safety, Quality and Standards Directorate
Office of the Chief Medical Officer

cc. Chief Executive, Regulation & Quality Improvement Authority
Chief Executive, Health Estates Agency
Chief Officers, HSS Councils
Chief Executive, NI Social Care Council
Chief Executive, NI Practice & Education Council
Chief Executive, NI Medical & Dental Training Agency
Chief Executive, Mental Health Commission
Director, NI Centre for Post Graduate Pharmaceutical Education and Training
Sub-Group members
Risk Managers/CSCG Leads
CSCG Support Team, Director
Regional Governance Adviser
Chief Professional Officers- DHSSPS
Policy Directorate leads- Primary, Secondary Care and Social Policy Group

A PRACTICAL GUIDE TO CONDUCTING PATIENT SERVICE REVIEWS OR LOOK BACK EXERCISES

REGIONAL GOVERNANCE NETWORK
NORTHERN IRELAND SUB GROUP

February 2007

Index

Introduction

A number of patient reviews have taken place in Northern Ireland in recent years, including the review of contaminated endoscopes in 2004 and Breast Radiology review in 2005.

Trusts involved in these reviews felt there was benefit in sharing experiences and offering a practical guide for others who may need to take part in similar exercises in the future. This guide does not offer an in-depth dialogue into this area, however suggests the practical steps that might be considered by future review teams in facing comparable circumstances.

1.0 What or Who initiates a service review or look back exercise?

1.1 The decision that an exercise is required usually occurs by chance after a patient or staff member has reported concerns about a healthcare worker or the healthcare environment. It may be that a healthcare worker is found to be infected and is involved in exposure-prone procedures which place patients at risk.

1.2 It may be that equipment is found to be faulty or contaminated and there is the potential that patients may have been placed at unacceptable risk.

1.3 Another healthcare worker may feel that he/she must report or whistleblow on a colleague who is placing unnecessary risk to patients as a result of clinical incompetence or outdated practice.

1.4 The decision to conduct a look back exercise will be taken by the Health & Social Services Board /Health & Social Services Authority (HSSA) and Department of Health, Social Services and Public Safety (DHSSPS). There may be occasions when the Trust initiates a look back review and it is undertaken internally. Look back reviews would, by their nature, be reported as a serious adverse incident to the relevant authorities.

1.5 Once a decision is taken to conduct a look back exercise a series of high level meetings with the Trusts involved and HSS Board/HSSA and DHSSPS will be convened to plan the nature and scope of the review.

1.6 While the public will need to be reassured that every effort is being made to conduct a full and thorough review, it is essential that the health care worker is protected and supported during this time. He/she needs to be kept fully informed at all times during the exercise. Support from a peer and counselling should be offered by the employer. This is particularly important during the early stages of the look back exercise when there will be intense media interest. One point of contact, such as the Director of Human Resources should be identified to lead on this aspect throughout the process.

1.7 It is vital to advise the Communications Manager at an early stage so that proactive or reactive media responses can be prepared.

2.0 Initial Planning

2.1 An incident planning meeting needs to be convened as soon as possible after the disclosure of the issue of concern. If the issue straddles a number

of organisations, it may be necessary for the HSS Board/HSSA to convene the meeting with senior officers from each organisation. This will usually include the Chief Executive, Executive Directors of Medicine and Nursing, Director of Public Health, Head of Division or speciality concerned and Public Relations lead. It would also be important to include the appropriate professional lead should the review involve a specific speciality or professional grouping.

It would also be advisable to convene an expert group at this stage who would develop the evidence base for the scope or limits of the recall. There needs to be clarity on the level of risk so to minimise unnecessary public anxiety by agreeing the at risk population.

2.2 The purpose of the meetings will be to co-ordinate and steer the process and ensure a regional approach to conducting the exercise. Meetings will usually need to take place daily at this level in the initial stages. A clear agenda with concise minutes are essential so that everyone is fully conversant with what action is required. Meetings should be time limited so that Trust staff have time to return to the front line and implement the review process.

2.3 Background briefing papers should be prepared by the HSS Board/HSSA to ensure that a consistent and clear message is being cascaded through the service. These may then be used by Trusts to brief staff at base.

2.4 Scheduling of the Look Back needs to be agreed, as does the launch of the press release and handling of Public Relations. Ideally one individual should co-ordinate all PR on behalf of the service and agree when and who is interviewed.

2.5 Protocols need to be agreed for the review process.ie. which patients should be recalled.

2.6 There needs to be agreement as to who will bear the financial risks associated with the Look Back. Many staff will be required to work substantially long, additional hours to conduct the exercise as speedily and effectively as possible.

3.0 Setting Up a Patient Helpline

3.1 Once it has been agreed that the Look Back exercise is to be publicly announced, organisations need to have in place a system to deal with potentially large numbers of calls from patients and their families.

3.2 Planning at this stage is vital to ensure public confidence in the service is not further eroded.

3.3 An individual, such as an Executive Director should be identified to co-ordinate and implement the Telephone Help Line.

3.4 A meeting needs to be convened with a small number of individuals, with the necessary knowledge of the speciality, to establish the necessary systems. It may be that Lead and Specialist Nurses are ideally placed to

assist at this crucial stage of planning.

3.5 Information Technology staff are essential members of this team to assist in establishing databases and the necessary technology. A senior member of staff from the Telephone Exchange is invaluable at this stage in planning.

3.6 Tasks need to be identified and allocated to this team eg.

- Identification of a suitable venue for the Telephone Helpline. This includes appropriate cabling for additional telephones and PC's. Identification of dedicated telephone numbers. (Support from IT and Telephone Exchange staff is vital).
- Identification of patient database and sizing the scope of the exercise
- Preparation of Background papers for those who will be manning the helpline.
- Production of simple algorithms which those manning the Helpline will use to assist in giving reliable and accurate information.
- Production of "key messages" for Helpline staff.
- Production of proforma to collect data on those calling the Helpline so that follow-up is streamlined.
- Production of Rotas.
- Open/Closing Time of Helpline.
- Staff briefing.

3.7 Identification of Venue

3.7.1 Ideally the Helpline should not be isolated from the main hub of the organisation. Staff need to be able to access others to seek advice while the Helpline is operational. However it does need to allow confidential conversations to take place and requires a dedicated space.

3.7.2 Cabling to allow sufficient telephones is required. Once the media report on the issue then there is likely to be a influx of calls. Each telephone line will realistically only be able to handle 100 calls in a 12 hour period. Additional capacity is required during the initial days, with surges of activity following each news bulletin.

3.7.3 Free phone telephone numbers need to be agreed with Telephone Exchange staff or relevant department.

3.7.4 It is advisable to have a fail safe system to capture additional calls if the telephone lines become blocked with calls. This may involve agreeing with the Telephone Exchange staff to take details from those callers who are unable to get through quickly and ensure one of the Helpline staff return the call within an acceptable timeframe.

3.7.5 Once the number of Helpline stations are agreed, personal computers are required for each to facilitate easy access to patient information. IT staff will assist in accessing the necessary cabling and hardware.

3.8 Establishing the Patient Database

3.8.1 It is essential to have a database of patient details that are involved in the Look Back exercise. This may already exist on one of the Trust's IT systems. Crucial however at this stage is the checking of this patient details data with the Central Services Agency database which will identify if any of these patients have since deceased. Clerical Administrative support is essential to facilitate this.

3.8.2 Letters will usually be sent to patients affected by the issue of concern using this database, simultaneously with the public announcement. **Validating of this data is therefore essential and cannot be over emphasised.** Patients and their families will be alarmed at this stage and increasing stress should be tolerated.

3.8.3 As the Look Back exercise progresses it will be necessary to continuously update the database. This will ensure that patients are given the most up-to-date and reliable information.

3.8.4 A database of patient details may already exist in one of the Trusts IT systems however if one does not exist a suggested core dataset for patients at risk is outlined below: -

- Unique patient identifier number
- Surname
- Forename
- Title
- Date of birth
- Sex
- Address line one (House name, number and road name)
- Address line two (town)
- Address line three (county)
- Postcode

- GP name
- GP address line one
- GP address line two
- GP address line three
- GP postcode

- Named consultant
- Date of appointment/procedure 1
- Date of appointment/procedure 2
- Date of appointment/procedure 3
- Procedure one description
- Procedure two description
- Procedure three description

- Reviewer 1 identification

- Reviewer 2 identification
- Data entered by - identification
- Data updated 1 by – identification
- Data updated 2 by – identification
- Data updated 3 by – identification

The data above is a suggested minimum dataset it is however subject to change depending on the individual situation. Ideally, the use of an existing database is preferred.

3.8.5 It is important to consider the output from the patient notification database at the outset. The list of patients will be needed to: -

- generate letters to patients
- check that patients at risk have made contact
- keep track of who requires further review/testing
- record who has had results back
- at the end of the exercise generate information on numbers of patients identified, further assessed and outcomes

3.8.6 Progress Reports - It is essential that the Incident Planning Team meet on a daily basis to ensure a co-ordinated approach continues to steer the process. Minutes should be shared with appropriate parties to ensure helpline and other key staff are kept informed. Briefing papers/key messages, for helpline operators, should be updated on a regular basis.

3.9 Preparation of Background Papers

3.9.1 It is important that those manning the Helpline should be trained and briefed. They should be provided with training and background information on the circumstances surrounding the Look Back exercise.

3.9.2 Files should be prepared and updated daily with the initial press release and briefing notes on the subject (see below).

3.10 Production of Algorithms

3.10.1 Staff manning the Helpline will find it useful to have simple algorithms which assist in giving accurate information to callers. It may be that the caller has no reason to be alarmed when they are informed they are not within the affected group of patients.

3.11 Production of Key Messages

3.11.1 Helpline staff need to be confident in the messages they are giving to callers. To assist this “key messages” should be agreed with the clinical teams and these are read to callers in response to specific questions. **Helpline staff must not deviate from these messages.**

Some anxious callers will ring on many occasions and it is vital

that if they speak to different Helpline staff they are being given a consistent message.

3.11.2 Key messages will change as the review progresses. These then require to be updated in the individual files for Helpline staff.

3.12 Production of Proforma

3.12.1 As each call is received it is important to maintain a record. A proforma should be designed to capture the relevant information. It should not be so detailed that the caller feels annoyed, however there needs to be sufficient to ascertain if follow up action is required.

3.12.2 If the Helpline staff believe that follow up is required then a system needs to be agreed to segregate proformas, perhaps by identifying follow up calls with a red dot. By the following day these need to have been actively followed up, probably by clinical staff in the speciality being reviewed.

3.12.3 For completeness and post Look Back audit purposes a database of Helpline calls might be helpful.

3.13 Production of Rotas

3.13.1 The Helpline opening times need to be agreed at the outset so that rotas can be produced. However as stated earlier the extent to which the matter is covered in the media will largely dictate when the calls might be made and some flexibility might be required. There is a strong correlation between media reports and number of calls made.

3.13.2 In the early stages it will be essential to have staff with good communication skills. Staff will need to be released very quickly from their “normal” duties to assist with this work. There may need to be back filling of these posts to release these staff to assist.

3.13.3 While staff should not be asked to work more than 6 hours at any one time on the Helpline, it is recognised that in the first few days resources may be stretched. On occasion some normal hospital business may need to be suspended temporarily.

3.13.4 Ideally if new staff are coming onto the rota there should always be one member of staff who is familiar with the system and can advise others and co-ordinate overall. As far as possible the help lines should be staffed by experienced people with an understanding of the governance and duty of care responsibilities. Briefing on this area is helpful to understand the corporate responsibility.

3.14 Staff Briefing

3.14.1 Briefing of staff, particularly in the early stages of the exercise is

vital. A leader needs to be identified to take this role. This would normally be an Executive Director.

3.14.2 Staff need to feel they are being listened to during the exercise. If they believe that the system could be improved they should have that opportunity to discuss their views at a daily staff briefing session.

3.14.3 Catering arrangements should be in place for staff who assist in this work. Regular coffee breaks should be accommodated.

4.0 Communication with Patients

4.1 One of the most important areas of managing any Look Back Exercise is Communication with all the relevant patients, while at the same time maintaining confidentiality.

4.2 Patients need to be informed of the Look Back Exercise simultaneously. The method of doing this will be dictated by the numbers of patients involved and must be co-ordinated with public announcements from the Public Relations Department within the organisation

4.3 Dependent on the nature of the review the organisation may need to review the notes of all patients who may be affected/involved. However those patients affected may have already been previously identified. (Refer to Appendix 1: Process for Service Review).

4.4 In an ideal situation patients should be contacted before a media announcement is made. However this is not always possible given the nature/scale of some Look Back Exercises.

4.5 The Department of Health's publication " Practical Guidance on Notifying Patients" in 1993 advises on communication methods.

4.6 Patients should be notified by letter, signed by the Chief Executive or a Director of the Trust. It is advisable for patient letters to be approved by the legal advisors representing the Trust/HSS Board/HSSA. (Refer to Appendix 5: Patient Letters)

4.7 Patient letters should be sent by first class post in an envelope marked "Private and Confidential -To be opened by addressee only" and "If undelivered return to...(*the relevant Trust*)..."

4.8 **Continuous validation of the database is essential and cannot be over emphasised. It is essential to check with the CSA database/General Practitioner to ensure letters are not sent to deceased patients.** There is no obligation to contact relatives of patients who have died, however there may need to be consideration given to the handling of relatives of deceased patients. This will be unique to each individual Look Back Exercise and legal advice should be sought.

4.9 Letter to the patient should include the following if appropriate: -

- Unique patient identifier number
- Patient fact sheet
- The freephone helpline number(s) and hours of opening
- Location map with details of public transport routes
- Free access to parking facilities
- Arrangements for reimbursement of travelling expenses

It can be helpful to include a reply slip with a pre-paid envelope to confirm that patients have received the letter and will or will not be contacting the helpline. This identifies those patients contacted successfully but who do not wish any follow-up.

4.10 Depending on the individual Service Review the Trust may need to identify any patients under 16 and other vulnerable groups to write to their parent/guardian/ representative.

4.11 "Every reasonable effort" should be made to contact all patients at risk. Patients may have moved out of the district, to Great Britain or abroad.

5.0 Setting up a Service Review

5.1 Service Review Team

5.1.1 The purpose of the Service Review Team is to identify those patients/clients that may be affected as a result of the review. This will involve clinical staff with necessary knowledge of the specialty.

5.1.2 The team will initially be required to screen the patients' notes/x-rays/test results etc to establish if they are in the affected cohort.

5.1.3 Following initial screening and identification of patients affected, further clinical assessment may be required.

5.1.4 If further clinical assessment is required, organisations must have systems in place to manage this process. In doing so it is vital to consider the following:-

- Identify venue for the duration of the review
- Secure administrative support
- Establish an appointment system
- Secure clinical support i.e. laboratory/x-ray etc
- Arrange transportation of samples and results
- Agree a system for recording of results
- Agree a communication strategy with the Incident Planning Team, public health medicine, commissioners etc.

5.2 Initial Identification of Patients involved in the Service Review (Refer to Appendix 1: Process for Service Review)

5.2.1 The retrieval of notes/x-rays/test results must be co-ordinated with the support from Medical Records staff.

5.2.2 A Service Review Pro Forma (Appendix 2) is attached to each set of notes.

5.2.3 The patient database needs to be updated after completion of this pro forma.

5.2.4 A quality assurance check is provided by Administration which is essential to ensure that the correct letter is sent to the correct patient.

5.2.5 The Service Review Pro forma should be transferred from the front of the notes and filed into the patient records.

5.3 Conducting Further Assessment (Notes/X-rays/Test Results etc.)

5.3.1 A Notes/X-ray/Test Results Review Pro Forma (Appendix 3) is attached to the front of each set of patient notes.

5.3.2 The service review team will undertake a further detailed audit of the patient notes to review the outcomes of previous assessment/scans/tests

5.3.3 The service review team will then decide if previous outcomes/diagnosis were accurate.

5.3.4 The proforma will be completed by the Service Review Team.

- A green or red sticker is placed on the pro forma. The **green** sticker identifies a positive outcome and that no further follow up is required - Letter D is sent to patient.
- A **red** sticker identifies a negative outcome that requires a further assessment – Letter E is sent to patient

5.3.5 The patient database needs to be updated after completion of this pro forma.

5.3.6 A quality assurance check is provided by Administration which is essential to ensure that the correct letter is sent to the correct patient.

5.3.7 The Notes Review Pro forma should be removed from the front of the notes and filed into the patient records.

5.4 Conducting Further Assessment (Clinical)

5.4.1 A Clinical Review Pro Forma (Appendix 4) is attached to the front of each set of patient notes.

5.4.2 The service review team will undertake a clinical examination/test/scan etc as appropriate to determine a positive or negative outcome. One must bear in mind that timescales for test/scan results may differ depending on individual situations.

5.4.3 The pro forma is then completed by the Service Review Team. A

green or **red** sticker is placed on the pro forma.

- The **green** sticker identifies a positive outcome and that no further follow up is required - Letter F is sent to patient.
- A **red** sticker identifies a negative outcome that requires further treatment which should be managed within normal clinical arrangements – Letter G is sent to patient

5.4.4 The patient database needs to be updated after completion of this pro forma.

5.4.5 A quality assurance check is provided by Administration which is essential to ensure that the correct letter is sent to the correct patient.

5.4.6 The Clinical Review Pro Forma should be transferred from the front of the notes.

If it has a **green** sticker attached: file into patient notes.

If it has a **red** sticker attached: return patient notes and pro forma to admin support for processing within normal clinical arrangements.

6.0 Patient Cohort Database

6.1 It is essential to have a database of patient details who are involved in the review process.

6.2 As referenced in 3.8.4 a database of patient details may already exist in one of the Trusts IT systems however if one does not exist a suggested core dataset for patients at risk is outlined below: -

- Unique patient identifier number
- Surname
- Forename
- Title
- Date of birth
- Sex
- Address line one (House name, number and road name)
- Address line two (town)
- Address line three (county)
- Postcode

- GP name
- GP address line one
- GP address line two
- GP address line three
- GP postcode

- Named consultant
- Date of appointment/procedure 1
- Date of appointment/procedure 2
- Date of appointment/procedure 3

- Procedure one description
- Procedure two description
- Procedure three description

- Reviewer 1identification
- Reviewer 2 identification
- Data entered by - identification
- Data updated 1 by – identification
- Data updated 2 by – identification
- Data updated 3 by – identification

The data above is a suggested minimum dataset it is however subject to change depending on the individual situation. Ideally, the use of an existing database is preferred.

6.3 It is important to consider the output from the patient notification database at the outset. The list of patients will be needed to: -

- generate letters to patients
- check that patients at risk have made contact
- keep track of who requires further review/testing
- record who has had results back
- at the end of the exercise generate information on numbers of patients identified, further assessed and outcomes

6.4 The database needs to be updated, by administration staff, on a regular, at least daily basis. This will ensure the information held is the most up to date and reliable.

6.5 Progress Reports
It is essential that the incident planning team meet on a daily basis to ensure a co-ordinated approach continues to steer the process. Minutes should be shared with appropriate parties to ensure helpline and other key staff are kept informed. Briefing papers/key messages, for helpline operators, should be updated on a regular basis.

7.0 Look Back Review

At the end of any Look Back exercise it is the responsibility of the Lead Director to ensure that an appraisal meeting is held, lessons learned and areas for improvement are identified and are documented. These findings should be included in a Look Back Review Report. The content will be unique to each Look Back Review. An audit of the review process may be beneficial.

This report should be shared with all relevant stakeholders.

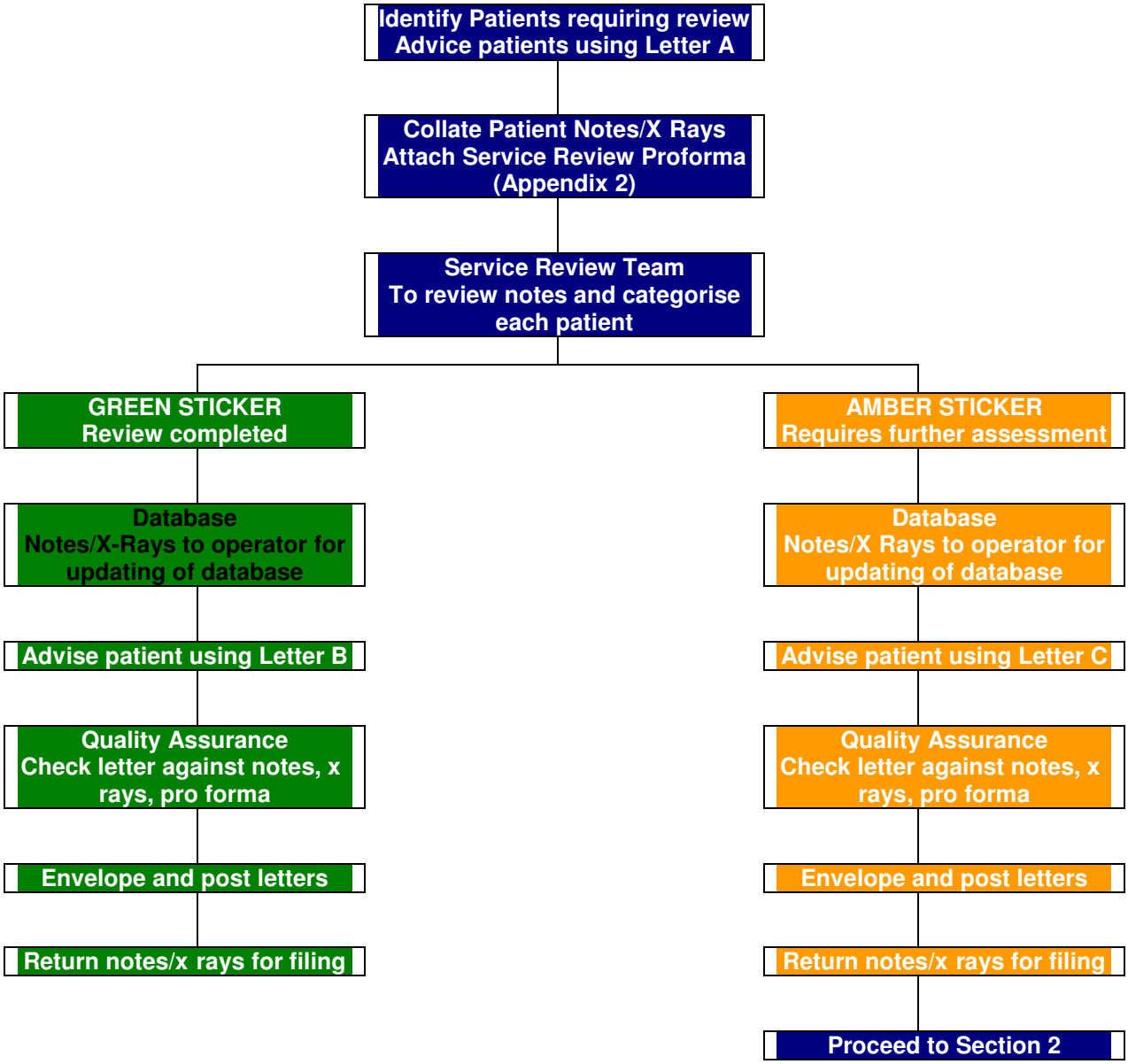
Glossary

Clinical Review	A re-examination of a medical and or clinical process(es) or individual(s) which has delivered results that were not to the expected quality standard.
Cohort	A sub-group selected by predetermined criteria.

Database	The ability to record information for retrieval at a later date. In this instance in may be on paper if the numbers involved are small. If the numbers are large, I.T. equipment and competent administration staff may be required.
Look Back Review	A re-examination of a process(es) or individual(s) which has delivered results that were not to the expected quality standard.
Pro Forma	A page on which data is recorded. The page has predefined prompts and questions which require completing.
Quality Assurance	A check performed and recorded that a certain function has been completed. Negative outcomes must be reported and actioned.
Service Review Team	A specially selected group of individuals, competent in the required field of expertise, to perform the Look Back Review.

Appendix 1

Process for Service Review
Section 1: Advising all patients who may have been affected



Appendix 1

Process for Service Review
Section 2: Advising patients known to be affected

APPENDIX 2

SERVICE REVIEW PROFORMA

PATIENT DETAILS (ATTACH LABEL)

CASENOTES REVIEWED ☐

X RAYS REVIEWED ☐

OTHER MEDICAL DIAGNOSTIC/DATA REVIEWED
(Give details) ☐

_____

DATE OF APPOINTMENT/SCAN/EXAMINATION REVIEWED ☐

REVIEWER 1
Signature & date

REVIEWER 2
Signature & date

GREEN STICKER- REVIEW COMPLETED

AMBER STICKER - FURTHER FOLLOW UP REQUIRED ◯

DATABASE UPDATED ☐ **(Signature & date)**

ADMIN QA CHECK ☐ **(Signature & date)**

LETTER SENT ☐ **(Signature & date)**

APPENDIX 3

NOTES/X RAY REVIEW PROFORMA

PATIENT DETAILS (ATTACH LABEL)

ADDITIONAL INFORMATION

CASENOTES REVIEWED ☐

X RAYS/SCANS REVIEWED ☐

OTHER MEDICAL DIAGNOSTIC/DATA REVIEWED ☐
(Give details)

_____

ADDITIONAL TESTS/SCANS/X RAYS REQUIRED ☐

CLINICAL REVIEW REQUIRED ☐

REVIEWER 1
Signature & date

REVIEWER 2
Signature & date

GREEN STICKER- REVIEW COMPLETED

RED STICKER - FURTHER FOLLOW UP REQUIRED

DATABASE UPDATED	☐	**(Signature & date)**	
ADMIN QA CHECK	☐	**(Signature & date)**	
LETTER SENT	☐	**(Signature & date)**	

APPENDIX 4

CLINICAL REVIEW PROFORMA

PATIENT DETAILS (ATTACH LABEL)

	OUTCOME +VE	OUTCOME -VE
CLINICAL EXAMINATION	☐	☐
TEST	☐	☐
SCAN/X RAY	☐	☐
BIOPSY	☐	☐
OTHER MEDICAL DIAGNOSTIC/DATA REVIEWED (Give details)	☐	☐

_____

	YES	NO
FURTHER FOLLOW UP REQUIRED: PROCESS INTO NORMAL CLINICAL ARRANGEMENTS	☐	☐

CONSULTANTS SIGNATURE: _____ DATE: _____

GREEN STICKER - REVIEW COMPLETED

RED STICKER - FURTHER FOLLOW UP REQUIRED
PROCESS INTO NORMAL CLINICAL ARRANGEMENTS

DATABASE UPDATED	☐	**(Signature & date)**	
ADMIN QA CHECK	☐	**(Signature & date)**	
LETTER SENT	☐	**(Signature & date)**	

DRAFT LETTERS

APPENDIX 5

Although there will be no need for a "master" letter, you will need to generate several variants from it for different circumstances (e.g. when the patient is a child. The following are provided for suggested content.

LETTER A: Advising of a service review/look back exercise
LETTER B: No further follow up required
LETTER C (version 1): Further follow up is required – Notes only
LETTER C (version 2): Further follow up is required – Clinical
LETTER D: Positive outcome of further assessment – Notes only
LETTER E: Negative outcome of further assessment –Notes only
LETTER F: Positive outcome of further assessment – Clinical
LETTER G: Negative outcome of further assessment – Clinical

LETTER A: Advising of a service review/look back exercise

Patient Reference Number

Confidential Addressee Only

DD Month Year

Dear Patient

<***xxxxxxxx Service Review***>

It has come to the attention of <*Trust or Board*> that < *a health care worker/system*> has <brief outline of the incident>.

We have decided as a precautionary measure to review each of the cases with which this <*health care worker/system*> has been involved since <*date range*>.

Your case will be included in this review, which will be a substantial process <*involving…..*>. We have initiated a Service Review Process and will endeavor to deal with this as timely as possible.

I wanted to inform you directly about this rather than letting you hear it through another source and I believe it is important that you are kept fully informed of the review process. We will write to you immediately after your case has been reviewed to advise you whether or not it will be necessary for you to have <*a follow up appointment/test*>.

If in the interim you have any queries, a special telephone helpline has been set up on <*freephone/Tel:xxxxxxxx*> so that you can discuss any concerns. It is staffed from <*date and time to date and time*>. This line is completely confidential and operated by professional staff who are trained to answer your questions.

Although there are a large number of call handlers, there will be times of peak activity and there may be occasions where you may not get through. In this event I would ask you to please call again at another time.

<*Enclosed is a fact sheet with more detailed information, which you may find helpful*>.

Please have your letter when you call the helpline, as you will be asked to quote the patient reference number from the top of the page.

Yours faithfully

(Chief Executive/Director of Trust)

LETTER B: No further follow up required

Patient Reference Number

Confidential Addressee Only

DD Month Year

Dear Patient

<***xxxxxxxx Service Review***>

We had previously written to advise you that <*Trust or Board*> had decided, as a precautionary measure, to review your individual case.

Your case was reviewed <*by xx / using the protocol*> and I am pleased to inform you that your <*case notes/assessment/test*> has now been reviewed and that **no further follow up is required.**

I fully appreciate that this has been a worrying time for you and I apologise for any upset this may have caused. However, I am sure you will understand that, although the risk <*of missed diagnosis/contracting xx*> was thought to be very low, we had an obligation to remove any uncertainty.

Yours faithfully

(Chief Executive/Director of Trust)

LETTER C (version 1): Further follow up is required – Notes only

Patient Reference Number

Confidential Addressee Only

DD Month Year

Dear Patient

<***xxxxxxxx Service Review***>

We had previously written to advise you that <*Trust or Board*> had decided, as a precautionary measure, to review your individual case.

Your case was reviewed <*by xx/using the protocol*> and the <clinician/consultant> has advised that **further follow up is required.** I must emphasis that this does not necessarily mean that <*illness/infection*> has been detected but that more investigation is required to reach a definite diagnosis.

I fully appreciate that this has been a worrying time for you and I deeply regret that your previous <*assessment/test/treatment*> has been found to be inadequate.

We have made special arrangements for <*name and grade of person*> to <*review patient notes/assessment*> and we will contact you again as soon as this is complete.

Yours faithfully

(Chief Executive/Director of Trust)

LETTER C (version 2): Further follow up is required – Clinical

Patient Reference Number

Confidential Addressee Only

DD Month Year

Dear Patient

<***xxxxxxxx Service Review***>

We had previously written to advise you that <*Trust or Board*> had decided, as a precautionary measure, to review your individual case.

Your case was reviewed <*by xx/using the protocol*> and the <clinician/consultant> has advised that **further follow up is required.** I must emphasis that this does not necessarily mean that <*illness/infection*> has been detected but that more investigation is required to reach a definite diagnosis.

I fully appreciate that this has been a worrying time for you and I deeply regret that your previous <*assessment/test/treatment*> has been found to be inadequate.

We have made special arrangements for you to be seen in <*where*> on <*date & time of appointment*>.

Our service review team will be available at this appointment to discuss the clinical aspects of your case. I have enclosed directions to <*xxxxxxx*> and information on parking arrangements.

If you are unable to attend this appointment please contact <*Tel xxxxxx*> to allow us to reorganise this for you.

Yours faithfully

(Chief Executive/Director of Trust)

LETTER D: Positive outcome of further assessment – Notes only

Patient Reference Number

Confidential Addressee Only

DD Month Year

Dear Patient

<***xxxxxxxx Service Review***>

Further to our letter dated <*date*> regarding the need for further assessment of your individual case.

I am pleased to advise you that your case has been reviewed by <*name and grade of person*> and we would wish to reassure you that <*he/she*> is satisfied with the quality of your original <*assessment/investigation/test*>.

We would however wish to offer you the opportunity to be reviewed by <*whomever*> at a forthcoming clinic. This will give us the opportunity to examine you and to help reassure you of the outcome of the Service Review Process we have undertaken.

If you wish us to arrange an appointment please contact <*Tel xxxxx*> quoting the patient reference number at the top of this letter.

Once again I would take this opportunity to apologise for the distress and anxiety caused by conducting this review. However, I am sure you will understand that, although the risk <*of missed diagnosis/contracting xx*> was thought to be very low, we had an obligation to remove any uncertainty.

Yours faithfully

(Chief Executive/Director of Trust)

LETTER E: Negative outcome of further assessment – Notes only

Patient Reference Number

Confidential Addressee Only

DD Month Year

Dear Patient

<***xxxxxxxx Service Review***>

Further to our letter dated <*date*> regarding the need for further assessment of your individual case.

Your case has been reviewed by <*name and grade of person*> and we are sorry to advise you that <*he/she*> has confirmed that the quality of your original <*assessment/investigation/test*> was unsatisfactory.

As a result of this we have arranged for you to be seen by <*whomever*> at <*where*> on <*date and time*>. This will give us the opportunity to examine you and to assess what further treatment you may require.

If the appointment above is unsuitable, please contact <*Tel xxxxx*> quoting the patient reference number at the top of this letter, so that we may reorganise it for you.

I would take this opportunity to apologise for the distress and anxiety caused by this letter, I have enclosed a fact sheet which may help answer any further queries you may have ahead of your appointment.

Yours faithfully

(Chief Executive/Director of Trust)

LETTER F: Positive outcome of further assessment – Clinical

Patient Reference Number

Confidential Addressee Only

DD Month Year

Dear Patient

<***xxxxxxxx Service Review***>

Thank you for attending <*special clinic*> on <*date*> for follow up assessment.

Your results have been reviewed by <*name and grade of person*> and we are pleased to advise you that <*he/she*> has confirmed that your <*investigation/test*> result was **NEGATIVE**. This indicates that you have not been exposed to <*infection/illness*>.

We would however wish to offer you the opportunity to be reviewed by <*whomever*> at a forthcoming clinic. This will give us the opportunity to examine you and to help reassure you of the outcome of the Service Review Process we have undertaken.

If you wish us to arrange an appointment please contact <*Tel xxxxx*> quoting the patient reference number at the top of this letter.

Once again I would take this opportunity to apologise for the distress and anxiety caused by conducting this review. However, I am sure you will understand that, although the risk <*of missed diagnosis/contracting xx*> was thought to be very low, we had an obligation to remove any uncertainty.

Yours faithfully

(Chief Executive/Director of Trust)

LETTER G: Negative outcome of further assessment – Clinical

Patient Reference Number

Confidential Addressee Only

DD Month Year

Dear Patient

<***xxxxxxxx Service Review***>

Thank you for attending <*special clinic*> on <*date*> for follow up assessment.

Your results have been reviewed by <*name and grade of person*> and we are sorry to advise you that <*he/she*> has confirmed that your <*investigation/test*> result was **POSITIVE**. This indicates that you have been exposed to <*infection/illness*>.

As a result of this we have arranged for you to be seen by <*whomever*> at <*where*> on <*date and time*>. This will give us the opportunity to examine you and to assess what further treatment you may require.

If the appointment above is unsuitable, please contact <*Tel xxxxx*> quoting the patient reference number at the top of this letter, so that we may reorganise it for you.

I would take this opportunity to apologise for the distress and anxiety caused by this letter, I have enclosed a fact sheet which may help answer any further queries you may have ahead of your appointment.

Yours faithfully

(Chief Executive/Director of Trust)

Membership of Sub-Group

Eleanor Hayes (Chair)	Director of Nursing, Belfast City Hospital Trust
Martine McNally	Clinical Governance Manager, United Hospitals Trust
Helen Hamilton	Governance & Risk Management Co-ordinator, Eastern Health & Social Services Board
Nigel McClelland	Senior Risk Manager, Armagh & Dungannon HSS Trust
Alan Finn	Director of Nursing, Down & Lisburn Trust

Policy for Implementing a Lookback Review Process

July 2021

Contents

This policy should be read in conjunction with the Regional Guidance for Implementing a Lookback Review Process.

This policy, and the accompanying Regional Guidance, replaces HSS (SQSD) 18/2007 issued by the Office of the Chief Medical Officer on 8 March 2007.

For immediate implementation

For review July 2031

Lookback Review Policy

1.0 Introduction

A Lookback Review Process is implemented as a matter of urgency where a number of people have potentially been exposed to a specific hazard, in order to identify if any of those exposed have been harmed and to identify the necessary steps to ameliorate the harm as well as to prevent further potential occurrences of harm.[1]

A Lookback Review is a process consisting of four stages:

- immediate action including a preliminary investigation and risk assessment to establish the extent, nature and complexity of the issue(s);
- the identification of the service user cohort to identify those potentially affected;
- the recall of affected service users; and finally
- closing and evaluating the Lookback Review Process and the provision of a report including any recommendations for improvement.

The decision that a Lookback Review is required, often occurs after a service user, staff member or third party such as a supplier has reported concerns about the death or harm to a service user, or the potential for death or harm, the performance or health of healthcare staff, the systems and processes applied, or the equipment used.

The triggers for consideration of a Lookback Review may include, but are not limited to the following:

- Equipment found to be faulty or contaminated and there is the potential that people may have been placed at risk of harm;
- Concern about missed, delayed or incorrect diagnoses related to diagnostic services such as screening, radiology or pathology services;

[1] Health Service Executive (HSE) 'Guideline for the Implementation of a Look-back Review Process in the HSE', HSE National Incident Management and Learning Team, 2015. Section 1 page 4.

- Concerns about incorrect procedures being followed or evidence of non-compliance with extant guidance;
- Concerns raised regarding the competence of practitioner(s) or outdated practices;
- A service review or audit of practice shows that the results delivered by either a service or an individual were not in line with best practice standards and there is a concern that there was potential harm caused to a cohort of service users as a result;
- Identification of a staff member who carries a transmissible infection such as Hepatitis B and who has been involved in exposure-prone procedures which have placed service user at risk; or as
- A result of the findings from a preceding complaint, Serious Adverse Incident review, or thematic review by the Regulation Quality and Improvement Authority.

This Policy, should be read in conjunction with the 'Regional Guidance for the Implementation of a Lookback Review Process' which documents the steps, including the service user and staff support and communication plans that are to be undertaken by Health and Social Care (HSC) organisations when a Lookback Review Process is initiated. HSC organisations should develop their own local policies and procedures, consistent with this Regional Policy and related Guidance, to address any potential Lookback Review Processes.

As the triggers for considering a Lookback Review process may also constitute a Serious Adverse Incident (SAI) and/or an Early Alert, the Policy should also be read in conjunction with the Health and Social Care Board (HSCB) SAI Regional Guidance [2] [3] and Department of Health (DoH) Early Alert Guidance.[4]

[2] HSCB 'Procedure for the Reporting and Follow up of Serious Adverse Incident'. November 2016.
[3] If the hazard is associated with a medical device then the HSC organisation should report this in line with the Norther Ireland Adverse Incident Centre (NIAIC) adverse incident reporting – guidance and forms. October 2018 'www.health-ni.gov.uk.
[4] DoH 'Early Alert System' Reference HSC (SQSD) 5/19.

The circumstances may also require the HSC organisation to notify other statutory bodies such as the Coroners Service for Northern Ireland, the Police Service for Northern Ireland and/or the Health and Safety Executive for Northern Ireland, or professional regulators e.g. Nursing & Midwifery Council or General Medical Council. In that regard, all existing statutory or mandatory reporting obligations, will continue to operate in tandem with this Regional Policy.

2.0 Purpose

The purpose of this policy and regional guidance is to ensure a consistent, coordinated and timely approach for the notification and management of potentially/affected service users carried out in line with the principles of openness and candour, [5] [6] [7] whilst taking account of the requirements of service user confidentiality and Data Protection. [8] [9]

3.0 Objectives

The objectives of this policy are to:

1. Assist HSC organisations adopt a risk-based approach and ensure the timely management of appropriate and relevant care for affected groups of service users.

2. Establish a standard approach to notification of service users, families/carers, healthcare managers and the public of adverse incidents involving potential injury, loss or other harm to groups of service users.

3. Ensure that communication with, and support for, all affected and potentially affected service users, their families and/or carers and also staff occurs as soon as reasonably practicable, and in as open a manner as possible.

[5] In his Inquiry into Hyponatraemia Related Deaths (IHRD), Judge O'Hara made recommendations concerning openness and candour. This included a recommendation for the legal duty of candour for HSC organisations and staff, as well as support and protections to enable staff to fulfil that duty. Work is underway to introduce the necessary legislation and policies to implement these recommendations.
[6] DoH 'Being Open – Saying sorry when things go wrong'. January 2020.
[7] National Patient Safety Agency (NPSA) 'Being open – communicating patient safety incidents with patients and their carers'. September 2005. Archived on 18 February 2009 at webarchive.nationalarchives.gov.uk.
[8] General Data Protection Regulation ((EU) 2016/679) (UK GDPR).
[9] Data Protection Act 2018 at www.legislation.gov.uk

4. Ensure that the HSC organisation adopts appropriate support mechanisms for the health and well-being of staff involved.

5. Ensure that communication with the Department of Health (DoH), the Health and Social Care Board (HSCB) and the Public Health Agency (PHA) and the public occurs in a consistent and timely manner.

6. Ensure that HSC organisations' services have established and consistent processes in place when a Lookback Review is undertaken, that also maintain the business continuity of existing services and public confidence;[10]

7. Ensure that HSC organisations appropriately reflect upon the issues which prompted the Review and any learning from the outcomes of a Lookback Review within their systems of governance.

4.0 Scope

This policy and related guidance applies to all HSC organisations. The purpose of the policy and guidance is to provide a person-centred risk-based approach to the management of a Lookback Review and support to any service users and their families/carers who may have been exposed to harm, and to identify the necessary steps to ameliorate that harm. The scope of the policy and related guidance also includes providing information and support to those not directly exposed to the harm in question i.e. concerned members of the public.

Whilst the outcomes of a Lookback Review may inform other processes e.g. Serious Adverse Incident reviews or a Coroner's Inquest, this is not the primary purpose of a Lookback Review Process.

Section 1 identifies some typical examples of the concerns which may lead to a Lookback Review Process being initiated. Where those concerns relate to the health, capacity or performance of practitioner(s) this may trigger a parallel process of investigation and/or performance management. This lies outside the scope of this guidance.

[10] South Australia Health ' Lookback Review Policy Directive', Safety & Quality, System Performance & Service Delivery, July 2016. Section 1 page 4.

5.0 Roles and Responsibilities

5.1 The Chief Executive is responsible for:

- Commissioning the Lookback Review Process and establishing a Steering Group to oversee the implementation of the Lookback Review in line with extant policy, procedure and guidelines. This will usually be delegated to an Executive Director/Service Director who will act as Chair of the Steering Group (see below);
- Ensuring that effective Lookback Review Processes are implemented, when required, in line with extant policies, procedures and guidelines and that adequate resources are allocated to facilitate effective Lookback Review Processes;
- Reporting the rationale for the implementation of a Lookback Review Process to the DoH, HSCB and PHA as appropriate and as per extant guidance; [11] [12]
- Ensuring that the Lookback Review process is conducted with openness and transparency; and
- Providing service users, families and/or carers with a meaningful apology, where appropriate;
- Communicating the findings of the Lookback Review Process to the HSC organisation's Board and to the DoH, HSCB and PHA as appropriate and as per extant guidance. [13] [14]

5.2 The Oversight Group/Steering Group is responsible for:

- Overseeing the service review/ risk assessment process to identify the scope of the issue and inform the decision to progress to the service review/audit and recall stages of the Lookback Review Process as required;
- Deciding on the requirement for progression to Stage 2 Identifying and Tracing the Service User at risk and Stage 3 Service User Recall;

[11] DoH. (SQSD) 5/19. *Op.cit.*
[12] HSCB. November 2016. *Op.cit.*
[13] DoH. *Op.cit.*
[14] HSCB *Op.cit*

- Communicating the need for the service review/audit and recall stages of the Lookback Review Process through the organisation's governance structures/Assurance Framework to the Board of Directors and external stakeholders (including DoH);[15]
- Developing the Scope and Terms of Reference for each element of the Lookback Review Process;
- Overseeing operational management of all aspects of the Lookback Review Process;
- Developing a Lookback Review Action/ Work Plan which outlines the methodologies to be implemented in relation to the Audit and the Recall stages of the Lookback Review Process;
- Ensuring that arrangements are in place to capture and report information on the outcome of the Lookback Review Process;
- Ensuring that the impact on 'business as usual' for all service users is assessed and reported on;
- Ensuring that service managers implement contingency plans for service continuity where necessary, including providing for additional health care demands which may arise as a consequence of the Lookback Review Process, this should include service users not included in the 'at risk' cohort who also may be affected by the impact on services as a result of the Lookback Review Process;
- Ensuring that arrangements are in place to provide support to both service users and staff e.g. counselling and welfare services;
- Ensuring that service managers allocate the necessary resources to implement the Lookback Review Process and to meet associated demands;
- Ensuring communication at the appropriate time and implementation of recommended actions arising from the Lookback Review Process.

[15] DoH. HSCB. *Loc. Cit.*

5.3 The Operational Group/Lookback Review Management Team are responsible for:

- Supporting the Steering Group in the implementation of the Steering Group Lookback Review Action/Work plan (see above);
- Putting in place arrangements to capture and report information on the progress of the Lookback Review Process;
- Implementing contingency plans for service continuity including implementing plans for referral pathways, rapid access clinics, diagnostic or pathology services;
- Providing support to both service users and staff e.g. counselling and welfare services;
- Providing the operational arrangements to support the communication plan, at the appropriate time with the implementation of actions arising from the Steering Group's Action plan to meet Stage 2 and Stage 3 of the Lookback Review Process.

5.4 The HSC Organisation Board of Directors is responsible for:

- Ensuring appropriate oversight of the Lookback Review and that this is reflected within the organisation's system of governance e.g. risk register;
- Satisfying itself that the Lookback Review Process is being undertaken in line with extant policy;
- Satisfying itself that the Lookback Review Process has been appropriately resourced in terms of funding, people with relevant expertise, access to expert advice and support, IT and any other infrastructure required;
- Satisfying itself that the impact of the Lookback review process on 'Business as Usual' is assessed, monitored and reported on with mitigating measures in place where possible;
- Satisfying itself that required actions identified by the Lookback Review Process are implemented;

- Providing challenge, management advice/guidance and support to the Lookback Review Commissioning Director and the Lookback Review Steering Group as required.

5.5 The Public Health Agency is responsible for;

- Providing advice/guidance and support to the Lookback Review Steering Group as required;
- Dissemination of information and notification to the wider health services of the adverse incident or concern as required;
- Assisting the HSC organisation with the Lookback Review Process Action Plan and Communication Plan as required.

5.6 The Health and Social Care Board is responsible for;

- Providing advice/guidance and support to the Lookback Review Steering Group as required;
- Dissemination of information and notification to the wider health services of the adverse incident or concern as required;
- Assisting the HSC organisation with the Lookback Review Process Action Plan and Communication Plan as required;
- Monitoring compliance with the HSCB 'Procedure for the Reporting and Follow-up of Serious Adverse Incidents';
- Assisting with the dissemination of learning from the Lookback Review Process.

5.7 The Department of Health is responsible for;

- Ensuring that the HSC reporting organisation complies with the Policy Directive;
- Providing advice and information to the Minister.
- Assisting the HSC organisation with the development and management of communication strategies to the wider health service.

6.0 Legislative and Regional Guidelines

- Health and Safety at Work (NI) Order 1978;
- Management of Health & Safety at Work Regulations (Northern Ireland) 2000;
- Freedom of Information Act 2000;
- General Data Protection Regulation ((EU) 2016/679) (UK GDPR);
- Data Protection Act 2018;
- Department of Health 'Code of Practice for protecting the confidentiality of service user information' April 2019;
- HSCB Procedure for the Reporting and Follow-up of Serious Adverse Incidents 2016;
- Department of Health Early Alert System HSC (SQSD) 5/19;
- Department of Health 'Being Open – Saying sorry when things go wrong'. January 2020.

SUBMISSION TO CHIEF EXECUTIVE

FROM: Paul Cavanagh, interim Director of Commissioning

DATE: **June 2021**

TO: **SMT/CEx**

ISSUE:	Update following receipt of SAI overarching report - SHSCT Urology Lessons learned and implications for all cancer pathway MDMs in each Trust
TIMING:	**Urgent**
PRESENTATIONAL ISSUES	Should the Director identify that there may be presentational issues the submission must be cleared by Comms Team prior to submission
FOI IMPLICATIONS	There are possible FOI implications as the SAI overarching report was causal to SHSCT Urology Public Inquiry
FINANCIAL IMPLICATIONS	There are no current financial implications
LEGISLATION/POLICY IMPLICATIONS	Consideration/Approval to be given to update the MDM policy guidance issued in 2010
EQUALITY/HUMAN RIGHTS/RURAL NEEDS IMPLICATIONS	Not applicable
RECOMMENDATION:	• To note the attached briefing that sets out the concerns which have been raised as a consequence of having received the SAI overarching report (referred to as the 10th SAI) relating to the 9 SAIs from SHSCT, Urology • To approve a task and finish group be established to design an assessment tool that Trusts will be asked to complete in order to undertake a review of all cancer related MDM structures and operating practices

Introduction/Background

The Health Minister gave an Oral Assembly Statement on the Urology Services in the Southern Trust, on 24 November 2020, outlining his serious concerns about the clinical practice of Urology consultant, Mr Aidan O'Brien and the requirement for a statutory public inquiry.

(Source of full extract: https://www.health-ni.gov.uk/sites/default/files/publications/health/doh-min-statement-241120.pdf)

As there were potential patient safety concerns identified, an initial lookback exercise in relation to the consultant's work was conducted, to ascertain if there were other areas of potential concern.

This initial lookback, which considered cases over a 18 month period of the consultant's work in the Southern Trust (from 1st January 2019 - 30th June 2020), concentrated on whether patients had a stent inserted during a particular procedure and if this stent had been removed within the clinically recommended timeframe. The initial lookback identified concerns with 46 cases within a total of 147 patients who had the particular procedure and were listed as being under the care of the Consultant during the period addressed by the initial lookback exercise.

The Trust also established a Review Group to assess the further findings of the initial lookback exercise and to explore the potential need for a further lookback exercise in the context of the concerns emerging.

In consultation with the Royal College of Surgeons, the Review Group has looked at the timeframe from 1 January 2019 until 30 June 2020 and during this time there were a total of 2,327 patients under the care of AOB. The Review Group identified the most vulnerable group of urology patients within this cohort and has concentrated on these patients initially. There are areas of concern relating to elective and emergency activity; radiology, pathology and cytology results; patients whose cases were considered in Multidisciplinary Team Meetings; oncology and in relation to the safe prescribing of an anti-androgen drug, outside of established NICE guidance in the management of prostate cancer.

Across those areas, to date 1,159 patients' records have initially been reviewed and 271 patients or families have been contacted by the Trust and their work continues across those areas of concern. Further details of the various review strands are appended in the above link.

So far 9 cases have been identified that meet the threshold for a Serious Adverse Incident (SAI) review and all 9 patients and/or their families have been contacted by the Trust to inform them of the position in relation to their respective cases.

A further 6 cases are currently being reviewed in more detail to establish if those patients have come to harm.

The overarching report (referred to as the 10th SAI) has been drafted and shared with all concerned. It was felt appropriate, given the enormity of the situation and impending Statutory Public Inquiry (to be chaired by QC Christine Smith) that it be shared with SMT.

2. **The aims and objectives of the SAI review were to:**

- To carry out a systematic multidisciplinary review of the process used in the diagnosis, multidisciplinary team decision making and subsequent follow up and treatment provided for each patient identified, using a Root Cause Analysis (RCA) Methodology.
- To review individually the quality of treatment and care provided to each patient identified and consider any factors that may have adversely influenced or contributed to subsequent clinical outcomes.
- To engage with patients/families to ensure where possible questions presented to the review team or concerns are addressed within the review.
- To develop recommendations to establish what lessons are to be learned and how our systems can be strengthened regarding the delivery of safe, high quality care.

- Examine any areas of good practice and opportunities for sharing learning from the incidents.
- To share the report with the Director of Acute Services/Medical Director of SHSCT/ HSCB/ Patients and families involved/ Staff involved.

3**. Lessons Learned**

- The SAI review of the 9 cases identified a number of areas which required lessons to be learned from. This paper focusses on one specific and pressing aspect which is that Cancer Care given by Dr 1 did not follow agreed MDM (multi-disciplinary meeting) recommendations nor follow regional or national best practice guidance. It was found that care was given without other input from Cancer Specialist Nurses, Oncology and Palliative Care. It was found to be inappropriate, did not meet patient need and was the antithesis of quality multidisciplinary cancer care.

- The review reinforced that we must ensure that all patients receive appropriately supported high quality cancer care irrespective of the professional delivering care.

- The review reinforced that we must ensure that all cancer care is multidisciplinary and centred on patient's physical and emotional need.

- The review reinforced that processes should be in place to provide assurances to patients and public that care meets these requirements.

- The review reinforced that the role of the Multidisciplinary Meeting Chair is defined by a Job Description with specific reference to Governance, Safe Care and Quality Care. That it should be resourced to provide this needed oversight.

4. Required action

In total there were 134 findings listed and11 recommendations within the report of which there are 3 issues which require immediate action for the SHSCT

(1) The Southern Health and Social Care Trust must provide high quality urological cancer care for all patients.

a) ***This will be achieved by***: Urology cancer care must be delivered through a co-operative multi-disciplinary team, which collectively and inter-dependently ensures the support of all patients and their families through, diagnosis, treatment planning and completion and survivorship

b) ***Assurance:*** must be demonstrated by comprehensive pathway audit for all patients care and experience. This should externally benchmarked within a year by Cancer Peer Review/External Service Review by Royal College

(2) All patients receiving care from the SHSCT Urology Cancer Services should be appropriately supported and informed about their cancer care. This should meet the standards set out in Regional and National Guidance and meet the expectation of Cancer Peer Review

a) This will be achieved by: Ensuring all patients receive multidisciplinary, easily accessible information about the diagnosis and treatment pathway. This should be verbally, and supported by documentation. Patients should understand all treatment options recommended by the MDM and be in a position to give fully informed consent.

b) Assurance: Comprehensive Cancer Pathway Audit and Patient experience

(3) The SHSCT must promote and encourage a culture that allows all staff to raise concerns openly and safely

a) ***This will be achieved by*:** Ensuring a culture primarily focused on patient safety and respect for the opinions of all members. The SHSCT must take action if it thinks that patient safety, dignity or comfort is or may be compromised. Issues raised must be included in the Clinical Cancer Services oversight fortnightly agenda. There must be action on issues escalated.

b) Assurance - Numbers of issues raised through Cancer Services, Datix Incidents identified, numbers of issues resolved, and numbers of issues outstanding.

There are 8 further recommendations which require action to be taken within 3 months for the SHSCT and these are listed in appendix 1

Considerations for the HSCB/PHA

Accepting that there will be a range of recommendations which are not yet fully agreed it is my view that, without hesitation, consideration should be given as to how best to apply the known learning regarding MDMs from the SHSCT Urology SAI overarching report regionally, across all cancer MDMs. The HSCB/PHA needs to ensure that there is a consistency of approach across Northern Ireland which is safe and meets the standards set out in Regional and National Guidance and meets the expectation of Cancer Peer Review. **It is essential that Trusts/HSCB/PHA are assured that at all times cancer patients receive high quality, timely care and support throughout the cancer pathway.**

While cancer peer review is a useful quality assurance tool, alongside other measures such as clinical appraisal and audit, it is not designed to identify or address individual performance issues. While the behaviour of individuals is difficult to legislate for, these SAIs suggest a need to look beyond peer review measures to understand the processes that exist around the MDM, ensuring that all patients are appropriately discussed and the advice of the MDM acted upon.

It is proposed that a task and finish group is established to design a regional MDM assessment tool that looks in detail at the processes and resources that underpin effective MDM functioning. The review of the baseline data will then enable us to identify areas of variation together with examples of good practice and will allow the development of regional recommendations/procedures that support effective MDM functioning and clinical governance. It is proposed that the work will be led by the Cancer Commissioning Team, supported by NICaN, and will report back via SMT.

There are 45 MDT across the region. Given the significant pressures in the system it is proposed that MDMs are reviewed in two phases:

- **Phase 1** - Tool to be undertaken for the "big five" tumour sites of breast, lung, gynaecology, colorectal and urology plus haematology (total 27 MDTs) over the Summer with initial report produced in September.
- **Phase 2** – Remainder of .specialist MDTs (n=18) will be completed and reported on by November 2021

The assessment tool

The self-assessment tool, which will draw on best practice guidance, will consider issues such as:

- the processes for listing patients for discussion at MDM;
- the process for referral, discussion at MDM and completion of CAPP's;
- the process for communicating the outcome to GPs;
- the process for communication of the outcome to patients;
- the process for making decisions outside of MDM;
- process for ensuring patients are referred to the CNS / have an identified key worker;
- adequacy of tracking support;
- how the role of MDM chair is operationalised and supported;
- the process for follow up of patients to ensure that first definitive treatment has commenced in line with MDM advice.
- the process to inform Consultants about MDT working and assessment of competence;
- use of protocolised registration of patients; and
- processes to ensure discussion of relapse/refractory disease.

Where possible Trusts will encourage MDT chairs to lead the review, undertaking peer review of MDTs within their Trust area. Where capacity does not allow, the tool will be completed by the Cancer Manager or Service Improvement lead on behalf of the MDT.

Fundamentally we know there are significant issues with the data infrastructure within cancer services which make undertaking routine clinical audit challenging. This issue is being progressed under the auspices of the Cancer Strategy but is likely to be something that is highlighted as an area of development by this process. The process is also likely to highlight challenges with tracking resource. While there is significant investment planned in year (13WTE trackers), further resource is required, particularly in the context of the impact of COVID on cancer pathways. This additional resource has been reflected in the Cancer Recovery Plan.

The recommendations to SMT represent the need for an enhanced level of assurance. They are in response to findings from nine patients where Dr 1 did not adhere to agreed recommendations, varied from best practice guidance and did not involve other specialists appropriately in care. They are to address what was asked of the Review by the families involved - "that this does not happen again."

Risks

Failure to review processes with a view to strengthening governance arrangements around MDMs creates a risk that similar SAIs might occur in the future

Recommendation to SMT

- To note Appendix 1 which sets out the recommendations and actions required which have been raised as a consequence of having received the SAI overarching report relating to the 9 SAIs from SHSCT and have provided justification for the Health Minister to instigate a full Independent Inquiry into care provided by the identified SHSCT Urology Consultant .

- To agree that a small task and finish working group be convened in June to develop a regional MDM self-assessment tool which will be issued to the Trusts for completion for 27 MDTs during July and August with an initial report to come

to SMT in September; the remaining MDMs will be reviewed and reported on by November 2021.

Name of Director - Mr Paul Cavanagh

Ext no.

Copied to:
As relevant e.g. Press Officer/Other Directors/ADs

Appendix 1 - Recommendations and Action Planning

1.0 RECOMMENDATIONS AND ACTION PLANNING

The recommendations represent an enhanced level of assurance. They are in response to findings from nine patients where Dr 1 did not adhere to agreed recommendations, varied from best practice guidance and did not involve other specialist appropriately in care. They are to address what was asked of the Review by families - "that this does not happen again".

Recommendation 1

The Southern Health and Social Care Trust must provide high quality urological cancer care for all patients.

This will be achieved by - Urology Cancer Care delivered through a co-operative multi-disciplinary team, which collectively and inter-dependently ensures the support of all patients and their families through, diagnosis, treatment planning and completion and survivorship.

Timescale - Immediate

Assurance - Comprehensive Pathway audit of all patients care and experience. This should be externally benchmarked within a year by Cancer Peer Review / External Service Review by Royal College.

Recommendation 2

All patients receiving care from the SHSCT Urology Cancer Services should be appropriately supported and informed about their cancer care. This should meet the standards set out in Regional and National Guidance and meet the expectation of Cancer Peer Review.

This will be achieved by - Ensuring all patients receive multidisciplinary, easily accessible information about the diagnosis and treatment pathway. This should be verbally and supported by documentation. Patients should understand all treatment options recommended by the MDM and be in a position to give fully informed consent.

Timescale - Immediate

Assurance - Comprehensive Cancer Pathway Audit and Patient experience.

Recommendation 3

The SHSCT must promote and encourage a culture that allows all staff to raise concerns openly and safely.

This will be achieved by - Ensuring a culture primarily focused on patient safety and respect for the opinions of all members. The SHSCT must take action if it thinks that patient safety, dignity or comfort is or may be compromised. Issues raised must be included in the Clinical Cancer Services oversight fortnightly agenda. There must be action on issues escalated.

1.0 RECOMMENDATIONS AND ACTION PLANNING

Timescale – Immediate

Assurance - Numbers of issues raised through Cancer Services, Datix Incidents identified, numbers of issues resolved, and numbers of issues outstanding.

Recommendation 4

The Trust must ensure that patients are discussed appropriately at MDM and by the appropriate professionals.

This will be achieved by - All MDMs being quorate with professionals having appropriate time in job plans. This is not solely related to first diagnosis and treatment targets. Re-discussion of patients, as disease progresses is essential to facilitate best multidisciplinary decisions and onward referral (e.g. Oncology, Palliative care, Community Services).

Timescale - 3 months

Assurance - Quorate meetings, sufficient radiology input to facilitate pre MDM QA of images - Cancer Patient pathway Audit - Audit of Recurrent MDM discussion - Onward referral audit of patients to Oncology/Palliative Care etc.

Recommendation 5

The Southern Health and Social Care Trust must ensure that MDM meetings are resourced to provide appropriate tracking of patients and to confirm agreed recommendations / actions are completed.

This will be achieved by - Appropriate resourcing of the MDM tracking team to encompass a new role comprising whole pathway tracking, pathway audit and pathway assurance. This should be supported by fail-safe mechanisms from laboratory services and Clinical Nurse Specialists as Key Workers. A report should be generated weekly and made available to the MDT. The role should reflect the enhanced need for ongoing audit/assurance. It is essential that current limited clinical resource is focused on patient care.

Timescale - 3 months

Assurance - Comprehensive Cancer care Pathway audit - Exception Reporting and escalation

Recommendation 6

The Southern Health and Social Care Trust must ensure that there is an appropriate Governance Structure supporting cancer care based on patient need, patient experience and patient outcomes.

1.0 RECOMMENDATIONS AND ACTION PLANNING

This will be achieved by - Developing a proactive governance structure based on comprehensive ongoing Quality Assurance Audits of care pathways and patient experience for all. It should be proactive and supported by adequate resources. This should have an exception reporting process with discussion and potential escalation of deficits. It must be multidisciplinary to reflect the nature of cancer and work with other directorates.

Timescale - 3 months

Assurance - Cancer Pathway Audit outcomes with exception discussion and escalation. Data should be declared externally to Cancer Peer Review.

Recommendation 7

The role of the Chair of the MDT should be described in a Job Description, funded appropriately and have an enhanced role in Multidisciplinary Care Governance.

Timescale - 3 months

Recommendation 8

All patients should receive cancer care based on accepted best care Guidelines (NICAN Regional Guidance, NICE Guidance, and Improving Outcome Guidance).

This will be achieved by - Ensuring the multi-disciplinary team meeting is the primary forum in which the relative merits of all appropriate treatment options for the management of their disease can be discussed. As such, a clinician should either defer to the opinion of his/her peers or justify any variation through the patient's documented informed consent.

Timescale - Immediate

Assurance - Variance from accepted Care Guidelines and MDM recommendations should form part of Cancer Pathway audit. Exception reporting and escalation would only apply to cases without appropriate peer discussion.

Recommendation 9

The roles of the Clinical Lead Cancer Services and Associate Medical Director Cancer Services should be reviewed. The SHSCT must consider how these roles can redress Governance and Quality Assurance deficits identified within the report.

Timescale - 3 months

1.0 RECOMMENDATIONS AND ACTION PLANNING
Recommendation 10 ***The families working as 'Experts by experience' have agreed to support the implementation of recommendations and will receive updates on the assurances at 3, 6 and 12 month intervals This recommendation will be agreed following discussion with families*** **Recommendation 11** ***The Southern Health and Social Care Trust should consider if assurance mechanisms detailed above, should be applied to patients or a subset of patients retrospectively.***

Chief Executive's Senior Management Team
Meeting held on Tuesday, 22 June 2021

Via zoom

Members in Attendance:

Sharon Gallagher	Chief Executive
Lisa McWilliams	Director of Strategic PMSI
Paul Cavanagh	Interim Director of Planning and Commissioning
Tracey McCaig	Interim Director of Finance
Brendan Whittle	Director of Social Care and Children
Shirlie Murtagh	Interim Head of Communications
Dr Stephen Bergin	Interim Director of Public Health

Apology:

Paula Smyth	Director of HR & Corporate Services (BSO)
Rodney Morton	Director of Nursing, Midwifery and AHP's
Louise McMahon	Director of Integrated Care

In attendance:

Denise Boulter	PHA
Dr Margaret O'Brien	Integrated Care, HSCB
Gareth McKeown	For agenda item 4
Kathryn Turner	for agenda item 5
Donncha O'Carolan	for agenda item 6

1. **Welcome**

   Sharon welcomed members to the meeting.

2. **Declaration Of Interests**

   Members of SMT confirmed that they had no interests to declare in relation to the issues being discussed at the meeting.

3. **Minutes, Actions and Matters Arising**

   Sharon noted the minutes of SMT held on 15 June 2021. She advised on the actions which had been completed. There were a number of actions which would be carried forward to the B/F system for future SMT meetings.

4. **Organisational Change/Transformation**

   Gareth McKeown gave a comprehensive update on Organisational Change/Transformation and raised issues pertaining to:

   - Legislation –oral and written evidence is being considered by the Committee. Committee stage will be concluded by summer recess;
   - The Oversight Board took place last Monday (14 June) where there were two papers from Integrated Care. These were agreed by the Oversight Board;

- A paper was presented in relation to Emergency Planning for enhanced oversight in HSCTs in respect of emergency preparedness;
- A paper on the new independent appeals panel was also presented to the Oversight Board there will be a consultation exercise on this;
- Work ongoing with the business partners to look at the non-recurrent funding to make best use of those funds;
- First meeting of the hosting working group has been setup;
- Work ongoing in relation to developing an external communications plan. This will be presented to the Oversight Board in July;
- Migration matters four will be released on Friday 9th July.

AP1-22/09: Gareth to send the emergency preparedness paper to SMT.

5. Community Pharmacy Services – Approval of COVID funding

Sharon welcomed Kathryn Turner to SMT. Kathryn gave a high level update of the three services:

- Emergency Supply Service;
- Living Well Service;
- Delivery Service;

Kathryn said that there would still be a requirement for community pharmacy to collect prescriptions from GP practices. This will come back as a separate paper to a future SMT meeting.

Tracey said she is content to approve, as the services are being funded through the Covid response funding in year. A plan for any future needs should be considered going forward.

Sharon was supportive of the services discussed and noted that these are worthwhile initiatives. Sharon advised that funding needs to be considered moving forward.

Kathryn recommended that Chief Executive/SMT: Approve the allocation of non-recurrent COVID funding to secure these three services from community pharmacy for 21/22.

SMT members approved the Community Pharmacy Services – Approval of COVID funding.

6. GDS COVID Response Template – Level 2 PPE Kit Supply

Donncha O'Carolan presented the paper on GDS COVID Response Template - Level 2 PPE Kit Supply. Donncha gave a comprehensive overview of the paper which had been provided to SMT members.

SMT approved COVID Response Template for General Dental Services Level 2 PPE Kit supply, approximately £8m.

7. Teriparatide

Paul presented the paper on Teriparatide. He advised that SMT are required to approve the commissioning of teriparatide for severe osteoporosis in men in line with the criteria set out in the NHS England interim commissioning policy statement on a cost per case basis for up to 12 men in 2021/22 until NICE provides a determination.

Sharon advised that the Teriparatide paper was considered previously by SMT. SMT approved the Direction of travel in light of consideration being given to funding moving forward.

AP2-22/09: Update paper to come to SMT on the next phase of Teriparatide.

SMT approved the commissioning of teriparatide for severe osteoporosis.

8. MDT IPTs

Dr Margaret O'Brien presented the MDT IPTs and noted that approval is required for MDT 21/22 IPTs. Dr O'Brien said that discussions have taken place with Finance and there was a large amount of slippage last year and this will be closely monitored going forward.

Tracey advised that the finance team have reviewed the papers and she is content to approve.

Sharon noted the slippage and challenges to recruiting into these types of posts. Sharon asked for confirmation that the paper reflects the challenges in relation to recruitment. Dr O'Brien confirmed that she is content that the paper reflects these challenges.

Sharon asked was there an evaluation/analysis of the MDTs and how effective these have been to date. Dr O'Brien said that the evaluation is being led by the DoH and a contract was in place; however the contract had not been extended. There is evidence at locality level of the effectiveness of MDTs.

AP3-22/09: Sharon to pick up with Gesroid Cassidy in relation to early learning in MDTs.

SMT approved the MDT 21/22 IPTs.

9. Sentinel Lymph Node Biopsy (SLNB)

Paul presented the paper on Sentinel Lymph Node Biopsy (SLNB).

Paul explained that SMT are formally asked to approve the NI Service Specification: Sentinel Lymph Node Biopsy (SLNB) for Malignant Melanoma.

Paul clarified that SMT are asked to seek approval to ask WHSCT to step down the uncommissioned SLNB service.

Paul to put a note under the finance section that a recurrent allocation of £557k to support the provision of SLNB for 200 melanoma patients per annum was confirmed with the understanding that the service in its entirety would be in place from 2021/22 with a combination of Trust and non-Trust provision (Blackrock and Bristol) in 2020/21.

AP4-22/09: Paul to add a note under the finance section of the SLNB paper.

Pending the input in the Finance section of the paper, SMT approved the Sentinel Lymph Node Biopsy (SLNB).

Items for Noting:

10. SHSCT Urology SAI Overarching Report

Paul presented the SHSCT Urology SAI Overarching Report.

Paul identified that SMT are asked to:

- Note Appendix 1 in the paper provided which sets out the recommendations and actions required which have been raised as a consequence of having received the SAI overarching report relating to the 9 SAIs from SHSCT and have provided justification for the Health Minister to instigate a full Independent Inquiry into care provided by the identified SHSCT Urology Consultant.

- To agree that a small task and finish working group would be convened in June to develop a regional MDM self-assessment tool which will be issued to the Trusts for completion for 27 MDTs during July and August with an initial report to come to SMT in September; the remaining MDMs will be reviewed and reported on by November 2021.

SMT noted the briefing that sets out the concerns which have been raised as a consequence of having received the SAI overarching report (referred to as the 10th SAI) relating to the 9 SAIs from SHSCT, Urology.

SMT approved a task and finish group be established to design an assessment tool that Trusts will be asked to complete in order to undertake a review of all cancer related MDM structures and operating practices.

11. RMB Paper –No More Silos update

This paper was not discussed by SMT.

12. GP Out of Hours

Dr O'Brien gave an update on the position in relation to GP Out of Hours. Sharon clarified that she asked for the paper to come to SMT following the SAI monthly report and to clarify the role of the HSCB in GP Out of Hours.

Sharon asked specifically about the BHSCT and the delay in moving to the multidisciplinary model. She asked did the HSCB have a risk profile against each of the 19 sites and asked for assurance that there is an understanding of the issues and interventions. Additionally, Sharon asked if there was a programme of work for the 19 sites. Dr O'Brien clarified the positon in relation to the performance management for the 19 sites.

Sharon acknowledged that there is a clear performance management framework in place however, there appears to be gaps. BHSCT have not yet looked at other disciplines to cover GP Out of Hours. Dr O'Brien said previously there had been direct Chief Executive to Chief Executive conversations in relation to concerns regarding GP Out of Hours.

Sharon clarified she is happy to intervene but said that she needs to understand where the risks are, and to obtain further details in relation to the providers and to what degree this needs to be escalated.

AP5-22/09: Paper to be provided to SMT identifying the risk profile for each of the 19 sites, an understanding of the models and the link between the audit recommendation.

Dr O'Brien confirmed that there is a current priority one internal audit recommendation in relation to the GP out of hours and the permanent secretary has written to the Board in relation to this.

SMT noted the GP Out of Hours paper.

13. Communications Update

SMT noted that External Engagement Summary for the period covering Monday 21 June 2021 to Friday 2 July 2021.

Shirlie gave an update on communications issues pertaining to GP out of hours in BHSCT and SHSCT; GP branch closure; data around ED trends –Monday and Tuesdays and confirming a regional response; comms to go out to Trusts on the July holidays; Design comms paper agreed with DoH and HSCB.

AP6-22/09: The External Engagement Summary to be kept up to date. Any meeting external to HSCB should be included in the External Engagement Summary.

14. Any Other Business

AP7-22/09: Dr Bergin to provide an update on the current Covid position to SMT on 29 June.

Tracey advised that there would be a request to complete a three year financial planning process, this needs to be completed by August. Tracey will complete guidance notes and send this out to Directors this week.

AP8-22/09: Tracey to send guidance notes to Directors in relation to the three year financial planning.

Date of next meeting: Tuesday 29 June 2021 @10am

NICaN Northern Ireland Cancer Network	**Adherence to best practice principals for MDTs - Review of Urology MDTs** **DRAFT Report March 22** **Confidential- do not circulate.**

1.0 Introduction

A SAI overarching report relating to the 9 SAIs from SHSCT Urology service, outlined lessons learned which may have relevance for all cancer MDMs regionally. The SAI concluded that MDM recommendations had not been followed and care had been given without full multidisciplinary input. In response to this, HSCB (now SPPG) and PHA asked NICaN to support them in taking forward a regional review of MDMs which looks at adherence to best practice principles and explores the processes and audit that underpin effective MDM working. HSCB therefore requested a review of all cancer related MDM structures and operating practices regionally to ensure that there is a consistency of approach across Northern Ireland which is safe and meet the standards set out in Regional and National Guidance and meets the expectation of Cancer Peer Review.

There are 49[1] separate tumour site multidisciplinary teams (MDTs) in trusts across NI. (See appendix). Due to the COVID 19 pandemic pressures on front line staff and as urology has been a focus of SAI, urology MDTs were chosen as the first tumour site to review. A review tool was tested across all 4 trusts that have a Urology MDT.

This paper outlines the findings of Urology MDT review across the 4 delivery trusts and makes recommendations for improvement to Urology MDT processes as well as recommendations that should be applied to all MDTs regionally.

The paper also makes recommendations for improvement to the review tool before roll out to other tumour sites MDTs.

1.1 Background

Principles of MDT/MDM working

Before the establishment of MDTs diagnostic assessments and cancer treatments were often delivered by generalists without the necessary knowledge and skills related to a specific cancer. Some factors relevant to decision making were being missed and patients may not have been considered for treatments which might have been beneficial. Information was not being collated and communication with patients, as well as between primary, secondary and tertiary care was poor. To address this Cancer MDTs were established and in 2010 the National Cancer Action team of the NHS published '*The Characteristics of an Effective Multidisciplinary Team (MDT)'* which set out defined characteristics of an MDT to ensure effective working of MDTs for patients.

[1] (BHSCT=17; SEHSCT=7; BT=7; WHSCT=10; SHSCT=8)

Effective MDT working should result in:

- *treatment and care being considered by professionals with specialist knowledge and skills in the relevant aspects of that cancer type;*
- *patients being offered the opportunity to be entered into high quality and relevant clinical trials;*
- *patients being assessed and offered the level of information and support they need to cope with their condition;*
- *continuity of care, even when different aspects of care are delivered by different individuals or providers;*
- *good communication between primary, secondary and tertiary care;*
- *good data collection, both for the benefit of the individual patient and for the purposes of audit and research;*
- *improved equality of outcomes as a result of better understanding and awareness of patients' characteristics and through reflective practice;*
- *adherence to national and local clinical guidelines;*
- *promotion of good working relationships between staff, thereby enhancing their job satisfaction and quality of life;*
- *opportunities for education/professional development of team members (implicitly through the inclusion of junior team members and explicitly when meetings are used to devise and agree new protocols and ways of working);*
- *Optimisation of resources – effective MDT working should result in more efficient use of time which should contribute to more efficient use of NHS resources more generally.*

MDTs were set up in NI from XXX and in 2014 NICaN commenced a 6 year rolling programme of external peer review funded by Macmillan Cancer Care.

Cancer peer review is a useful quality assurance tool, alongside other measures such as clinical appraisal and audit. However peer review cannot identify or address individual performance issues. The SAI suggested a need to look beyond peer review measures to understand the processes that exist around the MDM, ensuring that all patients are appropriately discussed and the advice of the MDM acted upon.

2.0 Review Approach

The review tool - *The MDM Principles, Process & Audit Assessment tool*

Multi-disciplinary meeting (MDM) principles (same ref?) are provided to support Cancer MDT working and to take forward any improvements required against operational, communication, governance, audit and research standards that should be evident for all Cancer MDMs. These cover aspects such as team membership, attendance, leadership and culture, meeting infrastructure, organisation and logistics, patient centered care, clinical decision making and team governance and communication.

A self-assessment tool (based on work already undertaken by BHSCT & SHSCT) and using MDM principles draws on a number of existing documents which seek to define and inform effective MDT working

- *The Manual of Cancer Services Standards.*
- *The Characteristics of an Effective Multidisciplinary Team (MDT)*, National Cancer Action Team (2010).
- *Improving the effectiveness of multidisciplinary team meetings in cancer services* – Cancer Research UK (2015)

- *Streamlining Multi-Disciplinary Team Meetings: Guidance for Cancer Alliances* – NHS England and NHS Improvement 2020
- MDT effectiveness tools developed by cancer collaborative elsewhere in the United Kingdom.

(see appendix XX)

The *MDM Principles, Process & Audit Assessment tool* includes 40 key principles / areas of guidance against which the MDM should be assessed (see Appendix 1). This tool asks teams to consider if they have evidence of adherence to a number of MDM principles under the themes of Operation, Communication and Governance and audit and research. Cancer services teams need to complete a number of audits and surveys to provide evidence of compliance against the principles.

For each principle teams were asked where possible to indicate the following:
- What quality indicator is being used (e.g. attendance quoracy)
- Evidence – is there documented evidence and what it is (e.g. attendance data).

Teams could then apply a score where one point is allotted to each principle or guideline that is evidenced.
On completion of the tool, each MDT should be given a compliance score marked out of 40 as follows:
- Quality mark awarded for 85% compliance- 33/40
- Quality standard reached for 75% compliance – 30/40
- MDTs who report below 75% compliance should be discussed by cancer service management at local level.

In autumn 2021 all local Urology MDTs completed the self-assessment tool to assess adherence to core MDM principles.

3.0 Findings

Cancer services teams must complete a number of audits and surveys to provide evidence of compliance against the principles. Regular audit against MDM functioning, communication and outcomes is extremely challenging for all Trusts. Providing evidence for a compliance score for local MDTs was not possible. While there may have been compliance or partial compliance for several items there was lack of evidence via survey or audit. Currently trusts do not have data /information capacity to carry out the work needed to provide the evidence for some key quality indicators to enable the tool to be completed for scoring.

Belfast Trust had carried out rigorous audit to enable scoring of the regional specialist MDT. The trust has only been able to do so by employing a band 5 information officer at risk. The Regional Urology MDM based at Belfast Trust has been self-assessed against these principles and has achieved a compliance score of 90%.

While scoring across all sites has not been possible the tool has highlighted areas of compliance, non-compliance and areas requiring further work regarding evidence. See tables X to X in appendix 1.

3.1 Compliance with Operational principles/standards

Compliance: All trust were compliant and able to provide evidence for 4 out of the 11 operational principles (see table X). These include the role of MDT chair, role of MDT coordinator, MDT discussion policy and MDT meeting space and IT resources.

Partial/lacking evidence: In some cases trusts may be compliant but did not have evidence available, this included item 2 (MDM etiquette agreed but not documented) partnership engagement not formalised, formal process for new MDT attendee's /observers not documented. Three out of 4 trusts say that they do not formally engage with a 'user Partnership Group' although in some trusts informal ad hoc engagement has taken place.

Non-compliance Three out of 4 trusts are non-compliant for team representation and quoracy (items 1&6) where there are issues of cover. For example one trust has a single handed pathologist and another has no cover for radiology and oncology.

3.2 Compliance with Communication principles/standards

Compliance: All trusts are compliant with 6 out of 17 principles. These include items 2.1, 2.4, 2.5, 2.12, 2.13

- All trusts have a communication protocol that cover pre and post MDM communication, there is locally agreed cut off time for inclusion of cases at MDT with flexibility for cases of clinical urgency, cases are organised logically with time for more complex cases and also for team members to leave when their input is ended.
- Patients are aware of the MDM and there is information on MDMs on trust websites.
- All trusts state compliance with giving patients a patient information leaflet and a *permanent record of consultation by the CNS.*

Partial compliance or /lacking evidence:
All trusts have good processes and protocols in place however there is a lack of audit to ensure processes are fully and accurately implemented and documented. This again is due in part to the lack of time at MDM, and lack of tracker resource to document what happens to a patient after MDM to ensure compliance with MDM outcome.
Areas noted include;

- **2.1.1** Pre MDT patient minimum dataset – 2 trusts are amending the pre meet dataset. Yet to be audited
- **2.1.2** Post MDM communication – Main issue is lack of audit. There is mixed interpretation of this item regarding *discrepancies noted and signed off*.
- **2.2** Communication with the patient/MDT decision recording- Two trusts are improving their MDT environment to ensure all members see MDT outcome written up on screen. One trust does not do live MDT outcome capture as time does not allow this and the field is completed post MDM.
- **2.3.** There is mixed quality of evidence to show that *Clinical decision making process results in clear recommendations in line with standard treatment protocols unless justified and this should be documented* – three trusts have indicated evidence of audit and one yet to audit. Again consistency across region on how this is audited may be required.

- **2.7** Evidence for this principle *Patient centered -someone who has met the patient in attendance,* is again varied *and needs* regional agreement. Is it enough to have this as a guiding principle in SOP or does it need audited?
- **2.8** Identification of key worker –again varied use of evidence. Recommend cross trust consensus on what evidence to use. There is work ongoing on CaPPS to enhance this data capture. This will require regional buy-in and MDT tracking will be required to verify and complete this field.

Non-compliance: as follows:

- **Item 2.10** – **patient experience surveys** to include questions relevant to MDT - patient experience surveys take place however all trusts will check need for inclusion of questions specific to MDT working. *These should include:*
  - Are patients aware of MDT, have seen/MDT information on trust website?
  - Have been given patient MDT leaflet?
  - Are aware of the purpose of MDT, aware of who sits in MDT (i.e. which professional groups)
  - Have been given the outcome of MDT and in timely way.

- **2.11- clinical trials-** 2 trusts acknowledge the need to be more proactive in terms of liaising with regional MDT on availability of Clinical trials. *NICaN Urology CRG to also share Clinical trial updates.*
- **2.14** – **discussion of private patients**, relevant in 2 trusts- one trust is drafting a policy.
- **2.15**- **deferral of cases** – Trusts currently do not monitors and review the number and reasons for deferral of cases. *An amendment to CaPPS is in process which should allow reason for deferral to be recorded and more easily audited.*

3.2 Compliance with Governance principles/standards

Areas of compliance: the majority of trusts are compliant with governance principals. MDTs are part of a formal governance framework within trusts. There is organisational support for MDTs and recognition that MDTS are the accepted model by which to deliver safe and high quality cancer care. MDTs/Trusts hold annual business meetings to discuss annual reports review guidelines and protocols and agree actions plans.

Areas of Partial compliance or /lacking evidence:
3.1 and **3.2** (focus on responsible clinician) are not routinely audited in all trusts due to lack of resource.
3.3- concerns raised with chair/monitor of MDT; review function of MDT and undertake continuous improvement. Trusts are partially compliant and providing different evidence. One trust is updating the MDT chairs job description and another is to carry out a survey.
3.4 Audit of outcomes and processes- limited resource to enable regular routine auditing of outcome. This aspect is most fundamental to the issues highlighted at SAI.

Areas of non-compliance:

- **Item 3.11 –** reflecting on equality of access- requires regional discussion on what needs to be measured with regard to equality of access. (How is this done elsewhere?)

Is the tool addressing the issues identified in SAI?

SAI recommended self-assessment that identifies:

Highlighted in HSCB briefing setting out concerns raised via SAI overarching report	Addressed?	Work needed
the processes for listing patients for discussion at MDM;	All trusts using MDT referral forms	
the process for discussion at MDM; (operational and communication)	Covered proforma/minimum data / protocolisation/ scheduling .	Benchmark minimum data set
the process for communicating the outcome to GPs	Letter via NIECR with 24 hrs (Check /all?)	CaPPS enhancements needed ?
the process for communication of the outcome to patients;	Check – consultant appt/ ?	Not specified
the process for making decisions outside of MDM;	Check	Not audited?
process for ensuring patients are referred to the CNS	Ad hoc	Work to enhance CaPPS field to complete at MDT. *Tracker will need to ensure.* If no CNS available??what should the process be ?
how the role of MDM chair is operationalised and supported	Sound SOP Processes in place. Role supported by MDT tracker. Role of MDT chair supported through annual appraisal and by a defined role specification. Time, including preparation time, recognised in job plans.	
the process for follow up of patients to ensure that first definitive treatment has commenced in line with MDM advice	Not audited in all trusts – insufficient capacity to track and compared against MDM advice	Flagged- audit resource not available in trusts

Discussion

All trusts have clear SOP, regular business meetings, review of operational policies &, production of annual reports and participate in NICaN CRG and Peer review. There is clear governance within trusts. There is good organisational support for MDT meetings and MDT membership (where professional workforce allows) and there is recognition that MDTs are the accepted model by which to deliver safe and high quality cancer care

However several aspects of these principles require detailed audit particularly patient follow up and outcomes to enable comparison with intended outcomes at MDT (SAI highlighted *the process for follow up of patients to ensure that first definitive treatment has commenced in line with MDM advice)*. Regular audit against MDM functioning, communication and outcomes is extremely challenging for all Trusts. Cancer Services teams are funded only to track new primary cancers to first definitive treatment (i.e.to enable monitoring of 31 day and

62 days targets).To undertake regular audit would require additional resource in every trust area.

In addition while it may be clear in SOPs when patient cases can be taken back to MDTs including when discussion of patients with metastatic disease/recurrence should take place these cases are also not tracked. Tracking of these patients would require a policy steer and resource. It *is also important to note that the cancer strategy suggests MDTs should be set up for patients with metastatic disease and CUP etc).*

- *Ensure actions agreed at the meeting are implemented;*
- *Ensure that the MDT is notified of significant changes made to their recommended treatment/care plan;*
- *manage referral of patient cases between MDTs (including to MDTs in a another provider);*
- *track patients through the system to ensure that any tests, appointments, treatments are carried out in a timely manner e.g. Within cancer waits standards where applicable.*

Current MDT tracker resource does not allow for timely tracking and full patient follow up and there are gaps in the MDM co-ordinator teams across several trusts. Some trusts experience difficulty with recruitment and retention of Patient Navigator/MDM co-ordinators. Frequent disruptions to the tracking team mean that there may be delays in patient tracking, a risk for patients and lags in data updating which also means that the system is *not showing accurate, real time performance data*.

SPPG have worked with trusts to identify need for additional navigator /tracker resource as part of the cancer strategy workforce planning. Cancer operations teams are also addressing navigator/tracker training and support. Navigator training devised in BT is being offered across the region- what other actions needed? *Tracker training programme devised by Scottish gov and Macmillan also to be explored.* There is now a MDT tracker portal on NICaN SharePoint to allow regional sharing of tracker training and resources.

Quoracy is proving difficult to achieve in 4/5 trusts due to lack of pathology, radiology and oncology staff. This ongoing issue has been part of oncology and haematology stabilisation plan and is also addressed in the strategy regional, multi-professional cancer workforce strategy.

While not an issue for Urology MDTs (CHECK) CNS provision is still inadequate across a number of specialties and many CNS's do not have access to a support worker. This impacts on ability to record who has had access to a CNS and to administer patient surveys. Action 39 of the cancer strategy indicates that all patients should have access to a CNS throughout the entire care pathway. Regional work has commenced to address issue of CNS capacity and phase 2 CNS expansion. An enhancement has been made to the CaPPS information system to indicate if a CNS is available to patients and work has also commenced to encourage CNS use of CaPPS information system to capture CNS activity.

Bt comment? MDM outcomes - poor performance in the MDT outcomes audits - what does poor performance look like?. Should anything less than 100% of MDT outcomes followed through be notified and to whom?

Limitations to Tool

- The tool cannot be adequately completed within current resource in trusts for patient tracking/ data input and data audit to provide the evidence.
- The tool is lengthy and in parts repetitive. Some items group too many important individual aspects of principles together. There should be separation of some to ensure clarity on where trusts are compliant. Parts 2.3 and 2.6 are arguably the most fundamental aspects of communication principals and most relevant to issues raised in SAI. These items should be separated into individual questions to focus on exactly where trusts are compliant/non-compliant.
- There is repetition of some aspects within elements of all three sections (op/comm/governance). The tool could be streamlined and more focussed.
- Some aspects of principles are open to interpretation**-** Needs clear understanding on difference between a policy in place and evidence to show policy is being properly implemented. Several items require an agreed, consistent evidence indicator.
- Recommend- discussion with trust colleagues to discuss strength and limitations of the tool, agree evidence indicators, interpretation, and streamlining.

Recommendations

Operational principles

Trusts

- Formalise and document MDT etiquette.
- MDT co-ordinator support, line management, training and development should continue and good practice shared regionally. BHSCT has developed MDT co-ordinators and tracker training which is currently being shared across trusts.
- Trusts should explore and formalise /document use of partnership groups.
- Ensure attendance is documented and there is a formal process for new MDT attendee's and observers, regarding sign in and confidentiality.
- Ensure patient experience surveys include questions relevant to MDT. These should include: if patients are:
  - aware of MDT, if they have seen MDT information on trust website
  - Given patient MDT leaflet
  - aware of purpose of MDT, aware of who sits in MDT (i.e. which professional groups)
  - given outcome of MDT and in timely way.

Regional Recommendations

- Quoracy compliance and cover –this is a workforce and funding issue.
- Tracking/MDM co-ordinator resource. Currently there are gaps in the MDM co-ordinator teams across several trusts. *- (admin /info requirements considered as part of workforce planning for Ca strategy- level of investment needed is significant.* While it may be clear in SOPs when patient cases can be taken back to MDTs including when discussion of patients with metastatic disease/recurrence should take place these cases are not tracked. Tracking of these patients would require a policy steer and resource. – *may want to add what strategy says about this.*

Recommendations – Communication and governance principles

For Trusts

- Continue to review and recommend cases are organised logically at MDM with time for more complex cases, and also organise so that team members can leave when their input is ended.
- Ensure MDT information on trusts websites is up to date.
- Ensure a permanent record of consultation at MDT is provided to patients by the CNS (audited?).
- Pre MDM data proforma-2 trusts are in the process of updating pre mdm data proforma- will require auditing.
- MDT decision recording- ideally recording of MDT outcome should happen in real-time in sight of the whole MDT. Trusts should ensure where possible that this is the case. One trust has highlighted that time demand on MDT does not allow- what do we suggest?
- Patient centered/ someone who has met the patient is in attendance: - evidence varied – needs regional agreement. Is it enough to have this as a guiding principle in SOP or does it need audited?
- Clinical trials -2 trusts acknowledge the need to be more proactive in terms of liaising with regional MDT on availability of Clinical trials.

Regional

- *Clinical decision making process results in clear recommendations in line with standard treatment protocols unless justified and this should be documented* and 2.6 *processes in place to ensure actions agreed at MDT are implemented?-* – All trusts have processes and protocols in place however there is a lack of audit to evidence and ensure processes are fully implemented and any changes to intended MDM outcome is documented.. (one of the key issues with Urology SAI ST). *A key aspect is the evidence - need patient tracking and follow up to allow for audit – being addressed with additional navigators trackers? Tracker resource does not allow for timely tracking and full patient follow up. Some trusts have gone at risk to employ a MDT information role to audit but this is not resourced for ongoing auditing. Issues with trackers – Not enough makes recruitment and retention difficult. Known to be a difficult role? This is due in part to the lack of time at MDM, and lack of tracker resource to document what happens to a patient after MDM to ensure compliance with MDM outcome. Trusts are funded to track patients to first treatment. Trusts who have managed to audit have done so by employing at risk. Resource*
- part 2.3 and 2.6 are the most fundamental aspects of communication principals. These items should be separated into individual questions to focus on exactly where trusts are non-compliant.
- Pre MDM proforma- may be value in benchmarking the pre MDM proforma across trusts. Trusts should also audit completeness and quality of information provided on the referral proformas.
- NICaN Urology CRG to share NICTN Clinical trial updates.
- Recommend cross trust consensus on what evidence to use to ensure all patients have a key worker. Work ongoing on CaPPS to enhance this data capture. Needs regional buy in and MDT tracker to verify and complete.

- Not all Trusts monitor and review the number and reasons for deferral of cases – an amendment to CaPPS is now being made which should allow reason for deferral to be recorded and more easily audited.

Limitations to Tool

- Tool cannot be adequately completed within current resource in trusts for data tracking and data audit.
- Some items group too many important individual aspects of principles together. There should be separation of some to ensure clarity on where trusts are compliant. Parts 2.3 and 2.6 are arguably the most fundamental aspects of communication principals. These items should be separated into individual questions to focus on exactly where trusts are compliant/non-compliant.
- Key aspect is evidence and the need for audit and patient tracking and follow up. There is repetition of theses aspects within elements of all three sections (op/comm/governance). The tool could be streamlined and more focussed
- Some aspects of principles are open to interpretation**-** Needs clear understanding on difference between a policy in place and evidence to show policy is being properly implemented. Several items required a consistent evidence indicator.
- Recommend- discussion with trust colleagues to discuss strength and limitations of the tool, agree evidence indicators, interpretation, and streamlining.

Action plan to compile

Other Thoughts re discussion

What value to trusts in completing- was it helpful – did it flag anything?

Align/support - or replicate peer review? Could we use SA measures from peer review? And add to it some key measures from this tool?

- Tool- is this a useful tool if refined? (focus in on priority aspects)
- Rolling programme of self-assessment using this approach - ? Instead of as well as peer review?
- Even if trusts resourced to complete NICaN does not have resources to do this on a rolling basis?
- Part of bigger data issue Cancer information systems to facilitate audit.

Part 1: MDT/MDM operational principles/standards

		BHSCT	SET	SHSCT	WHSCT	Local Issues
1.1	All relevant professions/disciplines (core & extended members) are represented in the team in line with the Manual of Cancer Services >95% of the time with cover. Their role should be added to their Job Plan					*Radiology & oncology cover*
1.2	MDM etiquette agreed and documented					*Not formally agreed & in SOP*
1.3	MDT meets at regular time. Punctuality/ pacing and length controlled by chair.					*no MDT Imp lead WHSCT?*
1.4	Role of MDT chair supported through annual appraisal and by a defined role specification. Time, including preparation time, should be recognised in job plans.					***none***
1.5	The MDT co-ordinator is recognised as a core member of the team and is supported to fulfil their role with clear line management, training and development.					***none***
1.6	Cross cover/deputies with authority to support recommendations are in place to cover planned (and where possible unplanned) absences. Advanced notice is given so cover can be organised if possible.					*BT-Single handed pathologist ST- NO cover for Rad & Onc*
1.7	User Partnership Groups have opportunity to advise on the development of MDT policy and practice and are given feedback in response to their advice including actions taken in response to their recommendations.					*Efforts made /ad hoc – not formalised.*
1.8	MDT chair will be made aware of any absences/ cover arrangements/ new attendees or observers in advance, and will introduce them at the start of the meeting. Observers details to include on attendance list. They should sign a confidentiality form.					*Happens in practice/ no formal process in place.*
1.9	The MDT will • Include discussion on investigation, treatment; follow up, ethical and social matters, comorbidities and practical problems. • Agree a policy for discussion of newly suspected/confirmed and recurrent malignancies. • Processes should be in place to ensure that all patients diagnosed with a primary cancer have their case considered by the relevant MDT. • It is clear when patient cases can be taken back to MDTs including when discussion of patients with metastatic disease/recurrence should take place. • There is information on when to refer patient to local and regional MDMs.					*All covered in MDT operational policy*
1.10	Protocol path pre meet- MDTs for tumour types for which a protocolised approach has been developed should agree and document their approach to administering protocols. This could include a 'pre-MDT triage meeting'. Patients on predetermined agreed algorithms will be recorded and not discussed by the full MDT. Decision making for patients put on a protocolised pathway should be regularly reviewed.		n/a	n/a	n/a	BT Currently piloting at regional MDT- uses pre meet triage and review
1.11	• A dedicated and appropriate meeting room should be available which has access to other essential technology and software for example access to projected digital images. • Trust ensures appropriate IT support for av and virtual equipment, and is able to respond to issues during meetings if required.				*	*IT issues not audited

	Part 2 : Communication	BHSCT	SET	SHSCT	WHSCT	Local Issues
2.1.0	A communication protocol should be in place for all MDMs to cover all communication aspects such as PRE- during and post MDM. If there are concerns that key data is missing this should be documented.	✓*annual audit results avail*				
2.1.1	**Pre meet minimum dataset -** must include - patient demographics (age and gender) - Clinical summary to include co-morbidities, psychosocial and specialist palliative care needs, along with patient preferences where known - Question to MDM/ Person responsible - Summary of the record	✓**annual** *audit results avail*		***Implemented feb22 not audited .***	***Not audited***	**WT -Work underway to streamline dataset*Audit not completed*
2.1.2	**Post MDM communication** - Informing GP/referring clinician - Filing of MDM record - Communication to core/non-core members - Referrals/Actions from MDM - MDM sign off - Discrepancies noted and audited (*what does this refer to exactly)*	✓**annual** *audit results avail*			***Not audited***	*SET -Deferred box to be added to Capps and ticked with the reason for deferral* *WT- audit required- discrepancies noted and audited- needs clarity.*
2.2	• The Chair should ensure a clear plan is in place for communication with the patient. • The decision of the MDT should be recorded on CaPPS in real time in full view of the MDM with person responsible for action listed where appropriate. The MDM outcome should be communicated to the relevant professionals (e.g. referring MDT, GP, CNS) to enable early discussion and management ideally on the same day and within 1 working day	✓**annual** *audit results avail*		***not real time data capture-***	***Not audited***	*SET Looking to moving to different rooms with 2 screens so Capps is displayed to all not just the chair*
2.3	The clinical–decision making process results in clear recommendations on the treatment/care plan resulting from the meeting. These recommendations are: • evidence-based (e.g. in line with NICE and/or cancer network guidelines); • patient-centered (in line with patient views & preferences when known and taking into account co-morbidities); • in line with standard treatment protocols unless there is a good reason against this, which should then be documented.	✓**annual** *audit at risk*	✓**annual resource**	**Sample audit**	***Not audited (resource)***	*ST audited sample- compliant –*
2.4	There is a locally agreed cut off time for inclusion of a case on the MDT/list agenda and team members abide by these deadlines - there is flexibility for cases that may need to be added last minute due to clinical urgency.					*In Operational policies*
2.5	Cases are organised on the agenda in a way that is logical for the tumour area being considered and sufficient time is given to more complex cases – the structure of the agenda allows, for example, the pathologist to leave if all cases requiring their input have been discussed.					

2.6	There are processes in place: • to ensure actions agreed at the meeting are implemented; • to ensure the MDT is notified of significant changes made to their recommended treatment/care plan; • to manage referral of patient cases between MDTs (including to MDTs in a another provider); • to track patients through the system to ensure that any tests, appointments, treatments are carried out in a timely manner e.g. Within cancer waits standards where applicable.	**✓annual audit**	**audit**	***Sample audit***	**Audit needed**	*MDM outcomes audit, ITT protocol, tracking of NEW cancer patients to First treatment tretament*
2.7	The MDT should be patient centred in its approach ensuring that wherever possible someone who has met the patient and can express their views, wishes and needs is in attendance.	**✓op**	**✓audit**			*CNS role – patients not always met prior to MDT* *WT to update OP policy*
2.8	The MDT/Service has responsibility for identifying a key worker for the patient.					*Varied evidence –* *BT- OP SET patient survey- ST /WT audit needed*
2.9	The MDT has responsibility for ensuring all clinically appropriate treatment options for a patient even those they cannot offer/provide locally are considered and that the patients information needs have been (or will be) assessed and addressed.			**evidence**		*Varied evidence* *BT audit* *Set – patient survey* *WT- Annual review of performance data and monthly analysis of patients waiting/breachers*
2.10.	Patient experience surveys include questions relevant to MDT working and action is taken by MDTs to implement improvements needed in response to patient feedback.					*BT/WT- current patient survey needed* *All to check survey include questions relate to MDT working* *ST new survey in process*
2.11	Every patient discussed should be considered for appropriate/available clinical trials, and this should be recorded.	***Annual report & audit***	***Annual report & audit***			*ST; Patients who are referred to the Specit MDT will have access to clinical trials ST to be more proactive as* *WT- Patients are not being considered - need better connection with BHSCT and wider. Resource neds allocated*
2.12	Patients are aware of the MDT, it's purpose, membership, when it meets and that their case is being/has been discussed and are given the outcome within a locally agreed timeframe. There is a section on MDM working on the trusts website for patients.			*		**STLine on website in In progress* *Wt – update needed*
2.13	Each MDT should have a patient information leaflet on the MDT and permanent record of consultation given out to them by the CNS, this is one of the peer review standards.					

2.14	The Trusts should have in place an agreed process for the discussion of private patients.			**n/a**	**n/a**	
2.15	The MDT should monitor and review the number and reason for deferral of cases					*Needs CaPPS amendment*

	Part 3 : Governance/audit/Research	**BT**	**SET**	**ST**	**WT**	**Local Issues**
3.1	MDT decisions are guidance for the responsible treating clinician. Accountability for any intervention remains with the clinician responsible for that intervention.			**Sample audit**	**Audit**	*WT- audit needed*
3.2	Clear governance arrangements should be in place to ensure that patients, relatives, medical and nursing staff in primary, secondary and tertiary care are all clear who is responsible for taking forward MDT action.				**Audit**	*WT- audit needed*
3.3	MDT members are encouraged to raise any concerns about the functioning of the MDT with the MDT chair. The MDT should agree a process for regularly monitoring and reviewing the functioning of the MDT and undertake continuous improvement activities and identify if there are any areas of training required.					*WT- to do survey/ covered at BM. ST -New JD for MDT Leads to be finalised &included in the MDT Principles Doc.*
3.4	Audit of MDT outcomes, processes and data will be central to the assurance of quality and results will be communicated with all core members of the MDMs and discussed at annual business meetings. Agreed audits include: 1. MDM communication (Referral proformas, communication with GPs and filing of MDM outcomes) 2. MDM outcomes "				**Audit**	*ST/Wt- audit n* Limited audits due to lack of resource available – support n*eeded*
3.5	Each service area supporting the MDM should ensure they have oversight and ownership of mortality and morbidity data to ensure all adverse outcomes can be discussed by the relevant professional group and learned from. All core members attend Trust M&M and ensure cancer patients are discussed. If required a selection of learning from M&M can be presented for educational purposes at the annual/bi annual business meetings.					ST-Unsure if learning from M&Ms is presented at the AGMs
3.6	The implementation and outcomes of protocolised approaches should be audited and reviewed by the full MDT in an operational meeting. Patients who are not discussed but who	**n/a**	**n/a**	**n/a**	**n/a**	

	are recorded at the MDT will have their data, treatment and outcome regularly audited for compliance to mandatory dataset collection requirements.					
3.7	Peer support and external scrutiny of MDT processes, functioning and outcomes are welcomed by all MDTs and NICaN Clinical Reference Groups (CRGs). The review should take place against peer review standards as set out in the manual of cancer standards. MDT members work in partnership with other peers to offer reciprocal peer support. Nominated members should attend the relevant NICaN CRG and should routinely feed back to the MDT CRG decisions / developments.					
3.8	MDTs should be a part of a formal governance framework within the Trust. Members of the MDT should ensure that they are aware of this governance framework and those relevant policies and procedures are followed by the MDT. The Clinical Lead should be responsible for raising issues through this governance process on behalf of the MDT however all members of the team should take responsibility for raising issues.					
3.9	There is organisational (employer) support for MDT meetings and MDT membership demonstrated via: · Recognition that MDTs are accepted model by which to deliver safe and high quality cancer care · Adequate funding/resources in terms of people, time, equipment and facilities for MDT meetings to operate effectively (as set out in this document)					
3.10	Trusts consider their MDT's annual reports via discussion of these at annual business meetings and act on issues of concern. Please confirm date of last meeting					
3.11	MDT policies, guidelines and protocols are reviewed at least annually. All annual reports, operational policies, cancer improvement plans are discussed at annual business meetings and signed off by all core members of the team					
3.12	MDTs reflect, at least annually, on equality issues, for example, that there is equality of access to active treatments and other aspects of treatment, care and experience for all patients.	**Data req**	**Data req**	**Data req Ethnicity**	**Data req**	

Appendix

List of MDTs for every trust to insert.