Mr. Ryan Wilson
Department of Health
Castle Buildings
Stormont
Belfast
BT4 3SQ

30 June 2022

Dear Sir

Re: The Statutory Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust

Provision of a Section 21 Notice requiring Witness Statement & the production of documents

I am writing to you in my capacity as Solicitor to the Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust (the Urology Services Inquiry) which has been set up under the Inquiries Act 2005 ('the Act').

I enclose a copy of the Urology Services Inquiry's Terms of Reference for your information.

You will be aware that the Inquiry is investigating the matters set out in its Terms of Reference. A key part of that process is gathering all of the relevant documentation from relevant departments, organisations and individuals.

In keeping with the approach we are taking with other departments, organisations and individuals, the Inquiry is now issuing a Statutory Notice (known as a 'Section 21 Notice') pursuant to its powers to compel the production of relevant documentation.

This Notice is issued to you as a representative of the Department of Health. It relates to documents within the custody or control of the Department of Health. The Schedule to the enclosed Section 21 Notice provides full details as to the matters which should be covered in the written evidence which is required from you. As the text of the Section 21 Notice explains, you are required by law to comply with it.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Please bear in mind the fact that the witness statement required by the enclosed Notice is likely (in common with many other statements we will request) to be published by the Inquiry in due course. It should therefore ideally be written in a manner which is as accessible as possible in terms of public understanding.

You will note that certain questions raise issues regarding documentation. As you are aware the Department of Health has responded to our earlier Section 21 Notice requesting documentation. If the documentation previously provided deals with a request made within this S21 Notice request, please highlight the relevant document and bring it to the Inquiry's attention. In addition, if you in your personal capacity hold any additional documentation which you consider is of relevance to our work and is not within the custody or power of the Department and has not been provided to us to date, then we would ask that this is also provided with this response.

If it would assist you, I am happy to meet with you, your officials and/or the Department's legal representative(s) to discuss what documents you have and whether they are covered by the Section 21 Notice.

You will also find attached to the Section 21 Notice a Guidance Note explaining the nature of a Section 21 Notice and the procedures that the Inquiry has adopted in relation to such a notice. In addition, as referred to above, you will also find enclosed a copy of the Inquiry's Terms of Reference to assist you in understanding the scope of the Inquiry's work and therefore the ambit of the Section 21 Notice.

Given the tight time-frame within which the Inquiry must operate, the Chair of the Inquiry would be grateful if you would comply with the requirements of the Section 21 Notice as soon as possible and, in any event, by the date set out for compliance in the Notice itself.

If there is any difficulty in complying with this time limit your organisation must make application to the Chair for an extension of time before the expiry of the time limit, and that application must provide full reasons in explanation of any difficulty. The Inquiry will be pleased to receive your documents in tranches; you do not have to wait until you are in a position to fully comply with the Notice before you begin to send

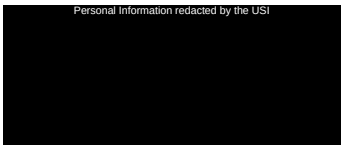
Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

documents. Indeed it will greatly assist the progress of the Inquiry's work if you immediately begin the process of forwarding documents to the Inquiry.

If your organisation does not hold documentation in respect of some of the categories of document specified in the Section 21 Notice, please state this in your response. If it is possible to indicate by whom such information might be held, if it is not held by your organisation, the Inquiry would find that of assistance.

Please do not hesitate to contact me to discuss any matter arising.

Yours faithfully



Anne Donnelly
Solicitor to the Urology Services Inquiry

Tel: Personal Information redacted by the USI
Mobile: Personal Information redacted by the USI

THE INDEPENDENT PUBLIC INQUIRY INTO
UROLOGY SERVICES IN THE
SOUTHERN HEALTH AND SOCIAL CARE TRUST

Chair's Notice

[No 65 of 2022]

Pursuant to Section 21(2) of the Inquiries Act 2005

WARNING

If, without reasonable excuse, you fail to comply with the requirements of this Notice you will be committing an offence under section 35 of the Inquiries Act 2005 and may be liable on conviction to a term of imprisonment and/or a fine.

Further, if you fail to comply with the requirements of this Notice, the Chair may certify the matter to the High Court of Justice in Northern Ireland under section 36 of the Inquiries Act 2005, where you may be held in contempt of court and may be imprisoned, fined or have your assets seized.

TO: **Mr. Ryan Wilson**
Department of Health
C5.11
Castle Buildings
Stormont
Belfast BT4 3SQ

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

IMPORTANT INFORMATION FOR THE RECIPIENT

1. This Notice is issued by the Chair of the Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust on foot of the powers given to her by the Inquiries Act 2005.

2. The Notice requires you to do the acts set out in the body of the Notice.

3. You should read this Notice carefully and consult a solicitor as soon as possible about it.

4. You are entitled to ask the Chair to revoke or vary the Notice in accordance with the terms of section 21(4) of the Inquiries Act 2005.

5. If you disobey the requirements of the Notice it may have very serious consequences for you, including you being fined or imprisoned. For that reason you should treat this Notice with the utmost seriousness.

DOCUMENTS TO BE PRODUCED

TAKE NOTICE that the Chair of the Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust requires you, pursuant to her powers under section 21(2)(b) of the Inquiries Act 2005 ('the Act'), to produce to the Inquiry the documents set out in the Schedule to this Notice by **12.00 noon on 11th August 2022.**

APPLICATION TO VARY OR REVOKE THE NOTICE

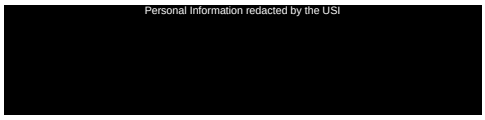
AND FURTHER TAKE NOTICE that you are entitled to make a claim to the Chair of the Inquiry, under section 21(4) of the Act, on the grounds that you are unable to comply with the Notice, or that it is not reasonable in all the circumstances to require you to comply with the Notice.

If you wish to make such a claim you should do so in writing to the Chair of the Inquiry at: **Urology Services Inquiry, 1 Bradford Court, Belfast BT8 6RB** setting out in detail the basis of, and reasons for, your claim by **12.00 noon on 4th August 2022.**

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Upon receipt of such a claim the Chair will then determine whether the Notice should be revoked or varied, including having regard to her obligations under section 21(5) of the Act, and you will be notified of her determination.

Dated this day 30th June 2022

Signed: 

Christine Smith QC

Chair of Urology Services Inquiry

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

SCHEDULE
[No 65 of 2022]

General

1. Having regard to the Terms of Reference of the Urology Services Inquiry, please provide a narrative account of your involvement in or knowledge of all matters falling within the scope of sub-paragraph (b) of those Terms of Reference. In particular you are required to address the circumstances in which the Department of Health ("the Department") became aware of the issues relating to potential concerns about patient care and safety within the Southern Health and Social Care Trust ("the Trust"), and the engagement which subsequently took place between the Trust, the Department and/or others and the processes and decision making which followed. You are asked to explain the Department's role and input, if any, in the process which led to the Trust conducting a 'Lookback Review' and adopting a 'Structured Clinical Record Review' ('SCRR') process. You are also required to explain the processes which led to the decision to establish this public inquiry, and the reasons for that decision. Your narrative account should include an explanation of your role, responsibilities and duties, and you should provide a detailed description of any issues raised with you, meetings attended by you, and actions or decisions taken by you and others to address any concerns. It would greatly assist the inquiry if you would provide this narrative in numbered paragraphs and in chronological order using the form provided.

2. Provide any and all documents within your custody or under your control relating to paragraph (b) of the Terms of Reference, except those documents that have previously been disclosed to the Inquiry by the Department. Provide or refer to any documentation you consider relevant to any of your answers, whether in answer to Question 1 or in response to the questions set out below. Where documentation has previously been provided to the Inquiry by the Department please reference same using the "DOH" Bates number which is to be found on the top right hand corner of the Inquiry Evidence Bundle. If you are in any doubt about the documents previously provided by the Department you may wish to contact the Department's legal advisors or, if you prefer, you may contact the Inquiry.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

3. Unless you have specifically addressed the issues in your reply to Question 1 above, answer the remaining questions in this Notice. If you rely on your answer to Question 1 in answering any of these questions, specify precisely which paragraphs of your narrative you rely on. Alternatively, you may incorporate the answers to the remaining questions into your narrative and simply refer us to the relevant paragraphs. The key is to address all questions posed. If there are questions that you do not know the answer to, or where someone else is better placed to answer, please explain and provide the name and role of that other person.

31 July 2020 – 30 October 2020

4. Prior to 31 July 2020, were you, or others within the Department, aware of any concerns in relation to Urology Services within the Trust, including service capacity or waiting list issues, or in relation to the practice of Mr Aidan O'Brien in particular. If you or others were so aware of any concerns relating to Urology Services, outline the following:

    I. The date on which you or others within the Department became aware;
    II. The identity of the individual who told you of those concerns if applicable;
    III. The specific information communicated to you in relation to any concerns;
    IV. What, if any, action you took on behalf of the Department to log, monitor, assess or address those concerns.

5. Outline all steps taken by the Department upon receipt of the Early Alert Communication from the Trust on 31 July 2020. Specifically, outline the following:

    I. The immediate action (naming each actor) taken by the Department on receipt of the Early Alert Communication;

II. The individuals within the Department to whom the Early Alert Communication was shared;
III. The nature of any discussions which officials from the Department had with the Trust concerning the contents of the Early Alert Communication or related matters;
IV. The nature of any discussions officials from the Department had with the Health and Social Care Board as it then was ("the HSCB"), Public Health Agency ("the PHA"), the Regulation and Quality Improvement Agency ("the RQIA") and any other relevant organisation concerning the contents of the Early Alert Communication or related matters;
V. The nature of any internal discussions within the Department regarding the content of the Early Alert Communication, or related matters, and next steps.

Please note that this question is directed to immediate action and immediate next steps upon receipt of the Early Alert. By contrast, you will note that question 13 is directed to subsequent actions within the period specified in that question.

6. From the Department's perspective, what is the purpose of an Early Alert, and was it properly used by the Trust in these circumstances?

7. Has the Department reached any view concerning the appropriateness, quality and timeliness of the steps taken by the Trust to communicate and escalate the reporting of issues of concern within the Trust to the Department? If so, fully outline the view which has been reached and set out the reasons for the view which has been reached. If the Department has not evaluated this issue, please explain why.

8. Has the Department reached any view concerning the effectiveness of the corporate and clinical governance procedures and arrangements within the Trust in the context of the matters which gave rise to the need to issue an Early Alert? If so fully outline the view which has been reached and set out the

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

reasons for the view which has been reached. If the Department has not evaluated this issue, please explain why.

9. Outline what advice, if any, was given to the Trust by the Department in response to the Early Alert and related matters.

10. In what way, if at all, did the Department make HSC Trusts (including the Southern Trust) aware of its publication, "*Practical Guide to Conducting Patient Service Reviews or Look Back Exercises: Regional Governance Network Northern Ireland Sub Group*" (February 2007) ("the 2007 Departmental Guidance")? If the Department has a record of disseminating the 2007 Departmental Guidance to the Southern Trust, provide full details.

11. After receipt of the Early Alert, outline whether the Department gave any consideration to, or advised the Trust of the availability and appropriateness of utilising the 2007 Departmental Guidance.

12. As appropriate, outline what, if any, advice was given to the Trust with regard to the application of the 2007 Departmental Guidance and in particular with regard to paragraph 1.4 of that Guidance. If no such advice was given, please explain why it was not given.

13. Outline any meetings or discussions between officials from the Department and the Trust, the HSCB (as it then was), the PHA, the RQIA and any other relevant organisation from the date of receipt of the Early Alert on 31 July 2020 to the first meeting of the Urology Assurance Group on 30 October 2020 concerning the handling of the concerns raised in the Early Alert, or related issues. With regards to each meeting or discussion, specify:

    I. The date;
    II. The attendees;
    III. The matters discussed;
    IV. Any decisions taken;
    V. Any advice provided by the Department or received by the Department;
    VI. Disclose or refer to any and all documentation relating to same.

Establishment of the USI

14. Outline the decision making process which led to the announcement of the establishment of a public inquiry by the Minister on 24 November 2020. Specifically please address:

    I. The steps which were taken as part of this process;
    II. The factors which led to the decision to establish a public inquiry;
    III. The individuals involved in reaching that decision;
    IV. Any briefings or submissions to the Minister, including the contents of SUB-2055-2020; and
    V. Any consultation the Department had with any of the following persons/bodies as part of the process leading to the establishment of the public inquiry:
        A. The Trust;
        B. The HSCB;
        C. The PHA;
        D. The RQIA;
        E. Mr O'Brien's representatives; and
        F. Any other relevant person or organisation.

'SCRR' Process and 'Lookback Review'

15. Outline the Department's understanding of, and its involvement, if any, in the process leading to a decision by the Trust to adopt a SCRR process as opposed to utilising the Serious Adverse Incident ('SAI') process. In answering this question reference should be made to all relevant meetings, discussions or correspondence.

16. What assurances did the Department seek and receive (if any) with regard to the appropriateness of the use of a SCRR process in the context of the concerns about patient care and safety which were made known to the Department, as opposed to utilising the SAI process? In particular, the Inquiry is concerned to understand the extent to which the Department sought to obtain assurances as to the robustness and thoroughness of the SCRR process, the

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

assurances provided, how they were tested and whether the assurances were considered satisfactory.

17. With specific reference to all relevant meetings, discussions or correspondence, outline the Department's understanding of and involvement in the decision by the Trust to engage in a Lookback Review.

18. What assurances did the Department seek and receive (if any) with regard to the appropriateness of the use of the Lookback Review undertaken in relation to the patients of Mr O'Brien from 1 January 2019 to 30 June 2020? In particular, the Inquiry is concerned to understand the extent to which the Department sought to obtain assurances as to the robustness and thoroughness of the Lookback Review process and its comprehensiveness in terms of the patient group which was to be reviewed and the temporal parameters of the review, the assurances provided, how they were tested and whether the assurances were considered satisfactory.

Oversight mechanisms now in place

19. The Inquiry understands that the oversight structures regarding urology and/or public inquiry engagement consists of the following:

Within the Trust

Urology Lookback Steering Group – Chaired by the Director of Acute Services

Within the Trust's internal Public Inquiry Governance structure

3 Strands –

(i) Urology Oversight Steering Group
(ii) Trust's Public Inquiry Steering Group
(iii) Trust's Public Inquiry Quality Assurance Group

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Outside the Trust within the Strategic Performance and Planning Group ("SPPG") (formally HSCB),

Southern Urology Co-ordination Group – Chaired by the Acting Director of Planning and Commissions at SPPG and made up of Senior Trust Staff from SHSCT

Outside the Trust within the Department

Urology Assurance Group – Chaired by the Permanent Secretary and made up of Senior Trust Staff from SHSCT

You are asked to confirm that the Inquiry's understanding of the existence of these structures is correct to the best of your knowledge. If there are additional working groups or committees working in these areas which are not referred to above, you should identify them. You are asked to briefly outline the function and/or terms of reference of those working groups or committees referred to above or otherwise identified by you, which involve or are engaged with personnel from the Department. As relevant, explain how all such structures (working groups / committees) in place within the Department, the SPPG and the Trust interact and share information and learning, if at all. Your reply should detail the names of the group members as relevant to the Department and the SPPG, and dates of all meetings, the frequency of meetings as well as all recommendations and actions to date.

Ongoing Assurance

20. In addition to the structures referred to above, outline the Department's ongoing role and steps taken, if any, in monitoring, seeking assurance and ensuring patient and general public safety arising out of the concerns about patient care and safety raised by the Trust. In addressing this question outline any engagement the Department has had or continues to have with any of the following concerning these matters:

    I. The Trust;
    II. The staff working within SPPG;

III. The PHA;
IV. The RQIA;
V. Mr O'Brien's representatives; and
VI. Any other relevant person or organisation.

21. Please set out:

I. What, if any, reforms the Department is aware of the Trust having made to clinical governance arrangements to address any issue which may have been identified?
II. What, if any, processes have been implemented or steps taken by the Trust to monitor or provide assurance that the clinical governance arrangements within the Trust are to the Department's satisfaction and ensure patient safety?
III. What, if any, assurances has the Department sought and received from the Trust with regard to any reforms to clinical governance arrangements?
IV. What, if any, monitoring has the Department implemented to ensure that the clinical governance arrangements within the Trust protect patient safety?

22. How, if at all, have any reforms or assurances been tested? In addressing this question also outline what, if any, assurances the Department received or continues to receive, and outline whether the assurances received to date are considered by the Department to be satisfactory.

23. Does the Department consider there remains outstanding work to be done by the Trust before its governance structures are sufficiently robust to prevent a reoccurrence of the issues which arose within the Trust's Urology Services? Whether your answer is yes or no, please explain.

24. In light of the Minister's Oral Statement to the Assembly on Tuesday 24 November 2020, where he stated:

> The consultant also had a significant amount of private practice and that much of this was carried out in private domestic premises, therefore sitting outside of the regulatory framework which requires registration and external assurance of facilities in the Independent Sector in which clinicians may undertake private practice. This is also of significant concern to me as many of these patients may be unknown to the Southern Trust or the wider HSC system.
>
> …
>
> *The Minister went on to list actions to be taken, which included the following:*
>
> Thirdly, in relation to his private patients who are not known to the Southern Trust, I have requested that his solicitors outline how Mr O'Brien intends to provide a similar independent process to ensure that those private patients are alerted to issues arising and that their immediate healthcare needs are being met. Whilst the Department has no explicit duty to take this particular matter forward, as part of our wider healthcare responsibilities, I want to do all I can to safeguard patients who may have received care or treatment in a private capacity from this consultant.

What, if any, assurances has the Department sought and received regarding the care and governance of Mr Aidan O'Brien's private patients from:

I. The Trust;
II. Mr Aidan O'Brien;
III. Mr O'Brien's legal representatives; or
IV. Any other relevant person, organisation or source.

25. If assurances have been sought and provided in respect of Mr O'Brien's private patients, how has the Department tested the effectiveness of these assurances? Is the Department satisfied by the assurances provided? If not, what are the Department's proposed next steps, if any, regarding Mr O'Brien's private patients?

26. Has the Department reached any view concerning the appropriateness, quality and timeliness of the steps taken by the Trust to address the issues of concern and ensure patient safety? If so, fully outline the view which has been reached

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

and set out the reasons for the view which has been reached. If the Department has not evaluated this issue, please explain why.

Updated Guidance

27. Provide copies of all consultations, reviews and documentation outlining the decision making process which led to the 2007 Departmental Guidance being replaced by HSC (SQSD) 6/21 “Regional Guidance for implementing a lookback review process” (“the 2021 Departmental Guidance”).

28. Please set out:

    I. The substantive changes or amendments introduced by the 2021 Departmental Guidance to the systems and processes contained in the 2007 Departmental Guidance.
    II. The policy objective or deficiency in the 2007 Departmental Guidance which any change or amendment is intended to address.
    III. How the change or amendment addresses that policy objective or deficiency.
    IV. Whether the Department provided any advice or direction to the Trust with regard to the applicability of the 2021 Departmental Guidance to its Lookback Review process in urology, and if so, provide details of that advice, when it was provided, and whether the Department took steps to ensure that the advice was implemented by the Trust.

Learning

29. From the information available to the Department to date, what does it consider went wrong within the Trust’s urology services and with regard to Trust governance procedures and arrangements? Has the Department reached any view on how such issues may be prevented from recurring? Has the Department taken any steps with a view to preventing the recurrence of such issues?

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

30. Does the Department consider that it did anything wrong or could have done anything differently which could have prevented or mitigated the governance failings of the Trust?

31. From the Department's perspective, what lessons have been learned from the issues of concern which have emerged from urology services within the Trust? Has this learning informed or resulted in new practices or processes for the Department? Whether you answer is yes or no, please explain.

NOTE:

By virtue of section 43(1) of the Inquiries Act 2005, "document" in this context has a very wide interpretation and includes information recorded in any form. This will include, for instance, correspondence, handwritten or typed notes, diary entries and minutes and memoranda. It will also include electronic documents such as emails, text communications and recordings. In turn, this will also include relevant email and text communications sent to or from personal email accounts or telephone numbers, as well as those sent from official or business accounts or numbers. By virtue of section 21(6) of the Inquiries Act 2005, a thing is under a person's control if it is in his possession or if he has a right to possession of it.

Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Ref: Notice 65 of 2022
Date of Notice:

Witness Statement of: Ryan Wilson, Director of Secondary Care, Department of Health

I, Ryan Wilson, will say as follows:-

1. On 3 August 2020 I took up post as Acting Director of Secondary Care, a Directorate within the Healthcare Policy Group in the Northern Ireland Department of Health ("the Department" or "DoH"). I have held various policy roles in the Department since 2005, including roles within Healthcare Policy Group since 2013, prior to taking up my current role, to which I was permanently appointed in August 2021.

2. In this statement I have set out a description of the events and issues relevant to the questions in Notice 65 of 2022 ("Notice 65") which I or my Directorate have first-hand knowledge of or responsibility for. Where events and issues relate to the responsibilities of other business areas within the Department, or those of external organisations, I have set out a description of these to the best of my knowledge and outlined where those responsibilities sit within the structure of the Department and/or the Health and Social Care ("HSC") system.

3. Before providing a narrative of my involvement in or knowledge of matters falling within the scope of sub-paragraph (b) of the Inquiry's Terms of Reference, and responding to any of the remaining specific questions at paragraphs 4-31 of Notice 65, this statement describes my role, that of Secondary Care Directorate, the statutory basis of the Department's relationship with its Arm's Length Bodies, and

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

the policy and commissioning context within which HSC urology services are provided. This includes the last comprehensive review of adult urology services in Northern Ireland which was completed in 2009, the prioritisation status of urology services in the context of the Department's overall health service transformation agenda under its current 10-year transformation strategy "Delivering Together", and the impact of the COVID-19 pandemic on the delivery of this transformation agenda.

My role

4. The Director of Secondary Care is an Assistant Secretary and the Department's senior advisor to the Minister of Health on secondary healthcare policy, with responsibility for developing and reviewing Departmental policies which underpin the delivery of healthcare mainly within hospital settings, and the clinical specialties through which these services are delivered. This includes hospital urology services, which were last reviewed between 2008-2009 (see further details at paragraphs 21-33 below).

5. Departmental policy in relation to healthcare in Northern Ireland is generally guided by the relevant legislation and by clinical and professional guidelines, e.g. those published by the National Institute for Health and Care Excellence ("NICE") and endorsed by the Department for implementation in Northern Ireland (further detail about NICE guidelines is set out at paragraphs 13-17 below), and professional bodies such as the Royal Colleges. The Department's policy position in relation to urology services is summarised at paragraphs 11-12 below.

6. Secondary Care Directorate also plays a key role in supporting the Health Minister by regularly providing policy briefing for Assembly business (including Oral and Written Assembly Questions, as well as correspondence and briefing requests from the Assembly's Health Committee) and Ministerial engagements, as well as preparing responses to correspondence received by the Minister or by the Department from service users and their elected representatives.

7. Where correspondence is received by the Department in relation to operational matters, including an enquiry or a complaint relating to the treatment or care of an individual patient, this is generally referred to the appropriate Arm's Length Body ("ALB"), which is usually the relevant HSC Trust responsible for the care of the patient or the delivery of the service in question. It would be inappropriate for the Department to investigate or advise on any individual patient's clinical care. The ALB is generally asked by the Department to investigate the matter in question and to provide a response to the correspondent's enquiry or complaint. Any complaint is processed by the ALB in accordance with the Health and Social Care Complaints Procedure.

8. In the performance of these functions, the Secondary Care Directorate works closely with many of the Department's ALBs, including the six HSC Trusts which are responsible for the operational delivery of secondary healthcare services, as well as commissioners from the joint commissioning functions provided by the Public Health Agency ("PHA") and the Department's Strategic Planning and Performance Group ("SPPG", formerly the Health and Social Care Board or "HSCB").

9. Paragraphs 8-15 of the Witness Statement of Peter May, Permanent Secretary of the Department of Health, sets out the relationship between the Department and HSC Trusts, outlining that DoH delegates its operational responsibilities to ALBs, including the six HSC Trusts.

10. Paragraphs 16-19 of Peter May's Statement set out the role of HSC Trusts in the employment and management of doctors within the HSC.

Departmental Policy in relation to HSC Urology Services

11. A Departmental document titled "Standard Policy Brief – Urology (reviewed Sept 2019)" has been provided to the Inquiry [DOH-12114 - DOH 12118]. This is one of a number of internal standard briefing documents held within the Secondary Care Directorate for the purposes of providing officials with accessible, factual, high

level information about the relevant clinical specialty (in this case urology), including the location of services, clinical guidelines, legislation, waiting lists, relevant issues, and date of the most recent service review.

12. The Urology Policy Brief document notes that:

- There is no single Departmental policy for urology services, as this clinical specialty covers diseases, trauma and congenital abnormalities of the kidney, bladder, genitalia and urinary tract as well as male sexual and reproductive health, the management of many non-surgical problems, such as urinary infections, and surgical problems such as the correction of incontinence, prostate problems and the treatment of cancer. It notes that urology is closely linked with cancer services, due to the related areas of prostate and bladder cancer, as well as gynaecology and genito-urinary medicine and sexual health specialties.

- A wide range of NICE clinical guidance is available on a range of urology related conditions, which is available on the NICE website.

- In common with HSC services generally, the principal legislation underpinning the delivery of urology services in Northern Ireland is the Health and Social Care (Reform) Act (NI) 2009 ("the Reform Act"). Further detail about the Reform Act is set out under "Commissioning and Funding of Trust Healthcare Services" at paragraphs 18-20.

- A regional review of urology services was completed in March 2009 by the HSCB; and,

- the date suggested by the Secondary Care Directorate for the next policy review of urology services was 2019. This reflected the time that had passed since the previous review, however it should be noted that the commencement of any major policy or service review would be subject to other Departmental priorities and the availability of Departmental and HSC resources to lead and

support this work. A further review has not been completed since the Policy Brief document was revised in September 2019. Further detail about the 2009 Review is set out at paragraphs 21-38 below. Detail about the Department's consideration and prioritisation of a review of urology services within a wider programme of high priority reviews, both in 2016, and in 2020 in the context of the COVID-19 pandemic, is set out at paragraphs 39-53 below.

NICE Guidelines

13. NICE is an independent organisation tasked with producing national guidance on good clinical practice and the cost-effective use of NHS resources in England. NICE provides a very robust and rigorous approach to its consideration of available evidence and provides expert guidance. The Institute publishes a range of guidance and their Clinical Guidelines relate to the management of broad conditions and groups of patients.

14. As NICE guidance is designed and developed for the NHS in England, it does not automatically apply in Northern Ireland. On 1 July 2006, the Department established links with NICE whereby all guidance published by the Institute from that date is locally reviewed for applicability to Northern Ireland and, where appropriate, is endorsed for implementation in the HSC.

15. Departmental policy underpinning these links with NICE, and the process for reviewing, endorsing and implementing NICE guidelines, is the responsibility of the Chief Pharmaceutical Officer (currently Cathy Harrison).

16. NICE guidelines can be complex and may require significant change to the existing service provision and additional investment. Therefore implementation of NICE guidelines, once they are endorsed by the Department, may take place over several years and is subject to the availability of additional recurrent funding.

17. Responsibility for implementing NICE guidelines, once endorsed and funded, sits with healthcare delivery organisations (mainly HSC Trusts), and is overseen by the

commissioning and performance management functions of SPPG (which transferred into the Department from the former HSCB from 1 April 2022).

Commissioning and Funding of Trust Healthcare Services

18. The statutory provisions governing the relationship between the Department, the former HSCB (whose functions transferred to the new Strategic Planning and Performance Group, or SPPG, within the Department on 1 April 2022), the PHA, and HSC Trusts are contained in Chapter 1 of the Reform Act, in particular S.6, 8 and 10 (a copy is provided to the Inquiry at Appendix 1). As required by Section 5 of the Reform Act, (a copy is provided to Inquiry at Appendix 2), the Department produced the HSC Framework Document in 2011 which describes the roles and functions of the various HSC bodies, the systems that govern their relationships with each other and the Department, and the service commissioning process. The former HSCB (now SPPG) and HSC Trusts have their own statutory functions and ultimately act subject to the direction of the Department. A copy of the 2011 HSC Framework Document has been provided to the Inquiry [DOH–35616 – DOH-35672].

19. In line with the requirements of the Reform Act, the majority of medical treatment in Northern Ireland is delivered by HSC Trusts. Trusts may be formally commissioned by SPPG to deliver particular medical services in accordance with parameters which may be set out in a service specification (e.g., describing aspects of service to be delivered including location, facilities, opening hours, staffing levels, diagnostics, funding arrangements, activity volumes, performance targets etc.). The Commissioning Directorate within SPPG is responsible for establishing appropriate mechanisms for this process in line with sections 8 and 10 of the 2009 Reform Act, the HSC Framework Document, and the policies and priorities set by the Department.

20. The commissioning of services by SPPG from HSC Trusts is dependent upon, and limited by, the funding made available to SPPG by the Department, which in turn receives a funding allocation from the UK Government via the NI Executive.

Functions such as financial planning, financial policy and financial management (including the allocation of budgets to SPPG and to some ALBs, and the in-year monitoring of expenditure) in respect of the overall Departmental budget allocated by the NI Executive, are the responsibility of the Departmental Director of Finance (currently Brigitte Worth). The equivalent functions in respect of the SPPG budget, which includes the commissioning of services from HSC Trusts, have transferred from the HSCB to the Department from 1 April 2022 and are the responsibility of the SPPG Director of Finance (currently Tracey McCaig).

2008/09 Review of Urology Services

21. In 2008, the Department's former Service Delivery Unit ("SDU") initiated a Regional Review of HSC Adult Urology Services. The Department has thus far been unable to locate any records preceding the initiation of the Review (though further checks of registered files in storage are taking place), including any policy advice recommending that it should be progressed at that time, however a submission subsequent to the completion of the Review from Secondary Care Directorate to the then Health Minister, Michael McGimpsey, dated 23 April 2009, outlined that the rationale for the Review proceeding was as follows: *"this was in response to concerns regarding the ability of HSC urology services to manage growing demand, meet cancer and elective waiting times, maintain quality standards and provide high quality elective and emergency services."* A copy of the submission of 23 April 2009 is provided to the Inquiry at Appendix 3.

22. A copy of a letter issued on 2 June 2008 by Hugh Mullen, the then Director of Performance and Provider Development, SDU, and Chair of the Regional Urology Steering Group, advising HSC Trusts that the review had been initiated, is provided to the Inquiry at Appendix 4.

23. The first meeting of the Regional Urology Steering Group was held on 17 September 2008. A list of members of the Regional Urology Steering Group is provided to the Inquiry at Appendix 5 and a copy of the Review's agreed Terms of Reference is provided to the Inquiry at Appendix 6. A copy of the final Review

Report, titled *"Review of Adult Urology Services in Northern Ireland - A modernisation and investment plan"*, which was published in March 2009 by the HSCB, is provided to the Inquiry at Appendix 7.

24. The Terms of Reference set the overall purpose of the Review as follows: "*To develop a modern, fit for purpose in the 21st century, reformed service model for Adult Urology Services which takes account of relevant guidelines (NICE, Good Practice, Royal College, British Association of Urological Surgeons, British Association of Urological Nurses). The future model should ensure quality services are provided in the right place, at the right time by the most appropriate clinician through the entire pathway from primary care to intermediate to secondary and tertiary care."*

25. The context for the Review, as noted in the Review Report, was the evolution of the field of urology from being *"the province of the General Surgeon"* into a separate surgical specialty, and the growth in the number of urologist appointments in NI hospitals from 10 in 1999 to 17 in 2008/09.

26. The Review was completed in March 2009. The Review Report, published by the HSCB in March 2009, as referenced above, contained 26 recommendations aimed at improving capacity and sustainability of urology services. Some key elements of a proposed service expansion and redesign included:

- An increase in the number of consultant urologists from 17 to 23;
- All radical pelvic surgery should be undertaken at a single site;
- At least 5 clinical nurse specialists should be employed;
- Increase the proportion of elective operations undertaken as day cases;
- Urology services to be configured into a 3 team model covering Northern, Southern and Eastern areas respectively.

27. The functions and staff of SDU transferred from the Department to the then newly formed Regional HSCB on 1 April 2009, including responsibility for overseeing, commissioning and monitoring the implementation of the completed Review and all of its recommendations. Policy responsibility in relation to urology services remained with the Secondary Care Directorate in the Department of Health.

28. The submission of 23 April 2009 from the Secondary Care Directorate, as referenced above, asked the then Minister of Health, Michael McGimpsey, to note the contents of the HSCB's Review Report, and sought the Minister's agreement for the HSCB to conduct a public consultation on the Report and its recommendations. The submission outlined the structure of urology service provision at that time and key challenges which related to the increased demand on urology services; the capacity to deliver a modern, quality service; the ability to achieve and sustain long term stability and the development of a stable workforce that can continue to attract the necessary expertise across all of the professions. The submission also detailed the potential financial considerations.

29. Following the Minister's agreement, in September 2009, a 12 week public consultation of the Review was conducted by the HSCB.

30. On 3 March 2010, a summary of consultation responses and considerations was submitted by Cancer Services, Diagnostics and Specialist Drugs Unit, part of Secondary Care Directorate, to Departmental Board Members. This submission asked the Departmental Board to approve the Review's 26 recommendations and agree to the HSCB implementing these as quickly as possible during 2010/11. A copy of this submission is provided to the Inquiry at Appendix 8.

31. On 4 March 2010, a similar submission was sent by Secondary Care Directorate to the Health Minister, recommending that the Minister approve the recommendations and agree to the HSCB implementing these as quickly as possible during 2010/11. The submission noted that the Board of the HSCB had discussed the results of the Urology Review consultation on 28 January 2010, and

had recommended that the Minister endorse all the recommendations. A copy of this submission is provided to the Inquiry at Appendices 9a and 9b.

32. The Health Minister agreed the recommendations should be taken forward but had asked that the Department to seek confirmation of clinician support for the recommendations. Clinicians' support was subsequently received and a further submission confirming this was sent by Secondary Care Directorate to the Minister on 18 March 2010. This submission also sought the Minister's approval to endorse the Regional Review recommendations, to announce this by way of a press release, and to agree that the HSCB should arrange to implement the recommendations as soon as possible. The Health Minister agreed and asked for a press release to issue on 30 March 2010. A copy of an email dated 29 March 2010 containing the Health Minister's approval is provided to the Inquiry at Appendices 10a and 10b.

33. Dr Miriam McCarthy, the then Director of Secondary Care in the Department, wrote to Hugh Mullen, HSCB, on 2 April 2010 to communicate this decision and to request that the HSCB implement the recommendations as soon as possible. A copy of Dr McCarthy's letter is provided to the Inquiry at Appendix 11.

Implementation of the 2009 Urology Review Recommendations

34. In response to Written Assembly Question AQW 133/2011 [DOH-21093 – DOH-21096] (issued on 22 September 2010), asking how many of the Review's 26 recommendations had been implemented by each HSC Trust, Minister Michael McGimpsey advised as follows, based on input received from the HSCB: *"The Review of Adult Urology Services in Northern Ireland contained 26 recommendations, of which four have been fully implemented and a further 12 are well progressed towards implementation. The timescale of full implementation is being guided by the Health and Social Care Board, and is subject to the approval of implementation plans by commissioners to fully deliver all of the recommendations. Trusts have submitted a draft implementation plan, which sets*

out the service model, key performance indicators and modernisation plans and the financial implications of delivering these important recommendations."

35. On 12 December 2011, in response to a Departmental request for briefing, Beth Malloy, Assistant Director Scheduled Services, Performance Management and Service Improvement Directorate, HSCB advised: *"the implementation of the recommendations of the Regional Review of Adult Urology Services is currently well under way. The [HSC] Board has agreed the volumes of activity associated with the introduction of the three Urology Teams and has approved the funding for the appointment of new consultants and the associated support staff. A number of these staff have now been appointed and the recruitment process is underway for the remaining staff. Trusts are expected to deliver the full volumes of activity from April 2012*." A copy of Ms Malloy's email is provided to the Inquiry at Appendix 12.

36. In early 2014, the then Health Minister Edwin Poots MLA received a number of Written Assembly Questions ("AQW") in relation to waiting times for urology appointments. In response to a request for briefing to inform the response to these AQWs, the HSCB advised at that time: "*To help improve the current provision of Urology services, the Board is undertaking a clinically led stock take of the 'Review of Adult Urology Services' which was completed in 2009. This exercise will help to identify the current challenges which have directly impacted on the service provision and will make recommendations to improve patient access and reduce waiting times across the region.*" The relevant AQWs are provided to the Inquiry at Appendices 13 - 18: AQW 30818/11-15 (Appendices 13a and 13b); AQW 31320/11-15 (Appendix 14); AQW 31453/11-15 (Appendix 15); AQW 31454/11-15 (Appendix 16); AQW 31455/11-15 [DOH-21113 – DOH-21116]; AQW 31612/11-15 (Appendix 17); AQW 32050/11-15 (Appendix 18).

37. The Department does not hold any records relating to the HSCB's stock take of the 2009 Review, nor of the HSCB's ongoing oversight of the implementation of the Review recommendations from that time onward. SPPG may hold this information.

38. On 23 January 2019, officials from the Secondary Care Directorate, Department of Health, wrote to the HSCB Chief Executive, Valerie Watts, to formally request an update and evaluation on the implementation of the Review recommendations, and for completion of a Post Project Evaluation on the 2009 Review of Urology Services [DOH-12120 – DOH-12128]. A response was requested by March 2019, however, the Department does not hold any record of a response from the HSCB.

Urology Services in the context of the Bengoa Report, Delivering Together and the Department's Programme of Priority Service Reviews

39. In October 2016 the former Health Minister, Michelle O'Neill MLA, launched "Health and Wellbeing 2026: Delivering Together" (referred to as "Delivering Together"), a ten-year strategy to reform the way health and social care services are designed and delivered in NI, with a focus on person-centred care, rather than on buildings and structures. A copy of the strategy is provided to the Inquiry at Appendix 19. Delivering Together was based on the 2016 report "Systems not Structures: Changing Health and Social Care" following a review by an expert panel which was led by Professor Rafael Bengoa (referred to as "the Bengoa Report"). A copy of the Bengoa Report is provided to the Inquiry at Appendix 20.

40. The Bengoa Report recognised the increasing demand for hospital based services influenced by demographic changes, particularly a growing, ageing population with more chronic health problems and complex health needs. It also recognised that demand for care has been outstripping the ability of the system to meet it for many years, and that this trend will increase in the years ahead and will only be addressed by action to increase capacity, promote healthier lifestyles and tackle health inequalities.

41. The Bengoa Report set out a rationale and a proposed criteria for reviewing services, and proposed a number of "Priority 1" individual services which should be prioritised by the Department for review. These were: emergency and urgent care, stroke, primary care including GP out of hours, general surgery, pathology,

and vascular services. It proposed that urology services should be among a number of “Priority 2” services for review.

42. Following the publication of Delivering Together in October 2016, the Department established the “Transformation Implementation Group” (“TIG”), chaired by the Permanent Secretary, and comprising senior officials from the Department and Chief Executives from the HSCB, PHA and the six HSC Trusts, to oversee planning and implementation of prioritised service reviews. TIG continued to provide this function during the period in which the NI Assembly was suspended (January 2017 – January 2020), providing strategic direction and endorsing the direction of travel across individual review projects during this period, in order to be in a position to develop and provide policy recommendations for decision by an incoming Health Minister once the Assembly was restored.

Impact of COVID-19 on the Department’s Programme of Priority Service Reviews

43. From February 2020, work on the programme of service transformation reviews, including the TIG oversight structure, was paused indefinitely as the Department entered what became a prolonged phase of business continuity operation requiring resources to be wholly diverted to managing the HSC response to the COVID-19 pandemic.

44. On 9 June 2020, following the first wave of the COVID-19, and in order to begin to address its impact on the health service and on patients awaiting care, the Health Minister, Robin Swann MLA, published a “Strategic Framework for Rebuilding Health and Social Care Services”. A copy is provided to the Inquiry at Appendix 21.

45. The Strategic Framework acknowledged the pressures that faced the health service prior to COVID-19, and the prevailing threat of further COVID-19 waves at that time.

46. Appendix B to the Strategic Framework provided a comprehensive assessment of the impact of COVID-19 across secondary care services. This did not include detail on specific specialities, such as urology services, but showed an overall marked decrease from 2019 to 2020 in hospital inpatient and outpatient activity, in both routine and "red flag" (suspected cancer) referrals, as well as hospital admissions and daycase procedures. A copy of Appendix B to the Strategic Framework is provided to the Inquiry at Appendix 22.

47. Appendix C to the Strategic Framework provided a comprehensive assessment of the impact of COVID-19 on Programmes and Projects. In relation to proposed Priority 2 reviews of urology, general surgery, vascular and palliative care services, Appendix C noted that "*No progress will be made on any of the extant / planned projects between 09 March and 30 June 2020. HSC and all of [Hospital Services Reform Directorate and Regional Health Service Transformation Directorate] resources have been redirected towards planning for and managing the impact of COVID-19. Service reviews are clinically led and require significant clinician input, the projects would not be able to proceed until the impact of COVID-19 reduces significantly. The longer the current situation persists, the more delay will be incurred in respect of all the projects. Continued social distancing measures could affect future public consultations."* The risk rating against these proposed reviews was assessed at that time as *"Amber (If the current situation with COVID-19 continues for a prolonged period of time, then this status should be escalated to RED)"* A copy of Appendix C to the Strategic Framework is provided to the Inquiry at Appendix 23.

48. Alongside the Strategic Framework, the Minister announced the creation of a new Rebuilding Management Board ("RMB"), with a similar membership and structure to TIG, which was to operate initially for two years with the aim of providing oversight and direction to the HSCB, PHA and the Business Services Organisation ("BSO", a shared service provider to the HSC) on the implementation of the Minister's priorities through the delivery of Trusts' service rebuilding plans. RMB's Terms of Reference reflected a need for ongoing focus on the transformation agenda, in the context of COVID-19 rebuilding priorities, by including a need to:

"Ensure that in implementing the Framework, transformation continues in an integrated way including embedding innovations that have emerged during the pandemic." A copy of the RMB's Terms of Reference is provided to the Inquiry at Appendix 24.

49. On 3 September 2020, a submission (SUB-1819-2020) from Jackie Johnston, Deputy Secretary, Healthcare Policy Group, updated the Health Minister on the status of the programme of HSC service transformation reviews, and sought the Minister's agreement to approve a proposed forward work programme which had been agreed by the RMB on 19 August 2020. The submission proposed that some Priority 2 reviews, including urology services, should be resumed or started in the period September 2020 to March 2021 subject to available resources and the prevailing COVID-19 conditions. A copy of SUB-1819-2020 is provided at Appendix 25, and a copy of RMB minutes from 19 August 2020 is provided to the Inquiry at Appendix 26.

50. Comments received by Mr Johnston on 3 and 4 September 2020 respectively from Deborah McNeilly, Deputy Secretary for Resources and Performance Management, and from Sharon Gallagher, Deputy Secretary for Strategic Planning and Performance and Interim Chief Executive of the HSCB, supported the need to maintain a focus on service transformation reviews but also highlighted a need to remain aware of budgetary and staff resourcing constraints on the capacity to take this programme forward at that time, taking account of the impact of COVID-19 and the anticipated further surge in COVID infections combined with winter pressures. A copy of the relevant email thread is provided to the Inquiry at Appendix 27.

51. On 9 September 2020 the Minister noted the content of SUB-1819-2020 and commented: "*We need an update on both the review of stroke and part 1 of breast cancer services. They were submitted for decision as the annex indicates, but further information was sought at the time. Why had the review of general surgery not started by March? Was it a case of capacity or DOH assessed priority etc?*" A

copy of an email containing the Minister's response to SUB-1819-2020 is provided to the Inquiry at Appendices 28a and 28b.

52. On 15 December 2020 Mr Johnston sent a further submission (SUB-2271-2020) advising the Minister that the RMB had reviewed its forward work programme on 9 December 2020 and had agreed that the proposed General Surgery service review should be given a higher priority and should be added to the list of reviews proposed to resume or start in the period to March 2021. The submission noted that, due to pressures on staff resources, it had not been possible to resume or start those reviews listed as immediate priorities in the previous submission of 3 September 2020 (SUB-1819-2020), and that doing so would be conditional on identifying the necessary staff resources (project management, clinical leads, managerial leads and administrative support) to lead and participate in forming the necessary review groups. RMB's review of the forward work programme did not re-prioritise a review of any other "Priority 2" services including urology services. It therefore remained, as noted in SUB-2271-2020, a review that was not started under "Priority 2", among a list of *"Service Reviews Proposed to Resume or Start in the period December 2020 to March 2021 Subject to Available Resources and the Prevailing Covid-19 Conditions."* A copy of SUB-2271-2020 is provided to the Inquiry at Appendices 29a – 29c and a copy of RMB minutes from 9 December 2020 is provided to the Inquiry at Appendix 30.

53. There followed a sustained period of high COVID-19 community transmission combined with winter pressures which continued to have a detrimental impact on health service capacity throughout 2021 and into 2022. Despite this, a number of high priority reviews have been progressed during this time, including the publication of a new 10-year Cancer Strategy for Northern Ireland (published on 22 March 2022, a copy is provided to the Inquiry at Appendix 31), the Review of General Surgery (published on 30 June 2022, a copy is provided to the Inquiry at Appendix 32), and a consultation on the Review of Urgent and Emergency Care (which ran from March until July 2022), as well as the publication of an Elective Care Framework (published on 15 June 2021, a copy is provided to the Inquiry at Appendix 33) to address growing waiting lists for planned treatment. A number of

other high priority service reviews and transformation initiatives are ongoing, including in stroke, neurology, pathology and orthopaedic services. It is currently envisaged that work on Priority 2 service reviews will only progress when sufficient capacity becomes available within the Department and its Arm's Length Bodies, through the release of resources once ongoing priority reviews are completed, or through further investment to increase resources and capacity, or both. The Department is currently not in a position to estimate a timescale for this given ongoing staff and budgetary constraints.

USI Notice 65 of 2022

54. Turning to the information requested within Notice 65 of 2022, I note that this was issued prior to the Inquiry's receipt of the witness statement of the Permanent Secretary (provided in response to Notice 50 of 2022), and therefore my response in the following sections may bear some degree of overlap with that statement. Where this is the case I have cross-referenced the Permanent Secretary's statement and provided additional detail where appropriate/available. I have stated either where I am responding on the basis of my direct knowledge, involvement, or responsibility as Director or Secondary Care, or otherwise where responsibility sits elsewhere within the structure of the Department and/or the HSC system.

The Department's Awareness of and Response to Urology Concerns within the Southern HSC Trust

55. The following paragraphs set out my response to paragraph 1 of Notice 65 by providing a narrative account of my involvement in or knowledge of all matters falling within the scope of sub-paragraph (b) of the Inquiry's Terms of Reference, including the circumstances in which the Department became aware of the issues relating to potential concerns about patient care and safety within the Southern HSC Trust ("the Trust"), and the Department's role in the process leading to the Trust conducting a Lookback Review and adopting a "Structured Clinical Record Review ("SCRR") process, and an explanation of the processes and reasons which led to the decision to establish this public inquiry. My response relates to

and overlaps with some of the information provided paragraphs 154-193 of the Permanent Secretary's statement under the section titled *"Mr Aidan O'Brien - Urology Concerns Timeline"*, however in the interests of completeness I have recounted events from my perspective in full.

56. My response will show that:
    - the Trust-led Lookback Review was already under way when the Department became aware of concerns relating to urology services in the Southern Trust, after which the Trust's progress with the Lookback Review was guided by ongoing discussion with the Department, HSCB and PHA, both prior to and subsequent to the establishment of a Department-led Urology Oversight Group in October 2020;
    - the adoption and development by the Trust of a SCRR process arose following discussions between the Trust and the Royal College of Physicians and subsequent discussion within the Urology Oversight Group;
    - the decision to establish a public inquiry arose following the establishment of the Urology Assurance Group and discussion with the Chair of the Independent Neurology Inquiry, with the decision taken by the Health Minister in light of the seriousness and extent of the concerns which were emerging from the ongoing scoping work by the Southern Trust in relation to the practice of Aidan O'Brien, and to ensure that the full extent of the concerns could be identified and pursued in a transparent and independent way.

<u>Early Alert EA 182/20</u>

57. The Department first became aware of the issues relating to potential concerns about patient care and safety relating to Urology Services within the Southern Trust on Friday 31 July 2020, when the Trust notified the Department of an Early Alert on the basis of the Trust potentially needing to contact patients about possible harm.

58. Prior to 31 July 2020 there was no awareness within the Department of concerns relating specifically to Aidan O'Brien or the issues referred to in the Early Alert

which gave rise to the Trust initiating a lookback exercise in relation to his patients. The extent of any knowledge held by myself, and to the best of my knowledge others in the Department, regarding concerns in relation to urology services generally, would have been at the level of the increasing gap between service capacity and growing demand regionally which, being common across many clinical specialties and Trust services, was the rationale underpinning the recommendations of the Bengoa Report and Delivering Together, and the subsequent prioritisation of service transformation reviews, as referred to above. The level of the Department's awareness in relation to the demand-capacity gap would have been informed by the routine processes of reporting waiting list statistics (a function of the Department's Information and Analysis Directorate), and performance monitoring and service improvement (a function of the HSCB at that time), both of which were known to have been detrimentally impacted by the effects of the COVID-19 pandemic on capacity across virtually all services.

59. On 31 July 2020, in accordance with the Early Alert protocol, the Early Alert was notified initially via a telephone call from the Trust Medical Director to the Office of the Department's Chief Medical Officer ("CMO"). This was followed up also on 31 July 2020 with the submission of Early Alert pro forma (registered by the Department with reference EA 182/20) [DOH-19704] to both the Office of the CMO and the Department's Early Alert mailbox. The proforma was copied to the HSCB in line with the protocol.

60. In line with the Early Alert protocol, the Early Alert proforma was shared by email on 31 July 2020 by Department's Early Alerts team with relevant senior Departmental officials with policy responsibility for the issues being reported – in this case to myself, as incoming Director of Secondary Care with policy responsibility for hospital urology services, to my predecessor, Kiera Lloyd, who was vacating the post that day, and to Preeta Miller, the then Director of Workforce Policy. Also in line with the Early Alert protocol, this email was copied to senior officials in the Department, as well as the Minister's Private Secretary [DOH-00685]. A copy of the original email from SHSCT is provided to the Inquiry at Appendices 34a and 34b. Also in line with the Early Alert protocol the Early Alerts

team sent a copy of the proforma to the RQIA, provided to the Inquiry at Appendices 35a and 35b.

61. The Early Alert proforma was also separately shared on 3 August 2020 by officials within the CMO's Office with the Minister's Private Office as well as senior officials including Richard Pengelly, the then Permanent Secretary; Professor Sir Michael McBride, CMO; Dr Lourda Geoghegan and Dr Naresh Chada, Deputy CMOs; Jackie Johnston, Deputy Secretary; and, the DoH Early Alert team mailbox [DOH-00664 – DOH-00666]

62. The Early Alert advised the Department that on 7 June 2020 the Southern Trust had become aware of potential safety concerns related to delays in treatment of surgery regarding a consultant urologist who was employed by the Trust from 6 July 1992 until his retirement on 17 July 2020. As a result of these potential patient safety concerns the Trust advised that it had conducted a lookback exercise of the consultant's work over a 17 month period (from 1 January 2019 - 31 May 2020) to ascertain whether there were wider service impacts.

63. The Early Alert advised that the lookback exercise concentrated on whether patients had a stent inserted during procedure and if this had been removed, and found that:

- of 147 patients taken to theatre who were listed as being under the care of the consultant during the lookback period, concerns were identified in 46 of these cases;

- of 334 elective-in patients reviewed, 120 cases were found to have experienced a delay in dictation ranging from 2 weeks to 41 weeks, one of whom had (at that time) been identified for screening for Serious Adverse Incident ("SAI") review;

- a further 36 patients were identified who had no record of care noted on the regional Electronic Care Record (NIECR) system. To date (at that time) one

of the elective in-patient cases had been identified for screening for SAI review.

64. In addition, the Early Alert advised that two recent cases managed by this consultant had been identified which were (at that time) being screened as potential SAIs. These cases involved two prostatic cancer patients that indicate potential deficiencies in care provided by the consultant, where these deficiencies potentially had an impact on patient prognosis.

65. The Early Alert advised that the following actions had been taken:
    - The Trust had held discussions with the General Medical Council's (GMC) employer liaison service;
    - The case had been discussed with NHS Resolutions who had recommended restrictions of clinical practice including a request to the consultant not to undertake private practice in his own home or other premises pending further exploration;
    - Restrictions had been placed by the Trust resulting in the consultant no longer being able to undertake clinical work or access or process patient information, either in person or through others either in hard copy or electronically.
    - The consultant had been requested to voluntarily undertake to refrain from seeing any private patients at their home or any other setting and to confirm the same in writing.
    - The Trust had undertaken a preliminary discussion with the Royal College of Surgeons' 'Invited Review Service' regarding the consultant's practice and potential scope and scale of any lookback exercise.

66. Following receipt of any Early Alert notification, if it is deemed necessary to provide the Minister with further briefing (additional to the initial information contained in the Early Alert proforma), this is the responsibility of the relevant policy lead official or their team.

67. On Monday 3 August 2020, the day when I took up post as Acting Director of Secondary Care, I received an email request from my line manager (a copy is provided to the Inquiry at Appendices 36a and 36b), Jackie Johnston, then Deputy Secretary and Head of Healthcare Policy Group, requesting that I:
    - Ask the Southern Trust whether they have notified this incident to the HSCB/PHA;
    - Advise the HSCB/PHA that we have received this Early Alert and look to them to assess this incident and decide whether it needs to be escalated to the Department; and,
    - Send a note to the Minister informing him of this incident.

68. In the days subsequent to the receipt of the Early Alert, I engaged in discussion with senior management within the Trust and HSCB in order to ask the above questions and to seek further details about the lookback exercise for the purposes of ascertaining the appropriate level of response and commissioner or Departmental oversight that may be required, and of advising the Minister accordingly. A record of my discussions including dates and times is not available, however the information that I gleaned was used to prepare an advice submission to the Health Minister.

69. My discussions with the HSCB at that time were with Paul Cavanagh, the then Acting Director of Commissioning. My recollection of our discussions was that these were focused on assessing the emerging information as known at that time, and how best the Department and HSCB could support and oversee the Trust's completion of the lookback exercise in order to reach an informed position from which the appropriate next steps could be agreed upon.

70. On Thursday 6 August 2020, based on the information contained in the Early Alert proforma and the further information I received during my subsequent discussions with the Trust I sent a submission (SUB-1740-2020) to the Health Minister titled *"Early Alert (182/20) - Consultant Urologist Restricted from Clinical Practice"* [DOH-00684 – DOH-00691]. This was to notify the Minister about the Early Alert, including the latest Trust advice received verbally, i.e. that the cohort as identified

at that time comprised approximately 230 patients who may have received sub-optimal care, and that the full scope of the consultant's practice (i.e. work potentially carried out in other Trusts, in cross-border or in private healthcare settings) was not currently known.

71. On Thursday 13 August 2020 an email from the Minister's Private Office, responding to the notification received from the Office of the CMO on 31 July 2020, confirmed that the Minister had noted Early Alert EA 182/20 [DOH-00664 – DOH-00666]. A further email from Private Office on 24 September 2020 confirmed that the Minister had noted my submission of 6 August 2020 (SUB-1740-2020). Copies of both emails are provided to the Inquiry at Appendices 37a and 37b.

Events and Departmental Actions following the immediate response to EA 182/20

72. On 18 August 2020, SHSCT submitted an update to the Chief Medical Officer via email [DOH-00667 – DOH-00670]. This update advised that:
    - the doctor had retired and that the Trust was in contact with him through his legal representative;
    - on advice of NHS Resolutions and the General Medical Council he had agreed not to see private patients;
    - the SHSCT did not have an oversight of his previous private patients;
    - to the best of the SHSCT's knowledge he was not working for another Trust and was not registered with the Medical Council of Ireland;
    - the SHSCT was liaising with GMC regarding professional matters;
    - the SHSCT was continuing to consider any potential quality of care issues;
    - the SHSCT was liaising with the Royal College of Surgeons to engage with the British Association of Urological Surgeons to consider the import and extent of its findings and to access subject matter experts in relation to Serious Adverse Incidents (SAIs);
    - the SHSCT was minded to make a decision on the requirement for a formal lookback exercise and what the nature and scope of such a process would look

like, and enquiring what information would be required by the Department to allow for a determination on this to be made; and,

- the SHSCT was preparing to contact the service users impacted as part of the SAI process.

73. On 24 August 2020, the Trust provided an update to the Department via a telephone call from the Medical Director (Maria O'Kane) to the Deputy Secretary, Healthcare Policy Group (Jackie Johnston). A copy of an email sent by Jackie Johnston following the telephone call to Olive MacLeod (PHA) and Paul Cavanagh (HSCB), which was copied to the CMO and myself, is provided to the Inquiry at Appendix 38 - this provided an outline of the issues which the Trust had identified at that time as requiring a decision on the appropriate way forward in relation to:
    - requesting the Royal College of Surgeons to carry out a lookback exercise;
    - an appropriate process for investigating the conduct of the Doctor concerned;
    - involvement of an expert patient to sit on the panel to be established to review the three SAI cases; and,
    - the timing of external communications including with SAI patients' families.

74. On 3 September 2020, SHSCT facilitated a Zoom meeting to discuss the above issues and to update the Department, HSCB, and PHA, which I attended. Unfortunately a written record of the meeting was not maintained by the Department, however it is my recollection that the main purpose of the meeting was to allow the Trust to provide an update regarding its ongoing internal scoping work in relation to Aidan O'Brien's patients, the development of operational plans regarding communications with patients and families, and the establishment of a dedicated helpline. It was agreed by the four organisations that these would then become weekly meetings, given the unfolding nature of the situation as the scoping work was progressing.

75. Accordingly, from 10 September 2020, senior officials from the Department, HSCB and PHA participated in weekly progress update calls hosted via Zoom by the Southern Trust. My recollection is that the Trust senior management (mainly

Shane Devlin, Trust Chief Executive; Maria O'Kane, Medical Director, and Melanie McClements, Director of Acute Services), led these meetings by providing updates on the progress with the lookback exercise, including support that was being received from other urology consultants from other HSC Trusts and the independent sector in the review of patient records.

76. Weekly update calls hosted by the Trust took place via Zoom on 10 September 2020, 17 September 2020, 24 September 2020, 1 October 2020, 8 October 2020, 15 October 2020, 22 October 2020 and 29 October 2020, prior to the formal establishment of the Urology Assurance Group from 30 October 2020 (further details on this are provided below). The Department does not hold a formal record of these calls and I am therefore unable to confirm exactly who attended from which organisation on which date. I attended these meetings as Director of Secondary Care. The Department was also represented at each meeting by some or all of the following senior officials: Michael O'Neill, Acting Director of General Healthcare Policy; Jackie Johnston, Deputy Secretary Healthcare Policy Group; David Gordon, Director of Communications; Richard Pengelly, Permanent Secretary; Professor Sir Michael McBride, CMO; Dr Lourda Geoghegan and Dr Naresh Chada, Deputy CMOs.

77. The HSCB and PHA, as joint commissioners of services with joint responsibility for the SAI process, were generally represented at these meetings by Paul Cavanagh, then Acting Director of Commissioning in HSCB, Olive MacLeod, Acting Chief Executive of the PHA, and Dr Brid Farrell, senior public health lead in the PHA.

78. Over the course of these weekly calls, a clearer picture evolved of the full scope of issues needing to be investigated and the number of patients within different cohorts about whom the Trust had identified concerns and potential SAI cases. The Trust advised that it was developing a comprehensive communications plan for the purposes of handling communications and call-backs with any patients impacted, their families, GPs, elected representatives and the media. Discussions took place over the course of these calls regarding the relative merits of making a

public announcement while the lookback exercise was ongoing, or alternatively endeavouring to make further progress to fully understand the scope and scale of issues in order to make a more informed public announcement at an appropriate time in the near future. My recollection is that the Trust advised that the Trust Board had taken the view that there was insufficient information available for a public announcement to be made at that time (i.e. during September and into October 2020), and that the Trust would need time to further establish facts, confirm the cohorts of patients potentially affected, or who otherwise could be assured that there were no concerns about their care, and prepare for the opening of public advice telephone lines.

79. The Trust also advised during these calls on progress to identify and appoint an expert panel, including Subject Matter Experts, to conduct the necessary SAI learning reviews, in relation to a potentially large number of patients.

80. The issues emerging during this period bore similarities with those covered by the ongoing Independent Neurology Inquiry (INI), for example, in relation to how Trusts manage concerns in relation to a consultant's professional practice, as well as potentially large volumes of patient call-backs. The Departmental policy lead who was overseeing the response to the INI, Michael O'Neill, then Acting Director of General Healthcare Policy, therefore attended these weekly urology update calls from an early stage in order to provide advice based on how the emerging findings of the ongoing recall of Belfast Trust neurology patients may relate to the Southern Trust's management of the urology lookback exercise, and on the appropriate level of oversight that may be required by the HSCB and PHA and by the Department.

81. Over the course of these weekly calls it also became likely that a more formalised oversight structure would be appropriate. In light of the emerging similarities with the ongoing recall of Belfast Trust neurology patients, it was agreed that lead policy responsibility within the Department for oversight of the response to urology concerns in the Southern Trust would transfer from Secondary Care Directorate to General Healthcare Policy Directorate (i.e. from myself to Michael O'Neill). This

arrangement formally commenced when the Department-led Urology Assurance Group (UAG) was established and had its first meeting on 30 October 2020 [DOH 00300 – DOH 00305]. Further details about the UAG are provided at paragraphs 96-103 below. While lead policy responsibility transferred, I have been a member of the Urology Assurance Group in my role as Director of Secondary Care until the present time.

82. At the weekly update call on 8 October 2020 the Department requested a comprehensive report about the Trust's scoping exercise to date in order to inform Ministerial briefing and possible next steps.

83. Further to this request, a *"Report to Department of Health on Consultant A",* dated 14 October 2020, was submitted by the Trust to the HSCB and received by the Department on 15 October 2020. Further details about the Trust update report are contained at paragraphs 87-95 below, which describe the details of a submission (SUB-2055-2020) which I sent to update the Minister on 26 October 2020 setting out the facts as known at that time and recommending a number of next steps. A copy of the written submission SUB-2055-2020 is provided to the Inquiry at Appendix 39. A copy of the Trust report was appended to my submission SUB-2055-2020 [DOH-00702 – DOH-00718].

84. On 15 October 2020, the Early Alert EA 182/20 was updated by the Southern Trust on the basis of three criteria, i.e. that urgent regional action was required, that patients/clients would need to be contacted about possible harm, and the potential for regional media interest. A copy of the EA 182/20 is provided to the Inquiry at Appendix 40. This was due to new and significant concerns arising from the scoping work about the consultant's prescribing practice, which had been identified following an initial meeting of the Trust's Serious Adverse Incident review team that week. These concerns were also documented in the Trust's update report as referenced above.

85. These new concerns related to the consultant's prescribing practices which included alleged use of unlicensed and sub-therapeutic dosages of Bicalutamide,

which the Trust considered to be a significant and potentially wide patient safety risk requiring immediate action. The Trust advised that staff were working with the HSCB medications team to gain a better understanding of the implications of this latest development in terms of scale and scope and to identify patient groups that may be at risk. It was recognised that this prescribing issue involves medicines that are prescribed by primary care providers on advice from the secondary care team. In addition to updating the Early Alert, the Trust noted that senior staff at HSCB, PHA and Department of Health had been briefed directly of this development, and that the Trust was continuing to liaise directly with colleagues in each organisation in order to determine and take appropriate action.

86. On 22 October 2020, further to consideration of the Trust's update report, and in light of parallels with the ongoing recall of Belfast Trust neurology patients, the Department wrote to the Southern Trust Chief Executive to advise that a Department-led Urology Assurance Group would be established from week commencing 26 October 2020 to provide the necessary oversight to the ongoing review process and the management of issues arising from it, given the seriousness of the findings to date. A copy of the Permanent Secretary's letter [DOH-43730 – DOH-43732] and terms of reference for the Urology Assurance Group [DOH-00297 – DOH-00299] have been provided to the Inquiry.

SUB-2055-2020 - Written Statement in relation to Confidential Early Alert (182/20) – Southern Trust Consultant Urologist Restricted from Clinical Practice

87. On 26 October I sent a written submission (SUB-2055-2020) to the Minister in order to:
    - provide a detailed update (further to my submission of 6 August 2020) on the Southern Trust's ongoing internal scoping exercise;
    - bring the Minister's attention to the Trust's update report received on 15 October 2020, which included information confirming that the Trust had previous concerns in 2016 regarding this consultant's practice;

- advise the Minister about the establishment of a Departmental Urology Assurance Group to oversee the ongoing exercise and Trust management plan; and,
- provide a draft written statement for the Minister's consideration.

88. SUB-2055-2020 advised that a total of nine SAIs had been confirmed to date, including two in respect of deceased patients, and that an SAI panel has been established with a Chair and Subject Matter Experts identified. Patients/families of the nine confirmed SAIs had been individually notified, but had not been advised of the related cases and wider issues at that stage.

89. SUB-2055-2020 included a summary of the Trust exercise as it stood at that time in relation to the various patient cohorts being reviewed, and related to this the nine confirmed SAIs, as follows:

- Emergency stent procedures (Jan 2019 – June 2020)
  Three out of 160 emergency stent patients had not had their stent management plans enacted. Clinical Management has been subsequently arranged for these three patients.
- Elective-in patients taken to theatre (Jan 2019 – June 2020)
  343 patients reviewed leading to two confirmed SAIs.
- Pathology and Cytology results (Jan 2019 – June 2020)
  Exercise completed by clinical nurse specialists. 168 results identified; of which 50 required review, leading to three confirmed SAIs with further 5 requiring a review follow-up.
- Radiology results (Jan 2019 – June 2020)
  Ongoing consultant-led exercise to review 1536 patients whose electronic care records do not confirm sign-off or action – as this may have been done manually these cases need to be reviewed for confirmation and follow-up if required. One confirmed SAI to date.
- Cancer Multi-disciplinary Meeting (MDM) discussions (Jan 2019 – June 2020)
  Ongoing consultant-led exercise to review 271 patients who were discussed at MDM, leading to two confirmed SAIs with a further 2 needing a review follow-up.

- Oncology Review Backlog (Jan 2019 – June 2020)

  236 review oncology outpatients will be seen face to face by a retired Urologist in the independent sector. This consultant will either discharge or make appropriate plans for ongoing management and referral back the Southern Trust Urology Team MDM for further review/management. One confirmed SAI to date.

90. A copy of the Trust update report was appended to SUB-2055-2020. It included the following summary of previous governance and patient safety concerns in relation to this consultant, which had initially been raised by Trust management in a letter to Aidan O'Brien in March 2016:
    - 253 Un-triaged outpatient referral letters dating back to December 2014.
    - 679 patients on the consultant's review backlog dating back to 2013, with a separate oncology waiting list of 286 patients.
    - Concerns/frustrations of consultant colleagues at lack of records of consultations / discharges on Patient Centre system or on patient notes.
    - Concerns that a number of patients' hospital charts (as yet not quantified) had been kept at Consultant A's home.

91. The Trust report also provided a timeline of events since then, including an SAI commencing in the autumn of 2016 about a patient with a poor clinical outcome as their GP referral had not been triaged as red-flag by Aidan O'Brien. The resultant SAI investigation identified:
    - 783 un-triaged GP referrals from June 2015, of which 24 were subsequently deemed to need upgraded and a further four with confirmed diagnoses of cancer (i.e. four further SAIs in addition to the initial SAI patient);
    - Over 60 undictated clinics (668 patients) over 18 months with unclear clinical management plans;
    - 288 patients' clinical notes which had been taken to the consultant's home and thus not readily available on Trust systems.

92. The report advised that the Trust had initiated formal action from December 2016 to manage Aidan O'Brien within the Maintaining High Professional Standards

(MHPS) framework, including a 4-week immediate exclusion. My submission noted that this process included several investigation meetings, delays and prevarications, which continued through 2017-2018, culminating in the submission of a grievance by Aidan O'Brien in November 2018. The grievance process through the General Medical Council (GMC) was ongoing at the time of the Trust's report and of my submission. As he was no longer employed, the Conduct Hearing under MHPS could not be concluded, however the report noted that the GMC processes would continue regarding his fitness to practise in light of both the previous concerns and the most recent concerns.

93. SUB-2055-2020 also advised the Minister:

- About serious concerns outlined in both the report and the Early Alert update regarding Aidan O'Brien's prescribing of Bicalutamide;
- That the CMO had issued alert letters to the HSC Board, HSC Trusts, PHA, CMO Scotland, CMO Wales and NHS England regarding Aidan O'Brien (see reference to alert letters at paragraphs 114-115 below);
- That the Department had written to the Southern Trust Chief Executive on 22 October 2020 to advise that a Department-led Urology Assurance Group would be established from w/c 26 October 2020.

94. In conclusion, SUB-2055-2020 recommended that the Minister:

- Note the updated position as reported by the Southern Trust on 15 October 2020 including the summary of historic concerns regarding this consultant which were under investigation from 2016, and the recently identified serious concerns about his prescribing practice;
- Note the establishment of a Department-led Urology Assurance Group to oversee the ongoing Trust scoping exercise and future management plan; and,
- Publish a brief draft written statement indicating an intention to provide a more detailed oral statement to the Assembly in the following week.

95. Further to the advice in SUB-2055-2020, on 26 October 2020 the Health Minister provided a written statement to the Assembly [DOH-35133] which outlined the concerns relating to the Consultant's practice, and the establishment of the UAG,

but did not name the consultant. The statement outlined the Minister's intention *"to make an oral statement in the Assembly as soon as practicable in order to provide further details about this matter."*

Urology Assurance Group (UAG)

96. A copy of the original Terms of Reference for the UAG has previously been provided to the Inquiry [DOH-00297-DOH-299]. These were revised on 23 May 2022 to update the participant list and frequency of meetings, (a copy is provided to the Inquiry at Appendix 41), however the revisions did not alter the UAG's core objectives, which are to:
    - review the progress of the initial scoping exercise;
    - consider emerging strategic issues;
    - commission and direct further work as necessary;
    - monitor the impact on urology and related services;
    - ensure coordination with other associated reviews / investigations; and;
    - oversee communication across all stakeholder groups.

97. Paragraph 186 of the witness statement of the Permanent Secretary provides details about the dates of UAG meetings and copies of the corresponding UAG minutes which have been provided to the Inquiry.

Establishment of the Urology Services Inquiry

98. The minutes of the UAG meeting held on 6 November 2020 [DOH-00307-DOH-00311] refer to an update from Jackie Johnston about preliminary discussions that had taken place between senior officials and Brett Lockhart QC, Chair of the Independent Neurology Inquiry (INI), regarding the potential for considerable alignment between the ongoing work of the INI team and the issues arising for the UAG.

99. The minutes of the following UAG meeting held on 13 November 2020 [DOH-00313-DOH-00319] note that Jackie Johnston advised that the INI Review Panel

were unlikely to have the required capacity to add the issues arising within Urology into their remit. The minutes also noted that *"the group agreed it will be important to confirm the oversight arrangements and agreed Independent Urology Inquiry process within the Minister's Assembly Statement."*

100. Paragraph 188 of the witness statement of the Permanent Secretary refers to a submission sent to the Minister by Michael O'Neill on 20 November 2020 (INV-1873-2020 / SUB-2174-2020), [DOH-44004 - DOH-44008]. The submission recommended that, due to the seriousness and extent of the concerns identified with the practice of Aidan O'Brien, a Public Inquiry should be established under the Inquiries Act 2005 as an appropriate approach to ensure that the full extent of the concerns are identified and for the patients and families affected to see that these, and all relevant issues, are pursued in a transparent and independent way.

101. This recommendation was accepted by Minister, who subsequently provided an oral statement to the Assembly on 24 November 2020 regarding Urology in the SHSCT. The relevant Hansard extract has been provided to the Inquiry at Appendix 42.

102. The Minister's oral statement confirmed that a statutory public inquiry would be established, and provided an update on associated actions including the initial lookback exercise.

103. On 08 March 2021, Minister Swann announced the appointment of Christine Smith QC as Chair of the Urology Services Inquiry, by way of Written Assembly Statement [DOH-00938 – DOH-00940].

<u>Structured Clinical Records Review (SCRR)</u>

104. The following paragraphs provide an outline of the process which led to the Trust adopting a Structured Clinical Review Process ("SCRR"). My account is based on updates that were provided to the Department through the UAG, which I normally attend, however I was not closely involved in this aspect of the work which was

carried out at Trust level and primarily overseen by colleagues in General Healthcare Policy Directorate (part of Healthcare Policy Group in the Department) and Quality Safety and Improvement Directorate (part of CMO Group).

105. I understand that the origins of this process arose from a recognition that the established SAI process, which had been followed in relation to nine of the identified cases meeting the SAI threshold, would not provide an appropriate or practical means of considering a potentially large number of further cases, leading the Trust to seek an alternative, proportionate and robust review structure that could be used to review further cases in a timely manner. As a result of this the Trust developed the SCRR process, which was founded on Structured Judgement Review (SJR) methodology as developed by the Royal College of Physicians, to enable the Trust to identify any learning or areas where patient safety could be improved.

106. The minutes of the UAG meeting held on 4 December 2020 [DOH-00325 - DOH-00328] refer to discussion regarding the need to agree an appropriate review process, prior to the establishment of the Public Inquiry, for the further 6 cases – and potentially further cases – identified as individually meeting the usual SAI threshold. It was agreed that the Trust Medical Director and Trust Director of Acute Services would draft terms of reference for a SCRR process to ensure that patients are on the correct treatment pathway and that learning and areas for improvement could be captured, considered and implemented without delay.

107. The minutes of the UAG meeting held on 18 December 2020 [DOH-00330 - DOH-00333] refer to an update from the Trust Medical Director that the Trust had met with the Royal College of Physicians who were supportive of the use of Structured Judgement Review (SJR) methodology to develop, support and ensure an appropriate structured clinical review process for any patient cases falling outside of the 9 SAIs already under review. The minutes note that the Trust was in the process of agreeing a core virtual training programme with the Royal College of Physicians team for a core group of reviewers.

108. The minutes of the UAG meeting held on 22 January 2021 [DOH-00342 - DOH-00346] include an update from the Trust Medical Director about a meeting which had taken place on 21 January 2021 with the Royal College of Physicians regarding the use of SJR methodology to support patient reviews outside of the current SAIs, and confirmation that the Trust had now agreed a core virtual training programme with the Royal College of Physicians team for a core group of reviewers.

109. The minutes of the UAG meeting held on 5 March 2021 [DOH-00359 - DOH-00364] confirm that the Trust had developed a draft proposal for the SCRR which was at that time under consideration by the HSCB Urology Co-ordination Group. At subsequent UAG meetings, although the Trust did not submit a formal SCRR proposal for endorsement by the UAG, the group was content with the update reports provided by the Trust regarding the progress on the SCRR process which had been implemented, and which continued to be overseen by the HSCB Urology Co-ordination Group and the Department-led UAG.

110. In February 2022, the Trust requested that the RQIA undertake a review of the SCRR methodology and surrounding governance arrangements for Urology, to provide quality assurance and recommendations for any improvements."

111. I understand that the Trust Medical Director wrote to the Chief Executive of the RQIA on 20 February 2022, to ask the RQIA to undertake a review of the choice of SJR methodology to underpin the SCRR process, and to review the SCRR process in relation to its effectiveness in identifying learning. A copy is provided to the Inquiry at Appendices 43a and 43b. The Trust indicated that it would be useful to have a statement from RQIA to assure the UAG on the effectiveness of the SCRR process, or otherwise for RQIA to recommend an alternative approach.

112. On 2 March 2022 the Chief Executive of RQIA, Briege Donaghy, replied to the Trust Medical Director agreeing that it would be appropriate for RQIA to provide external independent assurance of the Trust's proposed approach, and advising

how RQIA would develop a methodology enabling it to do so. A copy is provided to the Inquiry at Appendices 44a and 44b.

113. This review commenced in May 2022, and I understand is ongoing. At the UAG meeting on 23 May 2022 the Trust presented a paper *"Proposal for Structured Clinical Review Record - Updated 4 March 2022"* and a paper *"Draft - Structured Clinical Record Review Update and Options Appraisal - 19 May 2022"* which was noted by the group and the Trust agreed to explore options further to support the continuation of the SCRR process and to provide an update to UAG in due course. A copy of the minutes are provided to the Inquiry at Appendix 45.

Alert Letters

114. Paragraphs 166-169, 174, and 176-180 of the witness statement of the Permanent Secretary provide a detailed narrative around the issuing by the Department of Alert Letters in relation to Aidan O'Brien. This is a process, distinct from the Early Alert process, whereby the Department, through the Office of the CMO and Quality Regulation Policy and Legislation Branch, informs other HSC organisations and CMO counterparts in other jurisdictions about the concerns with an individual doctor's practice.

115. While it is not necessary to repeat these details in full, I refer to Alert Letters here for the purpose of describing my personal involvement in this process, which was limited to liaising with the CMO's Office and providing advice and clarification in response to enquiries from the Southern Trust. My advice is contained in a series of emails between me and the Trust between 17 September 2020 and 7 October 2020, [DOH-43931 – DOH-43952], following on from an email which Dr Chada had sent to the Trust on 4 September 2020 providing a copy of relevant extant guidance. A copy of the extant guidance is provided to the Inquiry at Appendix 46. I advised that while the extant guidance covers alert letters in respect of dismissed/suspended staff, it could be applied to the case of a retired doctor as the issue is more or less the same. I advised that alert letters from the CMO to other providers were being progressed, and that the CMO had requested in the

meantime that the Trust Medical Director should contact other Trust Medical Directors by telephone, which she agreed to do.

116. The above concludes my narrative account in response to paragraph 1 of Notice 65 of my knowledge and involvement regarding these matters. In the following sections I have set out my response to the individual questions set out at paragraphs 4-31 of Notice 65.

USI Notice 65 of 2022 - Response to the Inquiry's Questions at Paragraphs 4-31

<u>31 July 2020 – 30 October 2020</u>

117. Paragraph 4 of Notice 65 asks about the Department's awareness of concerns in relation to Southern Trust urology services prior to 31 July 2020. My response is covered at paragraph 58 above.

118. Paragraph 5 of Notice 65 asks about the immediate steps taken by the Department upon receipt of Early Alert EA 182/20. My response is covered in the narrative of events provided at paragraphs 57-71 above, which sets out: (I) the immediate actions taken by officials; (II) the individuals with whom the Early Alert was shared; (III) the nature of communications which officials had with the Trust; (IV) the nature of communications which officials had with the HSCB and RQIA (to my knowledge, the Department did not have direct communications with the PHA regarding the receipt of the Early Alert); and, (V) the nature of internal communications within the Department.

119. Paragraph 6 of Notice 65 asks *"what is the purpose of an Early Alert"*. The Department's response to this has been addressed at paragraphs 134-143 of the witness statement provided to the Inquiry by the Permanent Secretary. In summary, this explains that the purpose of the Early Alert system is to provide a channel for Chief Executives and senior staff in HSC organisations to notify the Department in a prompt and timely way of events or incidents which meet any of the criteria, which have occurred in the services provided or commissioned by their

organisations, and which may require immediate attention by Minister, Chief Professional Officers or policy leads, and/or require urgent regional action by the Department.

120. In relation to paragraph 142 of the Permanent Secretary's statement, I would clarify that recommendation 23 of the INI report states, in addition to reviewing the SAI process, that the Department should also review (and if necessary, change) the *"early warning alert"* system. Accordingly, paragraph 143 of the Permanent Secretary's statement, confirming that officials will recommend to the Minister that INI recommendation 23 should be progressed by the Department as a priority, applies to both the Early Alert process and the SAI process.

121. Paragraph 6 of Notice 65 also seeks the Department's view on whether the Early Alert process was used properly by the Trust in these circumstances. While not wishing to pre-empt the Inquiry's consideration of any aspect of the Early Alert system, and notwithstanding the Department's commitment to reviewing the Early Alert process in response to INI recommendation 23, the Early Alert process provided an appropriate channel for the Trust to communicate concerns once a view was reached within the Trust that there was a need to alert senior officials about an emerging issue of serious concern. The Early Alert protocol was followed by the placing of an initial telephone call from the Trust to the Department, immediately followed by the submission of a completed proforma outlining the key issues. This enabled relevant senior officials in the Department and HSCB, including myself, to begin to develop an understanding of the emerging issues, for the dual purposes of briefing the Minister and supporting the Trust with appropriate oversight arrangements.

122. The extant guidance which was in place at that time, *"A Practical Guide to Conducting Patient Service Reviews or Look Back Exercises"* (February 2007), ("the 2007 Guidance"), which has been provided to the Inquiry at Appendix 47, stated at paragraph 1.5 that once a decision is taken to conduct a look back exercise, a series of high level meetings will be convened with the Trusts, HSCB and Department to plan the nature and scope of the review. It also stated at

paragraph 1.4 that *"there may be occasions when the Trust initiates a look back review and it is undertaken internally".* The Trust internally initiated a lookback review from 7 June 2020 before raising the Early Alert with the Department on 31 July 2020. My understanding is that the Trust did so in order to attempt to quantify the issues of concern before reporting them. Following this, the relevant high level meetings were held with the Department and HSCB, leading to the formal establishment of the UAG.

123. This guidance has subsequently been reviewed and updated. On 16 July 2021, the Department's Safety Strategy Unit (part of Quality, Safety and Improvement Directorate) issued policy circular HSC SQSD 06/2021, which included a revised *"Policy for Implementing a Lookback Review Process"* alongside new *"Regional Guidance for Implementing a Lookback Review Process"*. A copy of the email and revised guidance has been provided to the Inquiry at Appendices 48a to 48d.

124. The Trust proforma in relation to EA 182/20 did not specify the Early Alert criteria under which it was being reported, however it was understood from the outset by myself and Department colleagues that it had the potential to engage a number criteria, namely: (i) a need for urgent regional action; (ii) a need to contact patients/clients about possible harm; and, (iii) regional media interest.

125. Paragraph 7 of Notice 65 asks whether *"the Department has reached any view concerning the appropriateness, quality and timeliness of the steps taken by the Trust to communicate and escalate the reporting of issues of concern within the Trust to the Department"*. The Department has not evaluated this issue specifically with regard to the Trust's initial handling of EA 182/20, as the Department's primary focus in relation to these matters has been prospective with the aim of ensuring and supporting an appropriate response by the Trust to identifying, investigating and mitigating any harm to patients.

126. I previously noted at paragraph 62 that, in advance of submitting EA 182/20, an initial exercise was undertaken by the Trust in order to attempt to quantify the issues being reported, and at paragraph 122 that the extant guidance in place at

that time may have provided a degree of flexibility for Trusts in relation to the initiation of a lookback exercise. Section 2.1 of the new *"Regional Guidance for Implementing a Lookback Review Process"* as issued on 16 July 2021 (under circular HSC SQSD 06/2021) provides clarity in this regard. The guidance recognises that in the early stages of considering a Lookback Review process *"there may be limited information available to the HSC organisation until information and intelligence is gathered and the risk assessment is undertaken […] however, in line with extant guidance, the Director should notify the DoH of the emerging issues by way of an Early Alert".*

127. Paragraph 8 of Notice 65 asks whether *"the Department has reached any view concerning the effectiveness of the corporate and clinical governance procedures and arrangements within the Trust in the context of the matters which gave rise to the need to issue an Early Alert".* At this stage the Department has not evaluated the effectiveness of the corporate and clinical governance procedures within the Southern Trust in the context of the matters which gave rise to the Early Alert. This is mainly due to the fact that the process of establishing the scale and scope of issues within the Trust is ongoing, and will be further informed by the findings of this ongoing work to review Trust governance and assurance systems. I have provided further detail regarding this under "Oversight mechanisms now in place" (paragraph 19 of Notice 65) and "Ongoing Assurance" (paragraphs 20-26 of Notice 65) at paragraphs 147-165 below.

128. Paragraph 9 of Notice 65 asks *"what advice, if any, was given to the Trust by the Department in response to the Early Alert and related matters*". My response is covered in the narrative of events provided above at paragraphs 57-97, which describe the regular communications with the Trust leading to and after the establishment of the UAG, and paragraphs 114-116, which outline the advice provided in relation to Alert Letters.

129. Paragraph 10 of Notice 65 asks *"In what way, if at all, did the Department make HSC Trusts (including the Southern Trust) aware of its publication, "Practical Guide to Conducting Patient Service Reviews or Look Back Exercises: Regional*

Governance Network Northern Ireland Sub Group" (February 2007) ("the 2007 Departmental Guidance")? If the Department has a record of disseminating the 2007 Departmental Guidance to the Southern Trust, provide full details". The 2007 Guidance was issued by the Department's former Safety, Quality and Standards Directorate ("SQSD", which is now the Quality, Safety and Improvement Directorate) on 8 March 2007, under cover of a Departmental circular with reference HSS(SQSD) 18/2007. A copy of 18/2007 is provided to the Inquiry at Appendix 49. The circular cover page indicates that this was issued to what would have been a standard distribution list for such policy circulars at that time, as follows:

- 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

130. The current configuration of HSC Trusts (including the Southern Trust) came into being on 1 April 2009 under the Health and Social Care (Reform) Act (NI) 2009. The responsibilities of former Health and Social Services Trusts in relation to extant Departmental policies in place at that time transferred automatically to the new HSC Trusts. This included HSS (SQSD) 18/2007.

131. Unfortunately, the Department cannot locate in its electronic records the correspondence from the former Safety, Quality and Standards Directorate which issued circular HSS (SQSD) 18/2007. This is most likely due to the fact that the Department's current electronic records system was being put in place in around 2007/2008.

132. Paragraph 11 of Notice 65 asks *"After receipt of the Early Alert, outline whether the Department gave any consideration to, or advised the Trust of the availability and appropriateness of utilising the 2007 Departmental Guidance"*. Paragraph 12 of Notice 65 asks *"As appropriate, outline what, if any, advice was given to the Trust with regard to the application of the 2007 Departmental Guidance and in particular with regard to paragraph 1.4 of that Guidance. If no such advice was given, please explain why it was not given."* As noted above, the 2007 policy guidance automatically applied to HSC Trusts when they were formally constituted in April 2009. All Trusts are expected to be aware of and to implement or apply relevant Departmental guidance as appropriate. I was not personally aware of the 2007 guidance when I came into post on 3 August 2020 and therefore did not advise the Trust about it, nor do I recall discussion about it, during any of my early communications internally with Departmental colleagues or with the Trust after receipt of the Early Alert. Whilst I am not aware of any discussion or advice about the 2007 Guidance during the period up to 30 October 2020, as there is no record of any discussions, and no reference to the 2007 guidance in written communications from the Department at that time, it is not possible to provide a definitive response to this question on behalf of the Department. The CMO Group has overall policy responsibility within the Department for the 2007 guidance, as well as the revised Lookback guidance which was issued in 2021.

133. Paragraph 13 of Notice 65 requests an outline of *"any meetings or discussions between officials from the Department and the Trust, the HSCB (as it then was), the PHA, the RQIA and any other relevant organisation from the date of receipt of the Early Alert on 31 July 2020 to the first meeting of the Urology Assurance Group on 30 October 2020 concerning the handling of the concerns raised in the Early Alert, or related issues"*. My response is covered in the narrative of events

provided at paragraphs 57-97 which describe the regular communications with the Trust leading to and after the establishment of the UAG.

Establishment of the USI

134. Paragraph 14 of Notice 65 asks *"Outline the decision making process which led to the announcement of the establishment of a public inquiry by the Minister on 24 November 2020"*, specifically requesting details of the: (I) steps; (II) factors; (III) individuals; and (IV) briefings/submissions involved, including the contents of SUB-2055-2022. Part (V) requests details of any bodies the Department consulted as part of this process.

135. Firstly, with regard to part (IV), I refer paragraphs 87-95 below, which describe the details of SUB-2055-2020 which I sent to update the Minister on 26 October 2020 setting out the facts as known at that time and recommending a number of next steps. I refer also to my narrative of events provided at paragraphs 98-103 above, which include reference to a Ministerial submission from Michael O'Neill dated 20 November 2020 (INV-1873-2020 / SUB-2174-2020), [DOH-44004 - DOH-44008], which recommended the establishment of a public inquiry due to the seriousness and extent of the concerns identified with the practice of Aidan O'Brien.

136. In the following paragraphs further details are provided with input from colleagues in General Healthcare Policy Directorate about this process leading to the development of SUB-2174-2020 and the decision to establish an Inquiry.

137. On 04 November 2020, at an internal Departmental pre-meeting in advance of the UAG meeting of 06 November, Richard Pengelly advised participants (Michael McBride, Lourda Geoghegan, Jackie Johnston, Michael O'Neill, Anne-Marie Bovill) that he had engaged with Brett Lockhart QC, INI Chair, regarding potential alignment between Neurology and emerging Urology concerns. At this pre-meeting, a discussion took place regarding the importance of not delaying the progress of the ongoing Neurology Inquiry. It is understood Richard Pengelly intended to have a further discussion with Mr Lockhart, and also to discuss options with the Minister.

138. At the UAG meeting on 06 November, [DOH-00306 – DOH-00311], Jackie Johnston apprised the group of the preliminary discussions that had taken place with Mr Lockhart. It was noted that there was the potential for considerable alignment between the ongoing work of the INI team and the issues arising for the UAG. It was agreed that the work of the INI should not be adversely impacted by any additional responsibilities relating to Urology.

139. At the UAG meeting on 13 November 2020, [DOH-00312 – DOH-00319], it was confirmed that the INI Review Panel were unlikely to have the required capacity to add the issues arising within Urology into their remit. They expressed concerns regarding the potential risk for delay in the completion of the INI. It was agreed within the UAG that further consideration, including a discussion with the Minister, was required regarding the establishment of an appropriate Urology Review Panel and a planned Ministerial Oral Statement should be deferred by a week (to week commencing 23 November 2020) to allow this consideration to take place.

140. As is standard procedure with any Ministerial submission with potential cost implications, Mr O'Neill consulted colleagues from the Department's Finance Directorate who provided an assessment of the potential financial impact of a public inquiry for inclusion in SUB-2174-2020 [DOH-44004 – DOH-44008].

141. The minutes of the UAG meeting of 20 November 2020, [DOH-00320 – DOH-00323] refer to "a detailed discussion on the content and related timings of the Minister's intended Oral Statement on 24 November 2020", and noted "the communication plan continues to be drawn together liaising with HSCB, DOH and Trust Communications Teams and operational / professional staff". Although the Southern Trust were aware that a Ministerial Oral Statement was impending, it is understood the Trust were not aware a Public Inquiry was being announced as part of the Oral Statement until an embargoed copy of the Statement was shared with the Trust one hour in advance of it being delivered in the Assembly [DOH-00419 – DOH-00426]. In accordance with usual practice, an embargoed copy of the Statement was also issued to First Minister, Deputy First Minister, (a copy is

provided to the Inquiry at Appendices 50a and 50b); other Executive Ministers, (a copy is provided to the Inquiry at Appendices 51a and 51b); and Assembly Speaker (a copy is provided to the Inquiry at Appendices 52a and 52b), in advance.

142. Aidan O'Brien's legal representatives had received a letter from Richard Pengelly providing notification of the Minister's Written Statement on 26 October 2020 [DOH-35149 – DOH-35153]. His legal representatives received a copy of the oral statement a short time before the Minister delivered his Oral Assembly statement on 24 November 2020 [DOH-35225 – DOH-35234].

'SCRR' Process and 'Lookback Review'

143. Paragraph 15 of Notice 65 asks *"Outline the Department's understanding of, and its involvement, if any, in the process leading to a decision by the Trust to adopt a SCRR process as opposed to utilising the Serious Adverse Incident ('SAI') process."* I refer the Inquiry to my response at paragraphs 104-113 above which provides my account of this process.

144. Paragraph 16 of Notice 65 asks *"What assurances did the Department seek and receive (if any) with regard to the appropriateness of the use of a SCRR process in the context of the concerns about patient care and safety which were made known to the Department, as opposed to utilising the SAI process? In particular, the Inquiry is concerned to understand the extent to which the Department sought to obtain assurances as to the robustness and thoroughness of the SCRR process, the assurances provided, how they were tested and whether the assurances were considered satisfactory."* I refer the Inquiry to my response at paragraphs 110-113 above which refer to an ongoing independent review of the SCRR process by the RQIA, which has been commissioned by the Southern Trust and is ongoing at the present time. It is expected that the Trust will report the findings of this work to the UAG for consideration in due course.

145. Paragraph 17 of Notice 65 asks *"With specific reference to all relevant meetings, discussions or correspondence, outline the Department's understanding of and involvement in the decision by the Trust to engage in a Lookback Review"*. I refer the Inquiry to my narrative of events as outlined above from paragraph 56 onwards, which provides details of relevant meetings, discussions and correspondence in relation to the Trust's decision to engage in a Lookback Review. The Trust's initial Lookback Review had commenced in June 2020 and was under way when the Department became aware of concerns upon receipt of Early Alert EA 182/20 on 31 July 2020. Following this, the Trust's progress with the Lookback Review was guided by ongoing discussion with the Department, HSCB and PHA, both prior and subsequent to the formal establishment of the Department-led UAG in October 2020.

146. Paragraph 18 of Notice 65 asks *"What assurances did the Department seek and receive (if any) with regard to the appropriateness of the use of the Lookback Review undertaken in relation to the patients of Mr O'Brien from 1 January 2019 to 30 June 2020? In particular, the Inquiry is concerned to understand the extent to which the Department sought to obtain assurances as to the robustness and thoroughness of the Lookback Review process and its comprehensiveness in terms of the patient group which was to be reviewed and the temporal parameters of the review, the assurances provided, how they were tested and whether the assurances were considered satisfactory"*. I refer the Inquiry to my response to questions under the theme of *"Ongoing Assurance",* in particular my response at paragraph 150 below, which refers to the Department commissioning the RQIA to undertake and independent review of SHSCT Urology Services and its Lookback Review process for the purposes of obtaining assurances on these matters. I understand that this review is ongoing and the draft terms of reference are also provided at paragraph 150 below. The Department will consider the findings of this review when available, and has asked the RQIA to complete this work within 3 months (from August 2022).

<u>Oversight mechanisms now in place</u>

147. Paragraph 19 of Notice 65 asks for confirmation of the Inquiry's understanding of current oversight structures regarding urology and/or public inquiry engagement, including those within the Trust, within the Trust's internal Public Inquiry governance structure, outside the Trust within the Strategic Performance and Planning Group ("SPPG") (formally HSCB), and outside the Trust within the Department. The Department is aware that, following the appointment of Margaret O'Hagan as an Independent Advisor to the Trust in May 2022, the Trust has taken steps to secure a more robust internal structure and processes for delivering the Urology Public Inquiry Programme in order to provide greater transparency, increase accountability and oversight and enhance assurances. I understand that the Trust is in the process of transitioning to this new structure and would therefore be better placed to provide the Inquiry with detailed and up-to-date information on this. My understanding, based on advice from colleagues with policy lead responsibility for the UAG, is that the new structure is intended to be as follows:

<u>Within the Trust</u>

- Urology Lookback Review Steering Group – Chaired by the Independent Advisor to the Public Inquiry (*note this group incorporates the SPPG, PHA and RQIA);
- Lookback Review Operational Group – Chaired by Trust Director of Surgery and Elective Care, Maternity and Women's Health and Cancer and Clinical Services;
- Clinical Reference Group – to be Chaired by Trust Deputy Medical Director;
- Patient Review, Recall and Support Group – Chaired by Trust Assistant Director in Surgery and Elective Care;
- Learning and Improvement Group – Chair to be confirmed;
- Communication Group – Chaired by Trust Communications Manager;

<u>Within the Trust's internal Public Inquiry Governance structure</u>

- Established the Public Inquiry Programme Management and Assurance Board (PIPMAB)
- 3 Work Strands – (1) Urology Lookback Review Steering Group, (2) Public Inquiry Steering Group, (3) Quality Assurance and Learning Steering Group

Outside the Trust within the Strategic Performance and Planning Group ("SPPG") (formally HSCB),

- Southern Urology Co-ordination Group – Chaired by the Acting Director of Planning and Commissioning at SPPG and including Trust staff.
  NB. The Southern Trust advise that the ongoing requirement for the original HSCB Southern Urology Co-ordination Group is under consideration as the external stakeholders sit on the Trust's new Urology Lookback Review Steering Group and also as the HSCB functions have transferred to SPPG within the Department.

Outside the Trust within the Department.

- Urology Assurance Group – Chaired by the Permanent Secretary.

Ongoing Assurance

148. Paragraph 20 of Notice 65 asks *"In addition to the structures referred to above, outline the Department's ongoing role and steps taken, if any, in monitoring, seeking assurance and ensuring patient and general public safety arising out of the concerns about patient care and safety raised by the Trust"*, including *"any engagement the Department has had or continues to have with any of the following concerning these matters: (I) the Trust; (II) the staff working within SPPG; (III) the PHA; (IV) the RQIA; (V) Mr O'Brien's representatives; and (VI) any other relevant person or organisation"*.

149. In response to paragraph 20 parts (I) to (III), the UAG, which is chaired by the Permanent Secretary and includes membership from the Southern Trust, SPPG and PHA, continues to be the structure through which the Department oversees, monitors and seeks assurances on the current Urology Lookback Review by the Trust. This includes determining any requirements for further lookback review and any matters arising concerning patient care and safety raised by the Trust.

150. In response to paragraph 20 part (IV), the CMO wrote to the Chief Executive of the RQIA on 11 August 2022 to commission the RQIA to undertake an independent review of SHSCT Urology Services and Lookback Review in relation to potential concerns for patient safety, with the expectation that this should be completed within 3 months. A copy of the CMO's letter is provided to the Inquiry at Appendices 53a and 53b. The Department's nominated policy lead for the RQIA review, Robbie Davis, Director of General Healthcare Policy, will be best placed to provide further detail about this work as required. I am advised that the draft terms of reference for this review are:

1. A Review of the governance and assurance systems for patient safety within SHSCT Urology Services:
   - Review and assess the quality and effectiveness of governance and assurance arrangements in place for patient safety within SHSCT Urology Services, to ensure that each clinician within the Urology Services delivered by the Trust has adhered to all relevant trust, regional and national standards; and
   - Review and assess the quality and effectiveness of governance and assurance arrangements in place within SHSCT Urology Services, for all aspects of patient safety.

2. A Review of the robustness of the oversight and governance arrangements for the SHSCT Urology Lookback Review:
   - Review and assess the SHSCT operations and governance arrangements for the Urology Lookback Review; and
   - Review and assess the progress with the implementation of the recommendations made by the SHSCT's earlier investigation into the concerns identified relating to the Urology Lookback Review.

3. A Review of SHSCT fulfilling their roles and responsibilities as part of the Department of Health Urology Assurance Group (UAG):

- Review and assess the performance of SHSCT as a core member of UAG, to determine the extent to which it has achieved and fulfilled the Terms of Reference for the UAG; and
- Identify any particular learning to determine if any further measures are required to be taken to support an effective assurance, oversight and reporting function of the work associated with the UAG.

151. As noted in my response at paragraphs 110-113 above, the Trust also independently approached the RQIA to undertake a review of its Urology Structured Clinical Record Review (SCRR) process. The Trust will be best placed to provide details about this review to the Inquiry as required. The outcome of both of these RQIA Reviews will be considered and addressed when available.

152. In response to paragraph 20 part (V), paragraphs 177-179 of the witness statement of the Permanent Secretary refer to correspondence from Michael O'Neill, the Acting Director of General Healthcare Policy, who wrote to Mr O'Brien's solicitor on 24 November 2020 in relation to the issue and withdrawal of an alert letter, and later the Minister's intention to make an oral statement. All relevant records relating to this correspondence have been provided to the Inquiry [DOH-35224] [DOH-35220 – DOH-35221], [DOH-35225] and [DOH-35235]. I am not aware of any further engagement between the Department and Mr O'Brien's representatives. In addition to this, I am aware that the Trust has engaged directly with Mr O'Brien's representatives to request access to Mr O'Brien's private patients' records in order to ensure all private patients healthcare needs have been met, and the UAG continues to provide oversight in relation to this matter. This relates to the patient safety concerns referred to in the Minister's Statement on 24 November 2020 arising from the fact that most of this work was carried out in private domestic premises, therefore outside of the regulatory framework.

153. In response to paragraph 20 part (VI), I have nothing further to add.

154. Paragraph 21 of Notice 65 asks:

(I) What, if any, reforms the Department is aware of the Trust having made to clinical governance arrangements to address any issue which may have been identified?
(II) What, if any, processes have been implemented or steps taken by the Trust to monitor or provide assurance that the clinical governance arrangements within the Trust are to the Department's satisfaction and ensure patient safety?
(III) What, if any, assurances has the Department sought and received from the Trust with regard to any reforms to clinical governance arrangements?
(IV) What, if any, monitoring has the Department implemented to ensure that the clinical governance arrangements within the Trust protect patient safety?

155. I refer to my response to paragraph 20 of Notice 65, including reference to the two RQIA reviews which will consider both Southern Trust Urology Services and Lookback Review, as well as the Trust SCRR process, commissioned by the Department and the Trust respectively. The Department-led UAG will continue to oversee and seek assurances regarding both of these reviews, and will consider the findings to ensure that any recommended improvements are implemented and that the governance structures are sufficiently robust.

156. Paragraph 22 of Notice 65 asks *"How, if at all, have any reforms or assurances been tested? In addressing this question also outline what, if any, assurances the Department received or continues to receive, and outline whether the assurances received to date are considered by the Department to be satisfactory."* I refer to my response to paragraphs 20 and 21 of Notice 65. The Department has sought to obtain further assurance in relation to these matters by commissioning the RQIA to undertake an independent review of Southern Trust Urology Services and its Lookback Review, and will assess any findings when these become available.

157. Paragraph 23 of Notice 65 asks *"Does the Department consider there remains outstanding work to be done by the Trust before its governance structures are sufficiently robust to prevent a reoccurrence of the issues which arose within the Trust's Urology Services?"* I refer to my response to paragraphs 20-22 of Notice 65. The requirement for any further work to be done by the Trust to prevent any

recurrence of these issues will be informed by the ongoing assurance oversight structures and the two current RQIA reviews.

158. Paragraph 24 of Notice 65 asks *"In light of the Minister's Oral Statement to the Assembly […] What, if any, assurances has the Department sought and received regarding the care and governance of Mr Aidan O'Brien's private patients from: (I) The Trust; (II) Mr Aidan O'Brien; (III) Mr O'Brien's legal representatives; or (IV) any other relevant person, organisation or source."* Since the Minister's Oral Assembly statement on 24 November 2020 a number of work streams have been overseen by the UAG, including the completion of the SAI Review, the Lookback Review and SCRR process by the Southern Trust, and the patient safety concerns relating to Mr O'Brien's private patients. The UAG continues to provide oversight in relation to the Trust's efforts to secure access to the private patient information required to enable a review of the patient records, assess whether any patients require further assessment and/or treatment, and to ensure the appropriate care is provided to the private patients involved if required.

159. However, as Mr O'Brien's private practice was carried out in private domestic premises, this sat outside of the regulatory framework which ordinarily requires the registration and external assurance of any facilities in which clinicians may undertake private practice in the Independent Sector. The Department and the Trust are concerned that many of these patients may therefore still be unknown to the Southern Trust or the wider HSC system.

160. Additionally, it is possible that some private patients were/are resident in the Republic of Ireland as these premises were located close to the border. It was confirmed during the UAG meeting on 13 November 2020 [DOH-00312 – DOH-00319] that Mr O'Brien was not currently registered with the Irish Medical Council (IMC). I understand that the Permanent Secretary and the CMO's Office raised the potential of this emerging issue, relating to private patients living in RoI, with RoI counterparts, and can provide further information to the Inquiry as required. The Department is mindful of the potential need for further appropriate and timely

liaison with counterparts in RoI as and when details relating to the private practice patients become known.

161. My response to paragraph 20 part (V) of Notice 65 (at paragraph 152 above) refers to engagement between the Southern Trust and Mr O'Brien's representatives to request access to Mr O'Brien's establish the details of the private patients under his care. Unfortunately, despite ongoing engagement by the Trust with Mr O'Brien's legal representatives, the information required has not, to date, been forthcoming. I am advised that the exchange of correspondence between the Southern Trust and Mr O'Brien's legal representatives has included:

- In a letter dated 23 December 2020 (received by the Trust on 5 February 2021), in response to a Trust request asking Mr O'Brien to seek to engage an independent review of his private practice, Mr O'Brien's representative stated that he had received no complaint nor claim relating to his private practice therefore felt that there was no need for an investigative process of this nature. [DOH-35469 – DOH-35472]. The letter also referred to protections granted under the Data Protection Act regarding an independent review of these patients and the same reports being made available to the Department of Health. The correspondence suggests that the GMC using Section 35 A of the Medical Act 1983 can secure access to these records. The correspondence also queried what legal powers the Department or Trust would have to intervene to progress these enquiries;
- Accompanying this letter was further correspondence restating Mr O'Brien's position, which noted if the Trust or the Department set out the legal basis for any Court application, this would be considered and if there is a sound basis it may be possible for it to be dealt with by consent. [DOH-35473 – DOH-35482]. The letter also added if this is the case the Trust or the Department can then undertake such investigation as they consider necessary.
- Mr O'Brien, at the request of the Trust, confirmed he did issue a letter to his private patients which had been supplied to him by the Trust during the summer 2021. At 5 June 2021, Mr O'Brien's legal team confirmed to the Southern Trust that 248 letters to private patients had been issued, with no notifications of non-delivery.

162. Paragraph 25 of Notice 65 asks *"If assurances have been sought and provided in respect of Mr O'Brien's private patients, how has the Department tested the effectiveness of these assurances? Is the Department satisfied by the assurances provided? If not, what are the Department's proposed next steps, if any, regarding Mr O'Brien's private patients?"* The Department considers that all responses received from Mr O'Brien's representatives to date have fallen short of the confirmations and information requested by the Southern Trust. All attempts to gain access to information relating to Mr O'Brien's private patients (in order to allow the Southern Trust to review the patient records and determine if any private patients require further investigation and care) have thus far been unsuccessful.

163. I am advised by General Healthcare Policy Directorate that the Department has also explored the possibility of commissioning the RQIA to undertake a review of Mr O'Brien's private practice, but unfortunately as the service which this urologist provided from his own home was not a service registered with the RQIA, and was not associated with or part of any arrangement with the HSC system, it has therefore been determined that RQIA would not have any powers of entry for the purposes of inspection or examination of records.

164. I am further advised by General Healthcare Policy Directorate that the Southern Trust is giving consideration to issuing further correspondence to Mr O'Brien's representatives for the purposes of making another attempt to gain access to these private patient records, and that the outcome of this will be considered by the UAG in order to determine next steps as and when appropriate.

165. Paragraph 26 of Notice 65 asks *"Has the Department reached any view concerning the appropriateness, quality and timeliness of the steps taken by the Trust to address the issues of concern and ensure patient safety? If so, fully outline the view which has been reached and set out the reasons for the view which has been reached. If the Department has not evaluated this issue, please explain why."* I refer the Inquiry to my responses to paragraphs 20, 21 and 24 of Notice 65. The Department's evaluation of these issues is an ongoing process

which is primarily overseen by the UAG and informed by emerging information and actions undertaken to date, including the ongoing reviews by the RQIA.

Updated Guidance

166. Paragraphs 27 and 28 relate to the decision making process around the development, content and advice relating to HSC (SQSD) 6/21 *"Regional Guidance for implementing a lookback review process"* ("the 2021 Departmental Guidance"). My response at paragraph 123 above refers to this guidance being issued on 16 July 2021 by the Department's Safety Strategy Unit, which was at that time part of the Safety and Quality Standards Directorate (now named Quality, Safety and Improvement Directorate, of which Andrew Dawson is Director) within the Chief Medical Officer Group. My understanding is that the revision of this guidance was initiated in 2019 in response to the findings of the Inquiry into Hyponatraemia Related Deaths (IHRD). As my Directorate has not been involved in the development of this revised guidance, I am not in a position to provide details about the process or related decisions, nor the specific changes that it intended to introduce vis à vis the 2007 Guidance.

167. In response to the Inquiry's question at Part (IV) of paragraph 28, my understanding is that any advice given to the Southern Trust in relation to the applicability of the 2021 Guidance to the urology lookback process would have been relayed through and discussed either within the UAG, or by officials with policy oversight of the UAG.

Learning

168. Paragraph 29 of Notice 65 asks *"From the information available to the Department to date, what does it consider went wrong within the Trust's urology services and with regard to Trust governance procedures and arrangements? Has the Department reached any view on how such issues may be prevented from recurring? Has the Department taken any steps with a view to preventing the recurrence of such issues?"* The Department considers it a priority that any

learning arising from urology concerns in the Southern Trust must be identified and implemented at the earliest opportunity, both within the Southern Trust and across the HSC system as a whole, in order to prevent any risk of further recurrence or possible harm to patients.

169. It is recognised that this remains an ongoing process, which will build upon existing programmes of work and be further informed by the two ongoing RQIA reviews of Southern Trust Urology Services and its Lookback Review process, and of its SCRR process, as well as the findings of this Inquiry. Notwithstanding these ongoing processes, my statement demonstrates that the Department has to date identified a number of areas where revised policies and processes are necessary to mitigate or prevent further recurrence of similar issues and risks. Some of these have also been referenced in the Permanent Secretary's response to this Inquiry, which also recognised that similar issues and failings were identified through separate processes (including the Hyponatraemia and Neurology Public Inquiries), and in response to which a number of actions have been completed or are in progress. These include:

- the publication of updated Departmental policy and guidance to HSC organisations on a revised Lookback Review Process (HSC SQSD 06/2021) on 16 July 2021;
- the commissioning of an independent review by the RQIA of Southern Trust Urology Services and its Lookback Review process;
- the commissioning of a separate independent review by the RQIA of the Southern Trust SCRR process;
- completion of a review by the RQIA of SAIs in Northern Ireland, which the Minister will shortly publish (paragraphs 128-133 of the Permanent Secretary's statement to the Inquiry refer);
- the commitment to undertake and prioritise a substantive review of the Department's Managing High Professional Standards (MHPS) policy, which will be led by the Department's Workforce Policy Directorate within Healthcare Policy Group (paragraphs 107-112 of the Permanent Secretary's statement to the Inquiry refer);

- the commitment to develop a Being Open Framework, which will be led by the Department's Quality, Safety and Improvement Directorate within CMO Group (paragraphs 119-127 of the Permanent Secretary's statement to the Inquiry refer);
- the commitment to revise the Department's Early Alerts policy, which will also be led by the Department's Quality, Safety and Improvement Directorate within CMO Group (paragraphs 134-143 of the Permanent Secretary's statement to the Inquiry refer);
- the commitment to undertake a fundamental review of regulation (paragraphs 144-153 of the Permanent Secretary's statement to the Inquiry refer);

170. It is envisaged that the implementation of any learning identified through the various processes and reviews outlined in this statement, including any recommendations from the USI itself, will be taken forward at an appropriate juncture.

171. Paragraph 30 of Notice 65 asks *"Does the Department consider that it did anything wrong or could have done anything differently which could have prevented or mitigated the governance failings of the Trust?"* It is clear from the issues identified and actions under way to date that opportunities to improve processes and prevent or mitigate risks exist at a policy and oversight level, for which the Department accepts it has direct responsibility, as well as at an operational level.

172. The Department also recognises that its ability to adequately resource existing programmes of work aimed at addressing similar issues, as identified initially by the IHRD and later the INI panels, for example the review of various Departmental policies and functions as outlined in paragraph 169 above, has been constrained by a lack of resource which was further compounded by the impact of the pandemic response on both Departmental and HSC resources. As noted both in my statement and that of the Permanent Secretary, these actions are now firmly recognised as Departmental priorities, and have been progressed accordingly. The Department remains concerned by the continued budgetary uncertainty linked to the ongoing absence of an Executive, which continues to constrain the

Department's ability to fully deliver on the full range of its policy priorities and commitments. The effect of this is often that policy may be developed but the ability of the Department and the HSC to implement it may remain subject to the confirmation of available funding.

173. Without prejudice to the work of this Inquiry, and distinct from the policy responses which have been recognised above, the Department considers that its response to the emerging issues as they were being reported from 31 July 2020 onward, in the context of the ongoing pandemic response, has been appropriate. Oversight structures have been developed and refined commensurate with the emerging scale and scope of concerns, and these continue to provide a means of supporting and drawing assurance from the Southern Trust. Notwithstanding this, any further learning which may emerge from the Inquiry or any of the ongoing processes in relation to the Department's responsibilities will be considered and taken forward as appropriate.

174. Paragraph 31 of Notice 65 asks *"From the Department's perspective, what lessons have been learned from the issues of concern which have emerged from urology services within the Trust? Has this learning informed or resulted in new practices or processes for the Department? Whether you answer is yes or no, please explain."* I refer the Inquiry to my responses to paragraphs 29 and 30 of Notice 65 (paragraphs 168-174 above refer), which outline emerging lessons to date and associated actions identified or under way.

Statement of Truth

I believe that the facts stated in this witness statement are true.

Signed: __[redacted]_____

Date: ____01/09/2022_____

S21 para number	Name of Document	Description of document	Bates Number	Witness Statement para number	Appendix	Date Sent to Panel
1	Standard Policy Brief - Urology (reviewed September 2019)		DOH 12114- DOH-12118	11		01/09/2022
1	Excerpts Section 1 to Section 10 of Health and Social Care (Reform) Act (Northern Ireland) 2009			18	1	01/09/2022
1	Excerpt Section 5 of Health and Social Care (Reform) Act (Northern Ireland) 2009			18	2	01/09/2022
1	Framework for Department of Health social services and public safety 2011		DOH-35616- DOH- 35672	18		
1	Regional Review of Urology Services, April 2009 Submission to Minister			21	3	01/09/2022
1	Ltr from Hugh Mullen to Trusts advising of urology review			22	4	01/09/2022
1	Appendix 1-Regional Urology Steering Group			23	5	01/09/2022
1	Appendix 2-Regional Review of Adult Urology Services - Terms of Reference			23	6	01/09/2022
1	Review of Adult Urology Services in Northern Ireland - March 2009			23	7	01/09/2022
1	Submission to Departmental Board re review of adult urology services in Northern Ireland			30	8	01/09/2022
1	Email from Suzanne Beaney Submission_ SUB_226_2010 REVIEW OF ADULT UROLOGY SERVICES IN NORTHERN IRELAND			31	9a	01/09/2022
1	Submission 226.2010 to Minister (attached to email)				9b	01/09/2022
1	Email from Caroline White Submission_ SUB_284_2010 Minister's approval			32	10a	01/09/2022
1	Sub.284.2010 (attached to email)				10b	01/09/2022
1	Letter from Dr McCarthy to Hugh Mullen - Review of Adult Urology Services			33	11	01/09/2022
1	Email from Alison Marley to Joe Magee and Jim McComish attaching Minister's final response to AQW 133/11		DOH- 21093- DOH 21096	34		
1	Email from Beth Malloy RE_ URGENT_ FW_ Update on Modernising Endoscopy			35	12	01/09/2022
1	Email from Darren Magee Closing AQ AQW 30818_11-15			36	13a	01/09/2022
1	AQW 30818 11-15 Closing (attached to email)				13b	01/09/2022
1	AQW 31320 11-15				14	01/09/2022
1	AQW 31453 11-15				15	01/09/2022
1	AQW 31454 11-15				16	01/09/2022
1	Draft response to AQW 31455/11-15	Question from Roy Beggs the reasons for long waiting times for a urology day procedure within each Health and Social Care Trust; and what action he is undertaking to reduce lengthy waiting times	DOH-21113- DOH- 21115			
1	AQW 31455/11-15	Question from Roy Beggs ROY BEGGSre the reasons for long waiting times for a urology day procedure within each Health and Social Care Trust; and what action he is undertaking to reduce lengthy waiting times CLOSING - RESPONSE IS NOT IN EMAIL	DOH-21116			
1	AQW 31612 11-15				17	01/09/2022
1	AQW 32050 11-15				18	01/09/2022
1	Letter to HSBC-Update PPE Review Urology Jan 2019	Evaluation of Adult Urology Services	DOH-12120 - DOH-12128	38		
1	Health and Wellbeing 2026 -Delivering Together			39	19	01/09/2022
1	Systems not Structures - Changing Health and Social Care - full report				20	01/09/2022
1	Rebuilding Health and Social Care Services Strategic Framework - June 2020			44	21	01/09/2022

1	Appendix B - Impact of Covid-19 on Secondary Care Services			46	22	01/09/2022
1	Appendix C - Impact on Programmes and Projects			47	23	01/09/2022
1	TOR Management Board for Rebuilding HSC Services - RMB			48	24	01/09/2022
1	ASUB-XXX-2020 - Service Transformation Reviews (attached to email)			49	25	01/09/2022
1	RMB422020 Rebuilding HSC Services Management Board - notes of meeting 19 August 2020				26	01/09/2022
1	Email corrrespondence Deborah McNeilly and Sharon Gallagher_SUB_1819_2020 _ Comments from SG - Service Transformation Reviews			50	27	01/09/2022
1	Email from DOH Private Office to Jackie Johnston Submission Decision SUB-1819-2020 _ HSC SERVICE TRANSFORMATION REVIEWS			51	28a	01/09/2022
1	SUB-1819-2020 COVER NOTE (attached to email)				28b	01/09/2022
1	Email from DOH Private Office Submission Decision SUB-2271-2020 _ HSC SERVICE TRANSFORMATION REVIEWS			52	29a	01/09/2022
1	Email from Frances Tullin to DOH Private Office SUB-2271-2020 - Service Transformation Reviews (attached to email)				29b	01/09/2022
1	SUB-1819-2020 Service Transformation Review (attached to email)				29c	01/09/2022
1	Rebuilding Management Board Meeting - Draft note - 09 December 2020			52	30	01/09/2022
1	A Cancer Strategy for Northern Ireland 2022-2032 March-2022			53	31	01/09/2022
1	Review of General Surgery in Northern Ireland - Standards and a way forward				32	01/09/2022
1	Elective Care Framework - Restart-Recovery and Redesign				33	01/09/2022
1	Submission of Early Alert Pro Forma		DOH 19704	59		
1	Email from DOH Early Alert	Sharing of Early Alert proforma	DOH-00685	60		
1	Email from Diane - Corporate Governance Re Early Alert				34a	01/09/2022
1	EA JULY 2020 20 (attached to email)				34b	01/09/2022
1	Email from James Adams - providing RQIA copy of Early Alert - EA 182_20				35a	01/09/2022
1	Early Alert 18220 (attached to email)				35b	01/09/2022
1	EA 182/20 email from Lesley Gordon 3/8/20 -	Email from DoH Private Office to Jane Carson and others noting the Minister's receipt of Early Alert from Maria O'Kane in relation to lookback exercise	DOH-00664– DOH-00666	61		
1	Email from Jackie Johnston to Ryan Wilson HPRM_ FW_ Early Alert - Urology July 2020			67	36a	01/09/2022
1	Early Alert - Urology July 2020 (attached to email)				36b	01/09/2022
1	*SUB-1740-2020 - Early Alert (182/20) - Consultant Urologist Restricted from Clinical Practice*		DOH-00684 - DOH-00691	70		
1	Email from DoH Private Office to Jane Carson	noting the Minister's receipt of Early Alert from Maria O'Kane in relation to lookback exercise	DOH-00664 - DOH-00666	71		
1	Email from DOH Private Office to Ryan Wilson Submission Decision SUB-1740-2020 _ EARLY ALERT (182_20) - CONSULTANT UROLOGIST RESTRICTED FROM CLINICAL PRACTICE				37a	01/09/2022
1	SUB-1740-2020 COVER NOTE (attached to email)				37b	01/09/2022
1	Email from SHSCT update to Medical Officer		DOH-00667 - DOH-00670	72		
1	Email from Jackie Johnston to Olive MacLeod and Paul Cavanagh - four issues to address			73	38	01/09/2022
1	Urology Assurance Group meeting 30 October 2020		DOH-00300 - DOH-00305	81		
1	Report to Department of Health on Consultant A	Submitted by Trust to HSCB then the Department	DOH-00702 - DOH-00718	83		
1	Written submission to Minister - SUB-2055-2020				39	01/09/2022
1	EA 182 20 (Trust update)			84	40	01/09/2022
1	Permanent Secretary's letter to Trust	Advising establishment of UAG	DOH-43730 - DOH-43732	86		
1	UAG Terms of Reference		DOH-00297 - DOH-00299			
1	Minister's writtent statement to Assembly	Outlining concerns, establishment of UAG	DOH-35133	95		
1	UAG Terms of Reference		DOH-00297 - DOH-00299	96		
1	UAG Terms of Reference - revised 23 May 2022				41	01/09/2022

1	Urology Assurance Group meeting 6 November 2020		DOH-00307 - DOH-00311	98		
1	Urology Assurance Group meeting 13 November 2020		DOH-00313 - DOH-00319	99		
1	SUB-2174-2020 sent to Minister of Health	Ref set up of Inquiry	DOH-44004 - DOH-44008	100		
1	Oral Assembly Stm from Minister Swann regarding Urology and SHSCT	Hansard extract		101	42	01/09/2022
1	Written Statement to Assembly from Minister Swann	Appointment of Chair of Inquiry	DOH-00938 - DOH-00940	103		
1	Urology Assurance Group meeting 4 December 2020		DOH-00325 - DOH-00328	106		
1	Urology Assurance Group meeting 18 December 2020		DOH-00330 - DOH-00333	107		
1	Urology Assurance Group meeting 22 January 2021		DOH-00342 - DOH-00346	108		
1	Urology Assurance Group meeting 5 March 2021		DOH-00359 - DOH-00364	109		
1	Email from Andrew Dawson RE_ Sent on Behalf of Dr Maria O'Kane - Urology Structured Clinical Record Review Process			111	43a	01/09/2022
1	ltr RQIA SCRR Review (attached to email)				43b	01/09/2022
1	Email from Andrew Dawson FW_ Urology Structured Clinical Record Review Process			112	44a	01/09/2022
1	Reply to_ltr RQIA SCRR Review 020322 (attached to email)				44b	01/09/2022
1	Urology Assurance Group meeting 23 May 2022			113	45	01/09/2022
1	Email correspondence between Departmental officials and Trust	Ref EA182/20	DOH-43931 - DOH-43952	115		
1	Circular HSS(TC8) 698 Issue of Alert letters about hospital and community medical and dental staff under investigation by the HPSS			115	46	01/09/2022
6	A PRACTICAL GUIDE TO CONDUCTING PATIENT SERVICE REVIEWS OR LOOK BACK EXERCISES			122	47	01/09/2022
6	Email from James Adams HSC (SQSD) 6_21 - Regional lookback review policy			123	48a	01/09/2022
6	HSC (SQSD) 6-21 Regional lookback review policy (attached to email)			123	48b	01/09/2022
6	Policy for Implementing a Lookback Review Process 2021 (attached to email)			123	48c	01/09/2022
6	Regional Guidance for Implementing a Lookback Review Process 2021 (attached to email)			123	48d	01/09/2022
10	HSC (SQSD) 18/2007			129	49	01/09/2022
14	SUB-2174-2020 sent to Minister of Health		DOH-44004 - DOH-44008	135		
14	Urology Assurance Group meeting 6 Nov 2020		DOH-00306 - DOH-00311	138		
14	Urology Assurance Group meeting 13 Nov 20		DOH-00312 - DOH-00319	139		
14	SUB-2174-2020 - financial implications		DOH-44004 - DOH-44008	140		
14	Urology Assurance Group meeting 20 Nov 20		DOH-00320 - DOH-00323	141		
14	Email from Michael O'Neill to SHSCT - copy of oral statement		DOH-00419 - DOH-00426	141		
14	Email from Private Office to FM and dFM and Ministers SUB-2174-2020			141	50a	01/09/2022
14	Letter to FMDFM Oral Statement - Urology in SHSCT (attached to email)			141	50b	01/09/2022
14	Email from Private Office to Execuitve SUB-2174-2020 - Urgent Oral Statement by Minister Swann - Clinical Concerns within Urology at the SHSCT			141	51a	01/09/2022
14	Letter to Executive Colleagues - Oral Statement (attached to email)			141	51b	01/09/2022
14	Email from Private Office to Speakers Office SUB-2174-2020			141	52a	01/09/2022
14	Letter to Speaker re Oral Statement - Urology at SHSCT (attached to email)			141	52b	01/09/2022
14	Ltr from Richard Pengelly to Tughans		DOH-35149 - DOH-35153	142		
14	Email from Michael O'Neill to Andrew Anthony	Providing copy of oral statement	DOH-35225 - DOH-35234	142		
20	Email from Jane Carson to RQIA - RQIA REVIEW OF SOUTHERN HSC TRUST UROLOGY SERVICES AND LOOKBACK REVIEW			150	53a	01/09/2022
20	Letter from Prof Sir Michael McBride to Briege Donaghy - RQIA REVIEW OF SOUTHERN HSC TRUST UROLOGY SERVICES AND LOOKBACK REVIEW (attached to email)				53b	01/09/2022
20	Correspondence with Mr O'Brien's Solicitor		DOH-35220 - DOH-35221	152		
			DOH-35224			
			DOH-35225			
			DOH-35235			
24	Urology Assurance Group 13 Nov 20		DOH-00312 - DOH-00319	160		
24	Ltr from Tughans to Trust	ref independent review	DOH-35469 - DOH-35472	161		
24	Ltr from Tughans to Trust	ref legal basis for Court application	DOH-35473 - DOH-35482			

Changes to legislation: *There are outstanding changes not yet made by the legislation.gov.uk editorial team to Health and Social Care (Reform) Act (Northern Ireland) 2009. Any changes that have already been made by the team appear in the content and are referenced with annotations. (See end of Document for details) View outstanding changes*

Health and Social Care (Reform) Act (Northern Ireland) 2009

2009 CHAPTER 1

An Act to make changes to the administrative structures for health and social care; and for connected purposes. [21st January 2009]

BE IT ENACTED by being passed by the Northern Ireland Assembly and assented to by Her Majesty as follows:BE IT ENACTED by being passed by the Northern Ireland Assembly and assented to by Her Majesty as follows:BE IT ENACTED by being passed by the Northern Ireland Assembly and assented to by Her Majesty as follows:

Modifications etc. (not altering text)

C1 Act excluded (1.4.2015) by Care Act 2014 (c. 23), s. 127, **Sch. 1 para. 1(4)** (with Sch.1 para. 814); S.I. 2015/993, art. 2(x)(i) (with transitional provisions in S.I. 2015/995)

C2 Act modified (1.4.2015) by Care Act 2014 (c. 23), s. 127, **Sch. 1 para. 4(1)(a)** (with Sch.1 para. 814); S.I. 2015/993, art. 2(x)(i) (with transitional provisions in S.I. 2015/995)

C3 Act excluded (1.4.2015) by Care Act 2014 (c. 23), s. 127, **Sch. 1 para. 3(3)** (with Sch.1 para. 814); S.I. 2015/993, art. 2(x)(i) (with transitional provisions in S.I. 2015/995)

C4 Act excluded (6.4.2016) by Care Act 2014 (c. 23), s. 127(1), **Sch. 1 para. 2(6)** (with Sch.1 paras. 8, 14); S.I. 2016/464, art. 2(c)

C5 Act excluded (6.4.2016) by Care Act 2014 (c. 23), s. 127(1), **Sch. 1 para. 2(7)(b)** (with Sch. 1 paras. 8, 14); S.I. 2016/464, art. 2(c)

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

***Changes to legislation:** There are outstanding changes not yet made by the legislation.gov.uk editorial team to Health and Social Care (Reform) Act (Northern Ireland) 2009. Any changes that have already been made by the team appear in the content and are referenced with annotations. (See end of Document for details) View outstanding changes*

Restructuring of administration of health and social care

Restructuring of administration of health and social care

1.—(1) The following bodies are dissolved—

(a) Health and Social Services Boards;

(b) the Mental Health Commission;

(c) the Central Services Agency; and

(d) Health and Social Services Councils.

(2) The Northern Ireland Health and Personal Social Services Regulation and Improvement Authority established under Article 3 of the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 (NI 9)—

(a) is renamed the Health and Social Care Regulation and Quality Improvement Authority; and

(b) is referred to in this Act as "RQIA".

(3) Health and Social Services trusts established under Article 10 of the Health and Personal Social Services (Northern Ireland) Order 1991 (NI 1)—

(a) are renamed Health and Social Care trusts; and

(b) are referred to in this Act as "HSC trusts".

(4) Special health and social services agencies established under Article 3 of the Health and Personal Social Services (Special Agencies) (Northern Ireland) Order 1990 (NI 3)—

(a) are renamed special health and social care agencies; and

(b) are referred to in this Act as "special agencies".

(5) In this Act "the health and social care bodies" means—

(a) the Regional Health and Social Care Board, established under section 7 and referred to in this Act as "the Regional Board";

(b) the Regional Agency for Public Health and Social Well-being, established under section 12 and referred to in this Act as "the Regional Agency";

(c) the Regional Business Services Organisation, established under section 14 and referred to in this Act as "RBSO";

(d) HSC trusts;

(e) special agencies;

(f) the Patient and Client Council, established under section 16;

(g) RQIA.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

***Changes to legislation:** There are outstanding changes not yet made by the legislation.gov.uk editorial team to Health and Social Care (Reform) Act (Northern Ireland) 2009. Any changes that have already been made by the team appear in the content and are referenced with annotations. (See end of Document for details) View outstanding changes*

Department's role in promoting and providing health and social care

Department's general duty

2.—(1) The Department shall promote in Northern Ireland an integrated system of—

(a) health care designed to secure improvement—

(i) in the physical and mental health of people in Northern Ireland, and

(ii) in the prevention, diagnosis and treatment of illness; and

(b) social care designed to secure improvement in the social well-being of people in Northern Ireland.

(2) For the purposes of subsection (1) the Department shall provide, or secure the provision of, health and social care in accordance with this Act and any other statutory provision, whenever passed or made, which relates to health and social care.

(3) In particular, the Department must—

(a) develop policies to secure the improvement of the health and social well-being of, and to reduce health inequalities between, people in Northern Ireland;

(b) determine priorities and objectives in accordance with section 4;

(c) allocate financial resources available for health and social care, having regard to the need to use such resources in the most economic, efficient and effective way;

(d) set standards for the provision of health and social care;

(e) prepare a framework document in accordance with section 5;

(f) formulate the general policy and principles by reference to which particular functions are to be exercised;

(g) secure the commissioning and development of programmes and initiatives conducive to the improvement of the health and social well-being of, and the reduction of health inequalities between, people in Northern Ireland;

(h) monitor and hold to account the Regional Board, the Regional Agency, RBSO and HSC trusts in the discharge of their functions;

(i) make and maintain effective arrangements to secure the monitoring and holding to account of the other health and social care bodies in the discharge of their functions;

(j) facilitate the discharge by bodies to which Article 67 of the Order of 1972 applies of the duty to co-operate with one another for the purposes mentioned in that Article.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

***Changes to legislation:** There are outstanding changes not yet made by the legislation.gov.uk editorial team to Health and Social Care (Reform) Act (Northern Ireland) 2009. Any changes that have already been made by the team appear in the content and are referenced with annotations. (See end of Document for details) View outstanding changes*

(4) The Department shall discharge its duty under this section so as to secure the effective co-ordination of health and social care.

(5) In this Act—

"health care" means any services designed to secure any of the objects of subsection (1)(a);

"health inequalities" means inequalities in respect of life expectancy or any other matter that is consequent on the state of a person's health;

"social care" means any services designed to secure any of the objects of subsection (1)(b).

Department's general power

3.—(1) The Department may—

(a) provide, or secure the provision of, such health and social care as it considers appropriate for the purpose of discharging its duty under section 2; and

(b) do anything else which is calculated to facilitate, or is conducive or incidental to, the discharge of that duty.

(2) Subsection (1) does not affect the Department's powers apart from this section.

[F1Provision of health care outside Northern Ireland

3A. The Department may provide or secure the provision of health care mentioned in Article 5(1), 6(1), 7(1), 8(1) or 10(1) of the Order of 1972 (hospital etc. accommodation and health care services, including diagnostic services, after-care and ancillary services) outside Northern Ireland.**]**

Textual Amendments

F1 S. 3A inserted (10.5.2012) by The Health Care (Reimbursement of the Cost of EEA Services etc.) Regulations (Northern Ireland) 2012 (S.R. 2012/167), regs. 1, **3(1)**

Department's priorities and objectives

4.—(1) The Department shall determine, and may from time to time revise, its priorities and objectives for the provision of health and social care in Northern Ireland.

(2) Before determining or revising any priorities or objectives under this section, the Department must consult such bodies or persons as it thinks appropriate.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

***Changes to legislation:** There are outstanding changes not yet made by the legislation.gov.uk editorial team to Health and Social Care (Reform) Act (Northern Ireland) 2009. Any changes that have already been made by the team appear in the content and are referenced with annotations. (See end of Document for details) View outstanding changes*

(3) Where the Department is of the opinion that because of the urgency of the matter it is necessary to act under subsection (1) without consultation—

(a) subsection (2) does not apply; but

(b) the Department must as soon as reasonably practicable give notice to such bodies as it thinks appropriate of the grounds on which the Department formed that opinion.

The framework document

5.—(1) The Department shall prepare a document (in this Act referred to as "the framework document") setting out in relation to each health and social care body—

(a) the main priorities and objectives of the body in carrying out its functions and the process by which it is to determine further priorities and objectives;

(b) the matters for which the body is responsible;

(c) the manner in which the body is to discharge its functions and conduct its working relationship with—

(i) the Department, and

(ii) any other body specified in the document; and

(d) the arrangements for providing the Department with information to enable it to carry out its functions in relation to the body under section 2(3)(h) or (i).

(2) The framework document may contain—

(a) such guidance relating to the carrying out by each health and social care body of its functions, and

(b) such other material pertaining to the body or its functions,

as the Department considers appropriate.

(3) The Department—

(a) shall keep the framework document under review; and

(b) may from time to time revise it.

(4) The Department must carry out its duties under subsections (1) to (3) in the manner and to the extent that appear to it to be best calculated to promote—

(a) health and social care;

(b) the economy, efficiency and effectiveness of health and social care bodies; and

(c) economy, efficiency and effectiveness in connection with the matters in relation to which those bodies have functions.

(5) In preparing the framework document, or any revision of it which appears to the Department to be significant, the Department must consult—

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

***Changes to legislation:** There are outstanding changes not yet made by the legislation.gov.uk editorial team to Health and Social Care (Reform) Act (Northern Ireland) 2009. Any changes that have already been made by the team appear in the content and are referenced with annotations. (See end of Document for details) View outstanding changes*

(a) each health and social care body as respects its functions (or persons considered by the Department to represent that body); and

(b) any other bodies or persons the Department considers appropriate.

(6) Each health and social care body shall have regard to the framework document in carrying out its functions.

Power of Department to give directions to certain bodies

6.—(1) The Department may give directions of a general or specific nature to—

(a) the Regional Board,

(b) the Regional Agency, and

(c) RBSO,

as to the carrying out by that body of any of its functions.

(2) Before giving any directions to a body under subsection (1) the Department must consult that body.

(3) Where the Department is of the opinion that because of the urgency of the matter it is necessary to give directions under subsection (1) without consulting the body concerned—

(a) subsection (2) does not apply; but

(b) the Department must as soon as reasonably practicable give notice to that body of the grounds on which the Department formed that opinion.

(4) Where the Department is of the opinion that (for any reason other than the urgency of the matter) it is not reasonably practicable to comply with subsection (2)—

(a) that subsection does not apply; but

(b) the Department must as soon as reasonably practicable give notice to the body concerned of the grounds on which the Department formed that opinion.

(5) It is the duty of a body to comply with any directions given to it under subsection (1).

(6) Subsection (1) does not affect the Department's powers to give directions apart from this section.

The Regional Board

The Regional Health and Social Care Board

7.—(1) There shall be a body corporate to be known as the Regional Health and Social Care Board.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Changes to legislation: *There are outstanding changes not yet made by the legislation.gov.uk editorial team to Health and Social Care (Reform) Act (Northern Ireland) 2009. Any changes that have already been made by the team appear in the content and are referenced with annotations. (See end of Document for details) View outstanding changes*

(2) Schedule 1 applies in relation to the Regional Board.

Commencement Information

I1 S. 7 wholly in operation at 1.4.2009; s. 7(2) in operation for certain purposes at Royal Assent see s. 34(2)(a); s. 7 in operation at 1.4.2009 insofar as not already in operation by S.R. 2009/114, **art. 2**

Functions of the Regional Board

8.—(1) The Regional Board shall exercise on behalf of the Department—

(a) such functions as are transferred to it by section 24; and

(b) such other functions of the Department (including functions imposed under an order of any court) with respect to the administration of health and social care as the Department may direct.

(2) The Regional Board must exercise its functions with the aim of—

(a) improving the performance of HSC trusts, by reference to such indicators of performance as the Department may direct; and

(b) establishing and maintaining effective systems—

(i) for managing the performance of HSC trusts;

(ii) for commissioning health and social care;

(iii) for ensuring that resources are used in the most economic, efficient and effective way in commissioning such care.

(3) The Regional Board must in respect of each financial year prepare and publish a document ("the commissioning plan") setting out such details as the Department may direct concerning—

(a) the health and social care which the Board is to commission in that year; and

(b) the costs to be incurred in that regard.

(4) The Regional Board—

(a) must, in drawing up the commissioning plan, consult the Regional Agency and have due regard to any advice or information provided by it; and

(b) must not publish a commissioning plan unless it has been approved by the Regional Agency.

(5) The functions mentioned in subsection (1)(a) and any function conferred on the Regional Board by any other statutory provision (whenever passed or made) are deemed to be functions which the Department has directed the Regional Board to exercise under subsection (1)(b).

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

***Changes to legislation:** There are outstanding changes not yet made by the legislation.gov.uk editorial team to Health and Social Care (Reform) Act (Northern Ireland) 2009. Any changes that have already been made by the team appear in the content and are referenced with annotations. (See end of Document for details) View outstanding changes*

(6) For the purposes of carrying out its functions the Regional Board may, on behalf of the Department, exercise the Department's general power under section 3**[**F2or its power under section 3A**]**.

(7) It is the duty of the Regional Board to carry out its functions in the manner which it considers is best calculated to discharge the Department's general duty under section 2(1).

(8) Subsections (6) and (7) apply subject to any directions given to the Regional Board by the Department under section 6.

Textual Amendments

F2 Words in s. 8(6) inserted (10.5.2012) by The Health Care (Reimbursement of the Cost of EEA Services etc.) Regulations (Northern Ireland) 2012 (S.R. 2012/167), regs. 1, **3(2)**

Local Commissioning Groups

9.—(1) The Regional Board shall in accordance with paragraph 7 of Schedule 1 appoint a prescribed number of committees to be called "Local Commissioning Groups".

(2) Each Local Commissioning Group shall exercise its functions as regards such area of Northern Ireland as may be prescribed.

(3) Each Local Commissioning Group shall exercise—

(a) such functions with respect to the commissioning of health and social care as may be prescribed; and

(b) such other functions as the Regional Board may, with the agreement of the Department, determine.

(4) Each Local Commissioning Group must—

(a) exercise its functions in accordance with any scheme for the time being having effect under Article 18 of the Order of 1972; and

(b) in connection with the exercise of its functions—

(i) work in collaboration with the Regional Agency and have due regard to any advice or information provided by it; and

(ii) undertake such consultation as the Department may direct.

(5) Each Local Commissioning Group must exercise its functions with the aim of—

(a) improving the health and social well-being of people in the area as regards which the Local Commissioning Group exercises its functions;

(b) planning and commissioning health and social care to meet the needs of people in that area;

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

***Changes to legislation:** There are outstanding changes not yet made by the legislation.gov.uk editorial team to Health and Social Care (Reform) Act (Northern Ireland) 2009. Any changes that have already been made by the team appear in the content and are referenced with annotations. (See end of Document for details) View outstanding changes*

(c) securing the delivery to people in that area of health and social care that is efficient, co-ordinated and cost-effective;

(d) improving the availability and quality of health and social care in that area.

(6) Regulations may—

(a) make provision for the membership of Local Commissioning Groups;

(b) modify the application of paragraphs 7 to 11 of Schedule 1 in relation to those Groups;

(c) make such further provision in relation to those Groups as the Department considers appropriate.

(7) Before making regulations under subsection (6), the Department must consult the Regional Board.

Commencement Information

I2 S. 9 wholly in operation at 1.4.2009; s. 9 in operation for certain purposes at Royal Assent see s. 34(2)(b); s. 9 in operation at 1.4.2009 insofar as not already in operation by S.R. 2009/114, **art. 2**

Power of Regional Board to give directions and guidance to HSC trusts

10.—(1) The Regional Board may give directions of a general or specific nature to an HSC trust as to the carrying out by that trust of any of its functions.

(2) The Regional Board may give guidance to an HSC trust as to the carrying out by that trust of any of its functions.

(3) The Regional Board must—

(a) consult the HSC trust concerned, and

(b) obtain the approval of the Department,

before giving any directions under subsection (1).

(4) Where the Regional Board is of the opinion that because of the urgency of the matter it is necessary to give directions under subsection (1) without consulting the HSC trust concerned—

(a) subsection (3)(a) does not apply; but

(b) the Regional Board must as soon as reasonably practicable give notice to the HSC trust concerned of the grounds on which the Regional Board formed that opinion.

(5) The Regional Board must not give any direction under subsection (1) or any guidance under subsection (2) that would be inconsistent with—

(a) the framework document; or

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

***Changes to legislation:** There are outstanding changes not yet made by the legislation.gov.uk editorial team to Health and Social Care (Reform) Act (Northern Ireland) 2009. Any changes that have already been made by the team appear in the content and are referenced with annotations. (See end of Document for details) View outstanding changes*

(b) any direction given to the HSC trust by the Department under paragraph 6 of Schedule 3 to the Health and Personal Social Services (Northern Ireland) Order 1991 (NI 1).

(6) It is the duty of an HSC trust—

(a) to comply with any directions given to it under subsection (1);

(b) to have regard to any guidance given to it under subsection (2).

(7) The Department may by regulations provide that this section is to apply, subject to such modifications as may be prescribed, in relation to any prescribed body exercising on behalf of the Regional Board such functions as may be prescribed.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Changes to legislation: *There are outstanding changes not yet made by the legislation.gov.uk editorial team to Health and Social Care (Reform) Act (Northern Ireland) 2009. Any changes that have already been made by the team appear in the content and are referenced with annotations. (See end of Document for details) View outstanding changes*

Health and Social Care (Reform) Act (Northern Ireland) 2009

2009 CHAPTER 1

An Act to make changes to the administrative structures for health and social care; and for connected purposes. [21st January 2009]

BE IT ENACTED by being passed by the Northern Ireland Assembly and assented to by Her Majesty as follows:BE IT ENACTED by being passed by the Northern Ireland Assembly and assented to by Her Majesty as follows:BE IT ENACTED by being passed by the Northern Ireland Assembly and assented to by Her Majesty as follows:

Modifications etc. (not altering text)

C1 Act excluded (1.4.2015) by Care Act 2014 (c. 23), s. 127, **Sch. 1 para. 1(4)** (with Sch.1 para. 814); S.I. 2015/993, art. 2(x)(i) (with transitional provisions in S.I. 2015/995)

C2 Act modified (1.4.2015) by Care Act 2014 (c. 23), s. 127, **Sch. 1 para. 4(1)(a)** (with Sch.1 para. 814); S.I. 2015/993, art. 2(x)(i) (with transitional provisions in S.I. 2015/995)

C3 Act excluded (1.4.2015) by Care Act 2014 (c. 23), s. 127, **Sch. 1 para. 3(3)** (with Sch.1 para. 814); S.I. 2015/993, art. 2(x)(i) (with transitional provisions in S.I. 2015/995)

C4 Act excluded (6.4.2016) by Care Act 2014 (c. 23), s. 127(1), **Sch. 1 para. 2(6)** (with Sch.1 paras. 8, 14); S.I. 2016/464, art. 2(c)

C5 Act excluded (6.4.2016) by Care Act 2014 (c. 23), s. 127(1), **Sch. 1 para. 2(7)(b)** (with Sch. 1 paras. 8, 14); S.I. 2016/464, art. 2(c)

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Changes to legislation: *There are outstanding changes not yet made by the legislation.gov.uk editorial team to Health and Social Care (Reform) Act (Northern Ireland) 2009. Any changes that have already been made by the team appear in the content and are referenced with annotations. (See end of Document for details) View outstanding changes*

The framework document

1.—(1) The Department shall prepare a document (in this Act referred to as "the framework document") setting out in relation to each health and social care body—

(a) the main priorities and objectives of the body in carrying out its functions and the process by which it is to determine further priorities and objectives;

(b) the matters for which the body is responsible;

(c) the manner in which the body is to discharge its functions and conduct its working relationship with—

(i) the Department, and

(ii) any other body specified in the document; and

(d) the arrangements for providing the Department with information to enable it to carry out its functions in relation to the body under section 2(3)(h) or (i).

(2) The framework document may contain—

(a) such guidance relating to the carrying out by each health and social care body of its functions, and

(b) such other material pertaining to the body or its functions,

as the Department considers appropriate.

(3) The Department—

(a) shall keep the framework document under review; and

(b) may from time to time revise it.

(4) The Department must carry out its duties under subsections (1) to (3) in the manner and to the extent that appear to it to be best calculated to promote—

(a) health and social care;

(b) the economy, efficiency and effectiveness of health and social care bodies; and

(c) economy, efficiency and effectiveness in connection with the matters in relation to which those bodies have functions.

(5) In preparing the framework document, or any revision of it which appears to the Department to be significant, the Department must consult—

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

***Changes to legislation:** There are outstanding changes not yet made by the legislation.gov.uk editorial team to Health and Social Care (Reform) Act (Northern Ireland) 2009. Any changes that have already been made by the team appear in the content and are referenced with annotations. (See end of Document for details) View outstanding changes*

(a) each health and social care body as respects its functions (or persons considered by the Department to represent that body); and

(b) any other bodies or persons the Department considers appropriate.

(6) Each health and social care body shall have regard to the framework document in carrying out its functions.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

From: Ruth Fisher
Secondary Care Directorate

Date: 23 April 2009

Dr Miriam McCarthy (Agreed 29/4/09)
Michael McGimpsey

Summary

Issue:	**A regional review of Adult Urology Services was undertaken in response to service concerns regarding the ability to manage growing demand, meet cancer and elective waiting times, maintain quality standards and provide high quality elective and emergency services.**
Timing:	**Routine**
Presentational Issues:	**Likely to attract media and public interest.**
FoI Implications:	**Disclosable**
Financial Implications:	**To implement the review recommendations a recurrent (full year) investment of £3m has been estimated. This amount has been identified by the HSC Board, as a first call on available recurrent funding to address elective and access issues.**
Special Advisor's Comments:	**[To be provided]**

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Recommendation:	**That you note the attached review document and agree to the Health and Social Care Board conducting a public consultation on the report and its recommendations.**

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Background

1. A regional review of Adult Urology Services was undertaken in response to service concerns regarding the ability to manage growing demand, meet cancer and elective waiting times, maintain quality standards and provide high quality elective and emergency services.

2. The speciality of Urology predominantly covers the assessment, diagnosis and treatment of urogenital conditions involving diseases of the kidney, bladder, prostate, penis, testis and scrotum. Bladder dysfunction, male and female continence surgery and paediatric peno-scrotal conditions make up the rest.

3. Thirty years ago the field of Urology was one of the many that was the province of the general surgeon. Since that time, Urology has developed and evolved as a separate surgical specialty. Higher specialist training in General Surgery no longer covers Urology, which now has its own training programme.

4. A Review of Adult Urology Services in Northern Ireland was completed in March 2009. The Terms of Reference of the Review Group and a summary of its Recommendations are attached at **TAB A.** The Review Group was chaired by Mr Hugh Mullen, HSB Board and the Department was represented by Dr Miriam McCarthy. Hugh Mullen has submitted the report to the Department for your consideration.

Current Service and Key Challenges

5. Consultant led Adult Urology Services are provided in each of the five Trusts. The number of consultants, specialist nurses and main hospital bases is set out in the table below.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Consultant/Nurse Staffing and Inpatient Units

	Northern	Southern	South Eastern	Western	Belfast	Total
Consultants	3	3	2	2	7	17
Specialist Nurses	3	2	1	3 (2.6 WTE)	3	12 (11.6 WTE)
Hospital Base	Causeway	Craigavon	Ulster	Altnagelvin	BCH/ Mater	

6. Additional sites within each Trust provide a range of Outpatient and Day Surgical Services.

Current Service Challenges

7. Key challenges currently being faced by the service relate to the increased demand on urology services; the capacity to deliver a modern, quality service; the ability to achieve and sustain long term stability and the development of a stable workforce that can continue to attract the necessary expertise across all of the professions.

8 Over the past few years urology has been one of the main service areas which has required significant input from the independent sector to meet and maintain waiting time targets for elective access.

9 In 2008/09, additional urology activity to meet waiting time targets cost in the region of £5m, of which £4m was spent in the independent sector. The recommendations of the Urology Review would improve capacity and provide much more sustainable and value for money services, in due course virtually eliminating the need to seek services from independent sector providers.

10 The workforce is currently struggling to cope with the increased workload but reliance on the independent sector is not considered sustainable in the longer term.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

11 A number of small urology teams (ie comprising 2 or 3 consultants) exist, particularly outside Belfast, and this creates on call pressures and potentially also creates difficulties in the recruitment and retention of staff.

12 A further challenge is the ability of urology services to meet quality standards for cancer care as set out in the Improving Outcomes Guidance (IOG). To do so it will be necessary to concentrate the complex cancer surgery on 1 site, and to ensure that consultants undertake a minimum number of procedures to maintain specialist skills and expertise.

Recommendations

13 The review report makes a number of recommendations aimed at improving capacity and sustainability of urology services. A full list of the recommendations is attached at Tab C.

14 Throughout the review process there was acceptance that additional investment in urology services was necessary but that this alone was not sufficient. However, Review Group Members were of the view that coupled with better use of existing resources and service modernisation additional investment would secure sustainable services in the longer term.

15 Some key elements of a proposed service expansion and redesign include:

- The number of consultant urologists should be increased to 23 (from current level of 17).

- All radical pelvic surgery should be undertaken at a single site, in BCH by a specialist team of surgeons.

- At least 5 clinical nurse specialists should be employed.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

- Increasing the proportion of elective operations undertaken as day cases – currently ranging from 30-70%.

- Urology services should be reconfigured into a 3 team model covering northern, southern and eastern areas respectively.

Consultation

16 In light of the recommendations regarding the service expansion and redesign we are of the view that the report of the review group will require to be issued for public consultation. We recommend that the HSC Board should be asked to lead on the consultation and to advise you of its outcome following completion.

Financial Issues

17 As indicated, some £5m was spent in 2008/09 on additional activity to achieve elective care targets. To achieve sustainable high quality services and to decrease dependence on the independent sector, the HSC Board has estimated that some £3.2 million will be needed on a recurrent basis – and this amount has been identified as a priority expenditure against available recurrent funding from within the existing Board baseline to address the elective access issues.

18 We are aware that the HSC Board is keen to allocate additional resources to urology services as early as possible in the current financial year. In this context we ask that you agree to the Board issuing the Review of Urology Services in Northern Ireland at the earliest opportunity.

19 As the Board is keen to progress service developments in urology as quickly as possible it would be helpful if, pending the outcome of consultation, the Board was in a position to provide some initial recurrent funding to address the most acute service pressures. In this context you may wish, in approving the document for consultation, to announce some additional investment for 2009/10 to enhance service capacity. This will

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

help to make some inroad into the £5m non-recurrent investment which would otherwise be required in 2009/10.

20 This is one example of recurrent investment needed to meet the increasing demands for elective care services and the financial implications of such further investments (eg in cardiac and orthopaedic specialties) will be included in a separate submission in the near future.

Equality Issues

21 We have undertaken an equality screen on the report and are of the view that the recommendations would not disproportionately impact on any Section 75 group. It will also create a positive story against CSR efficiencies and loss of nurses jobs.

Presentational Issues

22 The publication of the Review of Urology is likely to attract media and public interest. Given the recommendations for considerable investment in urology services the review will be welcomed by service providers, clinicians; and patient groups.

23 You may wish to issue a press release to coincide with the Boards launch of the review. If you are content, we will draft this in conjunction with the Information Office.

Advice and Recommendation

24 It is recommended that you note this briefing and agree to the HSC Board issuing the Review of Urology Services for public consultation.

Ruth Fisher

Regional Services Unit

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Extension Personal Information redacted by

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

TAB A

SUMMARY OF RECOMMENDATIONS

Introduction and Context

1. Unless Urological procedures (particularly operative 'M' code) constitute a substantial proportion of a surgeon's practice, (s)he should cease undertaking any such procedures. Any Surgeon continuing to provide such Urology services should do so within a formal link to a Urology Unit/Team.

2. Trusts should plan and consider the implications of any impending retirements in General Surgery, particularly with regard to the transfer of "N" Code work and the associated resources to the Urology Team.

3. A separate review of urinary continence services should be undertaken, with a view to developing an integrated service model in line with NICE Guidance.

Current Service Profile

4. Trusts must review the process for internal Consultant to Consultant referrals to Urology to ensure that there are no undue delays in the system.

5. Northern Ireland Cancer Network (NICaN) Urology Group in conjunction with Urology Teams and Primary Care should develop and implement (by September 2009) agreed referral guidelines and pathways for suspected Urological Cancers.

6. Deployment of new Consultant posts (both vacancies and additional posts arising from this review) should take into account areas of special interest that are deemed to be required in the service configuration model.

7. Urologists, in collaboration with General Surgery and A&E colleagues, should develop and implement clear protocols and care pathways for Urology patients requiring admission to an acute hospital which does not have an acute Urology Unit.

8. Urologists, in collaboration with A&E colleagues, should develop and implement protocols/care pathways for those patients requiring direct transfer and admission to an acute Urology Unit.

9. Trusts should ensure arrangements are in place to proactively manage and provide equitable care to those patients admitted under General Surgery in hospitals without Urology Units (e.g. Antrim, Daisy Hill, Erne). Arrangements should include 7 day week notification of admissions to the

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

appropriate Urology Unit and provision of urology advice/care by telephone, electronically or in person, also 7 days a week.

10. In undertaking the ICATS review, there must be full engagement with secondary care Urology teams, current ICATS teams, as well as General Practitioners and LCGs. In considering areas of Urology suitable for further development they should look towards erectile dysfunction, benign prostatic disease, LUTS and continence services. The review should also take into account developments elsewhere within the UK and in particular developments within PCTs in relation to shifting care closer to home.

Capacity, Demand and Activity

11. Trusts (Urology departments) will be required to evidence (in their implementation plans) delivery of the key elements of the Elective Reform Programme.

Performance Measures

12. Trust Urology Teams must as a matter of urgency redesign and enhance capacity to provide single visit outpatient and assessment (diagnostic) services for suspected urological cancer patients.

13. Trusts should implement the key elements of the elective reform programme with regard to admission on the day of surgery, pre-operative assessment and increasing day surgery rates.

14. Trusts should participate in a benchmarking exercise of a set number of elective (procedure codes) and non-elective (diagnostic codes) patients by Consultant and by hospital with a view to agreeing a target length of stay for these groups of patients.

15. Trusts will be required to include in their implementation plans, an action plan for increasing the percentage of elective operations undertaken as day surgery, redesigning their day surgery theatre facilities and should work with Urology Team in other Trusts to agree procedures for which day care will be the norm for elective surgery.

16. Trusts should review their outpatient review practice, redesign other methods/staff (telephone follow-up/nurse) where appropriate and subject to casemix/complexity issues reduce new: review ratios to the level of peer colleagues.

17. Trusts must modernise and redesign outpatient clinic templates and admin/booking processes to ensure they maximise their capacity for new and review patients and to prevent backlogs occurring in the future.

Urological Cancers

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

18. The NICaN Group in conjunction with each Trust and Commissioners should develop and implement a clear action plan with timelines for the implementation of the new arrangements/enhanced services in working towards compliance with IOG.

19. By March 2010, at the latest, all radical pelvic surgery should be undertaken on a single site, in BCH, by a specialist team of surgeons. The transfer of this work should be phased to enable BCH to appoint appropriate staff and ensure infrastructure and systems are in place. A phased implementation plan should be agreed with all parties.

20. Trusts should ensure that surgeons carrying out small numbers (<5 per annum) of either radical pelvic operation, make arrangements to pass this work on to more specialised colleagues, as soon as is practicably possible, (whilst a single site service is being established).

Clinical Workforce Requirements

21. To deliver the level of activity from 2008/09 and address the issues around casemix and complexity it is recommended that the number of Consultant Urologists is increased to 23 wte.

22. Urology Teams must ensure that current capacity is optimised to deliver the number FCEs by Consultant as per BAUS guidelines (subject to casemix and complexity). This may require access to additional operating sessions up to at least 4 per week (42 weeks per year) and an amendment to job plans.

23. At least 5 Clinical Nurse Specialists (cancer) should be appointed (and trained). The deployment of these staff within particular teams will need to be decided and Trusts will be required to develop detailed job plans with caseload, activity and measurable outcomes agreed prior to implementation. A further review and benchmarking of cancer CNS's should be undertaken in mid 2010.

Service Configuration Model

24. Urology services in Northern Ireland should be reconfigured into a 3 team model, to achieve long term stability and viability.

25. Teams North and East (Northern, Western, Belfast and South Eastern Trusts) should ensure that prior to the creation of the new Teams, there are clear, unambiguous and agreed arrangements in place with regard to Consultant on-call and out of hours arrangements.

26. Each Trust must work in partnership with the other Trust/s within the new team structure to determine and agree the new arrangements for service delivery, including inter alia, governance, employment and contractual arrangements for clinical staff, locations, frequency and prioritisation of

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

outreach services, areas of Consultant specialist interest based on capacity and expertise required and catchment populations to be served.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

TAB B

Regional Review of Urology Services

Terms of Reference

Overall Purpose

To develop a modern, fit for purpose in the 21st century, reformed service model for Adult Urology services which takes account of relevant Guidelines (NICE, Good Practice, Royal College, BAUS, BAUN). The future model should ensure quality services are provided in the right place, at the right time by the most appropriate clinician, through the entire pathway from Primary Care to Intermediate to Secondary and Tertiary Care.

It is anticipated that the Review Report will be available for submission to the Department in December 08, subject to Steering Group approval. A multi-disciplinary, key stakeholder Steering Group, chaired by Mr Hugh Mullen will meet to consider and approve the review findings and proposals.

The Review will include the following;

1. Baseline assessment of current service model identifying what is provided where, by whom, performance against access standards and the current profile of investment.

2. Expand on the current capacity/demand modelling exercise to take account of case mix with a view to identifying capacity gaps and informing future investment plans.

3. Develop a service model with agreed patient pathways which informs the distribution of services. The model will also outline proposals for optimising safe, effective and efficient Urology services which meet both access and quality standards/outcomes. The following aspects of the service will be considered;

    - Management of referrals and diagnostics including urodynamics.
    - Development and use of ICATS services
    - Management of acute urological admissions
    - Core Urology (secondary care) Services
    - Andrology Services
    - Interventional Uro-Radiology
    - Endourology/Stone Service
    - Uro-oncology Services
    - Relationship with Uro-gynaecology Services
    - Reconstruction and Neurourology Service
    - Acute Urological management of nephrology patient

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

4. Make recommendations, as appropriate, on the relationship with the Transplant service and waiting time targets for live donor transplantations.

5. Review workforce planning and training / development needs of the service group and ensure any proposals take account of the need to comply with EWTD (European Working Time Directive.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

TAB C

Model 3: Three Teams/Networks

Team North and West:	• Upper 2/3rds of Northern and Western integrate to form one Team/Network • Main base Hospital - Altnagelvin • Potential for small number of inpatient beds in Causeway Hospital to be used for selected elective work subject to satisfactory arrangements for the post-operative management of these patients
Team South and West:	• Lower 1/3rd of Western (Fermanagh) and all of Southern integrate to form one Team/Network • Main base Hospital – Craigavon
Team East:	• SET and Belfast integrate to form one Team/Network • Continue to provide services to the southern sector of Northern population by outreach – Outpatient/Diagnostics/Day Surgery in Antrim and Whiteabbey hospitals with inpatients going to Belfast

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Elements and Arrangements in Three Team Model

Teams	Geographical Area/ Catchment Population	Consultant Staffing/Suggested Special Interest Areas**	Arrangements for Elective and Non Elective Services
Team North & West	Upper2/3rd of Northern* and Western integrate to form one Team/Network. Catchment population circa 480,000	Six wte All core Urology Uro-oncology – 2 Stones/endourology – 2* Functional/female Urology – 1 Andrology – 1	One on-call rota (1:6) Main acute elective and non elective inpatient unit in Altnagelvin Approximately 7 elective beds in Causeway(Selected minor/intermediate cases) Day surgery – Altnagelvin, Causeway, Tyrone County Outpatients – Altnagelvin, Causeway, Tyrone County, Roe Valley May wish to consider outreach outpatient and/or day case diagnostics in Mid-Ulster *Mobile ESWL (Lithotripter) on Causeway site
Team South & West	Lower 1/3rd Western (Fermanagh) and all of Southern integrate to form one Team/Network. Catchment population circa 410,000	Five wte All core Urology Uro-oncology – 2 Stones/endourology – 2* Functional/female Urology – 1	One on-call rota (1:5) Main acute elective and non elective inpatient unit in Craigavon Day surgery – Craigavon, South Tyrone, Daisy Hill Outpatients – Craigavon, South Tyrone, Daisy Hill, Banbridge, Armagh May wish to consider outreach outpatients and/or day case diagnostics in Erne/ Enniskillen *Static/fixed ESWL (lithotripter) on Craigavon site.
Team East	SET + Belfast integrate to form one Team/Network- continue to provide service to patients from Southern sector of Northern Trust (Newtownabbey, Carrickfergus, Larne, ?Antrim). Catchment population circa 870,000 Complex cancer catchment 1.76m	Twelve Wte All core Urology Uro-oncology/cancer centre – 4 Stones/endourology – 3* Functional/female Urology – 2 Reconstruction – 3	One on-call rota (1:12) (may wish to consider 2nd tier on-call) Main acute elective and non elective unit in BCH, with elective also in Mater and Ulster Day surgery – BCH, Mater, Lagan Valley, Ards, Downe Outpatients – BCH, Ulster, Mater, Royal, MPH, Ards, Lagan Valley, Downe Should provide outreach outpatient, day case diagnostics and day surgery in Antrim and/or Whiteabbey/Larne *Mobile ESWL lithotripter on

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

			BCH site.

*Population estimates for local District Council areas in Appendix 10 of Report. Precise catchment ‘lines’ on map to be clarified.
** Suggested special interest areas derived from discussions with clinicians and from BAUS guidelines.

From the Director of Performance and Provider Development

Joanne. Can you arrange to scan onto him please.

Department of
Health, Social Services and Public Safety
www.dhsspsni.gov.uk

AN ROINN
Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí

MÄNNYSTRIE O
Poustie, Resydènter Heisin an Fowk Siccar

Service Delivery Unit
Templeton House
411 Holywood Road
BELFAST BT4 2LP
Tel: Personal Information redacted by the USI
Fax:
Email: Personal Information redacted by the USI

Seamus McGoran, South Eastern HSS Trust
Joy Youart, Southern HSS Trust
Margaret Kelly, Western HSS Trust
Catherine Hinton, Northern HSS Trust
Jennifer Welch, Belfast HSS Trust
Anne Lynch, EHSSB
Iain Deboys, NHSSB
Aldrina Magwood, SHSSB
Bill McConnell, WHSSB

Our Ref: HM226
Date: 02 June 2008

Dear Colleagues

Regional Review of Urology Services

Further to discussion at the Chief Executive and the Performance meetings, I am pleased to confirm that SDU have initiated the above review. In overall terms the review will take account of the Commissioners capacity/demand modelling exercise currently being finalised and will consider the entire pathway from Primary Care to Secondary and if required Tertiary Care. Draft Terms of Reference are currently being finalised and will be shared and discussed with the relevant service groups in the HSC. Catherine McNicholl will be undertaking the review with support from Paul Cunningham.

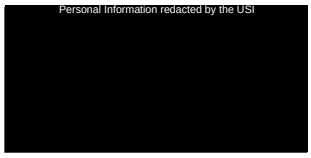
Catherine would welcome the opportunity to meet with the relevant service teams on an informal basis and I would be grateful if you would let her know how best to organise this within your Trust. The meeting will enable her to introduce herself to the key clinicians and managers involved in the provision of urology services, provide an opportunity for discussion on the draft TOR, give her an insight into the current services provided and provide your organisation with the opportunity to identify the strengths and weaknesses of the current system and suggest and discuss future service models.

As I would like Catherine to have visited all Trusts by end June I would appreciate you coming back to me or her as soon as you can with proposals for a date and time to meet. We will be flexible about the time so as to accommodate the time pressures of your staff. It would be useful if you could also let me know who will be present from your Trust. Depending on availability I may join her.

I look forward to hearing from you.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Yours sincerely



HUGH MULLEN
Director of Performance and Provider Development
Service Delivery Unit

cc: Catherine McNicholl
Dean Sullivan
Michael Bloomfield
Paul Cunningham
Dr Hubert Curran
Dr Miriam McCarthy
Dr Andrew McCormick
David Galloway

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

McNaughton, Margaret Rose

From: Galloway, David
Sent: 02 June 2008 16:25
To: McNaughton, Margaret Rose
Subject: FW: Regional Review of Urology Services

Can we discuss

dg

From: McCarthy, Miriam
Sent: 02 June 2008 16:14
To: Mullen, Hugh
Cc: Sullivan, Dean; Bloomfield, Michael; McCormick, Andrew; Galloway, David
Subject: RE: Regional Review of Urology Services

Hugh,

This is an important area from a policy perspective and I know we had discussed and agreed some time ago the principle of conducting a review. I think it would be important for the Secondary Care Directorate to be represented on the review group and would be grateful if you could seek a nominee from David Galloway.

May I also suggest that, in light of the medical workforce issues, you may wish to involve Paddy Woods in this work

Many thanks. Happy to discuss

Miriam

-----Original Message-----
From: Mills, Ursula
Sent: 02 June 2008 13:52
To: 'McGoran, Seamus'; joy.youart[redacted] 'Margaret.Kelly[redacted] Hinton, Catherine; Welsh, Jennifer; [redacted] 'iain.deboys[redacted] 'Aldrina Magwood'; [redacted]
Cc: Mullen, Hugh; McNicholl, Catherine; Sullivan, Dean; Bloomfield, Michael; Cunningham, Paul; Curran, Hubert; McCarthy, Miriam; McCormick, Andrew; Galloway, David
Subject: Regional Review of Urology Services

Dear all

Please see attached letter sent on behalf of Hugh Mullen.

Many thanks

Ursula

<< File: HM226 -Regional Review of Urology Services.doc >>

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Appendix 1

Regional Urology Steering Group

Membership

Mr Hugh Mullen (Chair)	SDU, Director of Performance and Provider Development
Mr Mark Fordham	External Advisor, Consultant Urologist
Ms Catherine McNicholl	SDU, Programme Director (Project Manager)
Mr Paul Cunningham	SDU, Performance Manager
Dr Hubert Curran	SDU, Primary Care Advisor
Dr Windsor Murdock	SDU, Primary Care Advisor
Dr Miriam McCarthy	DHSS&PS, Director Secondary Care
Dr Dermot Hughes	NICaN, Medical Director
Mr Patrick Keane	Belfast Trust, Lead Clinician NICaN Urology Group
Dr Diane Corrigan	SHSSB, Consultant Public Health
Dr Janet Little	EHSSB, Acting Director Public Health
Dr Christine McMaster	EHSSB, Specialist Registrar, Public Health
Dr Adrian Mairs	NHSSB, Consultant Public Health
Mr Alan Marsden	NHSSB, Elective Care Commissioning Manager.
Dr Bill McConnell	WHSSB, Director Public Health
Mrs Rosa McCandless	WHSSB, Information Manager
Mrs Karen Hargan	Western Trust, Assistant Director Surgery/Acute Services
Mr Colin Mulholland	Western Trust, Consultant Urologist
Ms Carmel Leonard	Western Trust, Lead Nurse Surgery
Mr Paul Downey	Northern Trust, Consultant Urologist
Mr Martin Sloan	Northern Trust, Director Elective and

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

	Acute Services
Dr Brian Armstrong	Belfast Trust, Co-Director Specialist Services
Mr Chris Hagan	Belfast Trust, Consultant Urologist
Mr Brian Duggan	Belfast Trust, Consultant Urologist
Mr Brian Best	South Eastern Trust, Consultant Urologist
Mr John McKnight	South Eastern Trust, Consultant Urologist
Mrs Diane Keown	South Eastern Trust, Assistant Director Surgery.
Ms Joy Youart	Southern Trust, Acting Director Acute Services
Mr Michael Young	Southern Trust, Consultant Urologist
Mrs Jenny McMahon	Southern Trust, Nurse Specialist.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Appendix 2

Regional Review of Adult Urology Services

Terms of Reference

Overall Purpose

To develop a modern, fit for purpose in the 21st century, reformed service model for Adult Urology services which takes account of relevant Guidelines (NICE, Good Practice, Royal College, BAUS, BAUN). The future model should ensure quality services are provided in the right place, at the right time by the most appropriate clinician, through the entire pathway from Primary Care to Intermediate to Secondary and Tertiary Care.

It is anticipated that the Review Report will be available for submission to the Department in December 08, subject to Steering Group approval. A multi-disciplinary, key stakeholder Steering Group, chaired by Mr Hugh Mullen will meet to consider and approve the review findings and proposals.

The Review will include the following;

1. Baseline assessment of current service model identifying what is provided where, by whom, performance against access standards and the current profile of investment.

2. Expand on the current capacity/demand modelling exercise to take account of case mix with a view to identifying capacity gaps and informing future investment plans.

3. Develop a service model with agreed patient pathways which informs the distribution of services. The model will also outline proposals for optimising safe, effective and efficient Urology services which meet both access and quality standards/outcomes. The following aspects of the service will be considered;

    - Management of referrals and diagnostics including urodynamics.
    - Development and use of ICATS services
    - Management of acute urological admissions
    - Core Urology (secondary care) Services
    - Andrology Services
    - Interventional Uro-Radiology
    - Endourology/Stone Service
    - Uro-oncology Services
    - Relationship with Uro-gynaecology Services
    - Reconstruction and Neurourology Service
    - Acute Urological management of nephrology patient

4. Make recommendations, as appropriate, on the relationship with the Transplant service and waiting time targets for live donor transplantations.

5. Review workforce planning and training / development needs of the service group and ensure any proposals take account of the need to comply with EWTD (European Working Time Directive.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Health and Social Care Board

Review of Adult Urology Services in Northern Ireland

A modernisation and investment plan

March 2009

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Ministerial Foreword

The health service in Northern Ireland has been able to make remarkable progress in improving access to services and sustaining the quality of those services. That work, as part of the current programme of modernisation and reform of health and social care services is ensuring that many more patients are gaining timely access to the services they need than was the case only a few short years ago. I am determined that this progress should continue.

However, whilst reducing waiting times generally there have been some concerns about the capability of our urology services as they are currently arranged, to continue to deliver care of the highest standard while striving to meet increasing demand. The capacity within the HSC to deal with an increasing demand for urology services was the principal reason why this review was commissioned.

The review considers workforce planning, training and development needs and future resourcing and proposes a model of service delivery which I am confident will produce a reformed service fit for purpose, with high quality services provided in the right place at the right time by appropriately trained and skilled staff.

Ensuring that the patients who need our health and social care services remain at the centre of everything we do is of course a fundamental step of developing and improving service provision. I hope that many of you, especially those with experience of the service, will respond with comments and suggestions which will inform the future development of this important
Speciality.



Michael McGimpsey
Minister for Health, Social Services and Public Safety

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Index

		Pages
1.	Summary of recommendations	5 - 6
2.	Introduction and Context	8 - 10
3.	Current Service profile	12 – 21
4.	Capacity, Demand and Activity	22 - 25
5.	Performance Measures	25 - 33
6.	Challenges and Opportunities	34 - 35
7.	Urological Cancers	36 - 39
8.	Clinical Workforce requirements	40 - 44
9.	Service Configuration Model	45 - 47
10.	Implementation Issues	48
Glossary of Terms/Abbreviations		49 - 52

Appendices

Appendix 1	Regional Review of Adult Urology Services – Steering Group Membership
Appendix 2	Regional Review of Adult Urology Services – Terms of Reference
Appendix 3	Urology Reports/Reviews
Appendix 4	Analysis of Urology Referral Letters (numbers)
Appendix 5	Analysis of presenting symptoms/conditions (numbers)
Appendix 6	NICE – Improving outcomes in Urological Cancers (IOG) - Key recommendations
Appendix 7	Estimated Cost of Implementing Recommendations
Appendix 8	Evaluation Criteria
Appendix 9	Model 3: Three Teams/Networks
Appendix 10	Mid-year population estimates 2007

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Tables

Table 1	Analysis of 'N' Code (Male Genital) Surgical Operations and Procedures Undertaken by Urologists and General Surgeons (2007/08)
Table 2	Consultant/Nurse Staffing and Inpatient Units
Table 3	Catchment populations served by each Trust
Table 4	Analysis of Urology Referral Letters (%)
Table 5	Analysis of presenting symptoms/conditions (%)
Table 6	Urology ICATS - Current Position
Table 7	Urology – Service and Budget Agreement Levels and Activity
Table 8	Urology Episodic Average Length of Stay
Table 9	Urology Day Surgery Rates
Table 10	Urology Outpatient Attendance New: Review Rates
Table 11	Radical Pelvic Surgery 2006/07
Table 12	Radical Pelvic Surgery 2007/08
Table 13	Clinical Nurse Specialist caseload benchmarking data
Table 14	Elements and Arrangements in Three Team Model

Figures

Figure 1	Demography – 65+ years projected increases by current HSS Board
Figure 2	Northern Ireland Urology Services – Inpatient Services
Figure 3	Northern Ireland Urology Services – Outpatients, Day Surgery
Figure 4	Urology waiting list position March 2007 – February 2009 (Outpatients)
Figure 5	Urology waiting list position March 2007 – February 2009 (Inpatients/Daycases)
Figure 6	Urology Cancer Performance – 62-day completed waits
Figure 7	Urology Cancer Performance – 31-day completed waits
Figure 8	Urology Inter Trust Transfer Patient Breaches – July 2008 – January 2009
Figure 9	Urological Cancer – 14-Day Current waits for suspected cancers
Figure 10	Urological Cancer Incidence (NI) 1993 – 2011
Figure 11	Urological Cancer Deaths (NI) 1993 – 2011

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

1. SUMMARY OF RECOMMENDATIONS

Section 2 – Introduction and Context

For the purposes of this review all Urology services and Urological related procedures should be taken in the context of Adult Urology only.

1. Unless Urological procedures (particularly operative 'M' code) constitute a substantial proportion of a surgeon's practice, (s)he should cease undertaking any such procedures. Any Surgeon continuing to provide such Urology services should do so within a formal link to a Urology Unit/Team.

2. Trusts should plan and consider the implications of any impending retirements in General Surgery, particularly with regard to the transfer of "N" Code work and the associated resources to the Urology Team.

3. A separate review of urinary continence services should be undertaken, with a view to developing an integrated service model in line with NICE Guidance.

Section 3 – Current Service Profile

4. Trusts must review the process for internal Consultant to Consultant referrals to Urology to ensure that there are no undue delays in the system.

5. Northern Ireland Cancer Network (NICaN) Urology Group in conjunction with Urology Teams and Primary Care should develop and implement (by September 2009) agreed referral guidelines and pathways for suspected Urological Cancers.

6. Deployment of new Consultant posts (both vacancies and additional posts arising from this review) should take into account areas of special interest that are deemed to be required in the service configuration model.

7. Urologists, in collaboration with General Surgery and A&E colleagues, should develop and implement clear protocols and care pathways for Urology patients requiring admission to an acute hospital which does not have an acute Urology Unit.

8. Urologists, in collaboration with A&E colleagues, should develop and implement protocols/care pathways for those patients requiring direct transfer and admission to an acute Urology Unit.

9. Trusts should ensure arrangements are in place to proactively manage and provide equitable care to those patients admitted under General Surgery in hospitals without Urology Units (e.g. Antrim, Daisy Hill, Erne). Arrangements should include 7 day week notification of admissions to the appropriate Urology Unit and provision of urology advice/care by telephone, electronically or in person, also 7 days a week.

10. In undertaking the ICATS review, there must be full engagement with secondary care Urology teams, current ICATS teams, as well as General Practitioners and LCGs. In considering areas of Urology suitable for further development they should look towards erectile dysfunction, benign prostatic disease, LUTS and continence services. The review should also take into account developments elsewhere within

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

the UK and in particular developments within PCTs in relation to shifting care closer to home.

Section 4 – Capacity, Demand and Activity

11. Trusts (Urology departments) will be required to evidence (in their implementation plans) delivery of the key elements of the Elective Reform Programme.

Section 5 – Performance Measures

12. Trust Urology Teams must as a matter of urgency redesign and enhance capacity to provide single visit outpatient and assessment (diagnostic) services for suspected urological cancer patients.

13. Trusts should implement the key elements of the elective reform programme with regard to admission on the day of surgery, pre-operative assessment and increasing day surgery rates.

14. Trusts should participate in a benchmarking exercise of a set number of elective (procedure codes) and non-elective (diagnostic codes) patients by Consultant and by hospital with a view to agreeing a target length of stay for these groups of patients.

15. Trusts will be required to include in their implementation plans, an action plan for increasing the percentage of elective operations undertaken as day surgery, redesigning their day surgery theatre facilities and should work with Urology Team in other Trusts to agree procedures for which day care will be the norm for elective surgery.

16. Trusts should review their outpatient review practice, redesign other methods/staff (telephone follow-up/nurse) where appropriate and subject to casemix/complexity issues reduce new:review ratios to the level of peer colleagues.

17. Trusts must modernise and redesign outpatient clinic templates and admin/booking processes to ensure they maximise their capacity for new and review patients and to prevent backlogs occurring in the future.

Section 7 – Urological Cancers

18. The NICaN Group in conjunction with each Trust and Commissioners should develop and implement a clear action plan with timelines for the implementation of the new arrangements/enhanced services in working towards compliance with IOG.

19. By March 2010, at the latest, all radical pelvic surgery should be undertaken on a single site, in BCH, by a specialist team of surgeons. The transfer of this work should be phased to enable BCH to appoint appropriate staff and ensure infrastructure and systems are in place. A phased implementation plan should be agreed with all parties.

20. Trusts should ensure that surgeons carrying out small numbers (<5 per annum) of either radical pelvic operation, make arrangements to pass this work on to more

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

specialised colleagues, as soon as is practicably possible, (whilst a single site service is being established).

Section 8 – Clinical Workforce Requirements

21. To deliver the level of activity from 2008/09 and address the issues around casemix and complexity it is recommended that the number of Consultant Urologists is increased to 23 wte.

22. Urology Teams must ensure that current capacity is optimised to deliver the number FCEs by Consultant as per BAUS guidelines (subject to casemix and complexity). This may require access to additional operating sessions up to at least 4 per week (42 weeks per year) and an amendment to job plans.

23. At least 5 Clinical Nurse Specialists (cancer) should be appointed (and trained). The deployment of these staff within particular teams will need to be decided and Trusts will be required to develop detailed job plans with caseload, activity and measurable outcomes agreed prior to implementation. A further review and benchmarking of cancer CNS's should be undertaken in mid 2010.

Section 9 – Service Configuration Model

24. Urology services in Northern Ireland should be reconfigured into a 3 team model, to achieve long term stability and viability.

25. Teams North and East (Northern, Western, Belfast and South Eastern Trusts) should ensure that prior to the creation of the new Teams, there are clear, unambiguous and agreed arrangements in place with regard to Consultant on-call and out of hours arrangements.

26. Each Trust must work in partnership with the other Trust/s within the new team structure to determine and agree the new arrangements for service delivery, including inter alia, governance, employment and contractual arrangements for clinical staff, locations, frequency and prioritisation of outreach services, areas of Consultant specialist interest based on capacity and expertise required and catchment populations to be served.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

2. INTRODUCTION AND CONTEXT

Introduction

2.1 A regional review of Adult Urology Services was undertaken in response to service concerns regarding the ability to manage growing demand, meet Cancer and elective waiting times, maintain quality standards and provide high quality elective and emergency services.

2.2 A multi-disciplinary and multi-organisational Steering Group was established under the Chairmanship of Mr H. Mullen, Director of Performance and Provider Development and this group met on five occasions between September 2008-March 2009. Membership of the group is included in Appendix 1.

2.3 An External Advisor, Mr Mark Fordham, a Consultant Urologist, Royal Liverpool and Broadgreen University Hospital Trust, was appointed and attended all Steering Group meetings and a number of other sub group sessions.

2.4 Terms of Reference were agreed (Appendix 2), with the overall purpose of the review being to;

Develop a modern, fit for purpose in 21century, reformed service model for Adult Urology Services which takes account of relevant guidelines (NICE, Good Practice, Royal College, BAUS, BAUN). The future model should ensure quality services are provided in the right place, at the right time by the most appropriate clinician through the entire pathway from primary care to intermediate to secondary and tertiary care.

2.5 A literature search of guidance and policy documents was undertaken. This included consideration of reports on previous reviews in Northern Ireland. A list of the key documents considered during this review is included as Appendix 3. Sections in italics within this report are direct quotes from these documents.

2.6 During the course of the review, a significant number of discussion papers, detailed information and datasets were collated, copies of which are not included in this report but are available on request.

Context

2.7 The speciality of Urology predominately covers the assessment, diagnosis and treatment of Urogenital Conditions involving diseases of the Kidney, Bladder, Prostate, Penis, Testis and Scrotum. Bladder dysfunction, Male and Female Continence Surgery and Paediatric Peno-Scrotal Conditions make up the rest.

2.8 Thirty years ago the field of Urology was one of the many that was the province of the General Surgeon. Since that time, Urology has developed and evolved as a separate surgical specialty. Higher specialist training in General Surgery no longer covers Urology, which now has its own training programme.

2.9 Prior to 1992, fully trained dedicated Urologists were based only at the Belfast City (BCH) and Royal Victoria (RVH) Hospitals providing a unified service to these two sites and a referral service for the rest of Northern Ireland. In 1992, Urologists were

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

appointed at Craigavon, Mater and Altnagelvin Hospitals. By 1999 there were ten full time Urologists in post, providing services on the above sites along with Lagan Valley and Coleraine Hospitals. In addition to these ten Urologists, there were two Consultant General Surgeons (one based in Mater, one based in Ulster) who were accredited as Urologists and whose workload was increasingly in the field of Urology. Since 2002, further appointments were made in the Belfast Hospitals, Altnagelvin and Craigavon Hospitals, along with the development of a Urology Service based in Causeway Hospital. At the time of this review 2008/2009, there is a funded establishment of 17 wte Consultant Urologists, which is in line with the recommendations of the 2000 Northern Ireland Review. However, the 2000 Review envisaged the Northern Board area Urology Services being based in Antrim Area Hospital rather than at Causeway Hospital.

2.10 Urology work can be divided into two categories;

- Medical and surgical treatment of the urinary tract, (kidneys, bladder, ureters, urethra, prostate), with these surgical procedures known as 'M'code (OPCS 4.4)
- Medical and surgical treatment of the genital and reproductive system (peno-scrotal), with these surgical procedures known as 'N'code (OPCS 4.4)

2.11 Both categories comprise elective and non-elective and cancer and non-cancer elements, albeit there are much fewer non elective and cancer cases in the 'N' code category.

2.12 In recent years, with the retirement of General Surgeons who historically undertook a substantial amount of Urology work, the number of General Surgeons who undertake urinary tract operative procedures (M Code) has significantly reduced. A small number continue to undertake diagnostic cystoscopies, which to varying degrees represents a substantial proportion of their workload. Should any subsequent treatment be required, the patient is referred into the Urology Team. A General Surgeon in the Northern Trust continues to undertake Inpatient and Day Case "M" code work in the Mid-Ulster Hospital.

Recommendation

1.	Unless Urological procedures (particularly operative 'M' code) constitute a substantial proportion of a surgeon's practice, (s)he should cease undertaking any such procedures. Any Surgeon continuing to provide such Urology services should do so within a formal link to a Urology Unit/Team.

2.13 Peno-scrotal operative procedures ('N' Code) continue to be undertaken by many General Surgeons predominately based outside of Belfast. This position is not surprising given the current number of urologists in the Southern, Western and Northern Trust areas.

2.14 Table 1 below identifies the type, volume and surgical speciality for N Code work.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Table 1 - Analysis of 'N' Code (Male Genital) Surgical Operations and Procedures Undertaken by Urologists and General Surgeons (2007/08)

Trust	Total Activity	General Surgeons	Urologists	% of 'N' Code undertaken by Urologists	Number / % undertaken as day case		V	C	H
NHSCT	807	767	40	5%	701	87%	517	129	35
SHSCT	612	521	91	15%	493	81%	314	135	36
WHSCT	614	544	70	11%	528	86%	318	143	38
SEHSCT	1244	650	594	48%	1148	92%	860	147	45
BHSCT	674	103	571	85%	407	60%	209	164	49
Total	3951	2585	1366	35%	3277	83%	2218	718	203

V Vasectomy
C Circumcision
H Hydrocele

2.15 Consultant General Surgeons have gained substantial experience and expertise in these procedures over the years and it is not envisaged that Trust's should make any immediate plans to pass this work onto Urologists. However, it is likely that future appointees to Consultant General Surgeon Posts, will have had little experience in undertaking such procedures and therefore Trust's will need to plan and consider the implications of impending retirements in General Surgery.

Recommendation

2. Trusts should plan and consider the implications of any impending retirements in General Surgery, particularly with regard to the transfer of "N" Code work and the associated resources to the Urology Team.

2.16 Gynaecology is another specialty which undertakes urinary tract diagnostic and operative 'M' code procedures and medical treatments for female bladder dysfunction (non cancer) and incontinence. The surgical specialty of Uro-Gynaecology has developed in the last decade, with most Trusts now having trained surgeons in post, for whom, such surgical procedures, represent a significant proportion of their surgical workload.

2.17 More complex surgical procedures are referred to Urologists and this aspect of Urology is termed as female/functional Urology. The demand for these specialist surgical services is increasing and there is a need, in some cases, to have joint working e.g. complex cancer Gynaecological Surgery and complex Urological Surgery.

2.18 Female continence (stress and urge incontinence) services (non surgical) are provided in Primary Care, Community Services and in Gynaecology Secondary Care. However, *there is evidence of large undeclared demand for continence services which is held in check by the embarrassment factor* (Action On Urology). Current services in NI are fragmented, disparate and are not managed in accordance with NICE Guidelines –Urinary Incontinence: The Management of Urinary Incontinence in Women (2006).

2.19 The referral review exercise undertaken as part of the review demonstrated that GP's are not generally referring these patients into urology and as 80-90% of such patients will not require surgical intervention, it was agreed that this service would not be considered as part of this review. However, it is clear from developments

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

elsewhere in the UK, that continence services can be significantly enhanced and redesigned within a multidisciplinary team model (GP's, Urologists, Gynaecologists, Physiotherapists and Nurse Practitioners) and is very suitable for development in a non secondary care environment.

Recommendation

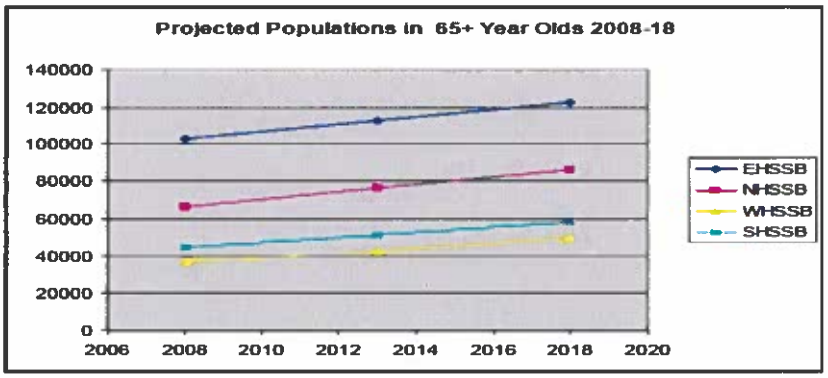
3.	A separate review of urinary continence services should be undertaken, with a view to developing an integrated service model in line with NICE Guidance.

Demography

2.20 The current population in Northern Ireland is 1.76 million with a projected rise to 1.89 million by 2018. The greatest increase will be seen in the 65+ year age group from 249,663 in 2008 to 316,548 (+27%) in 2018. This is particularly relevant for Urology as it is the ageing population that makes the heaviest demands upon Urology care (cancer and non cancer).

Figure 1

Demography 65+ years (Health and Social Services Boards)



Source NISRA

Total	249,663	282,877	316,548

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

3. CURRENT SERVICE PROFILE

Location of Urology Services

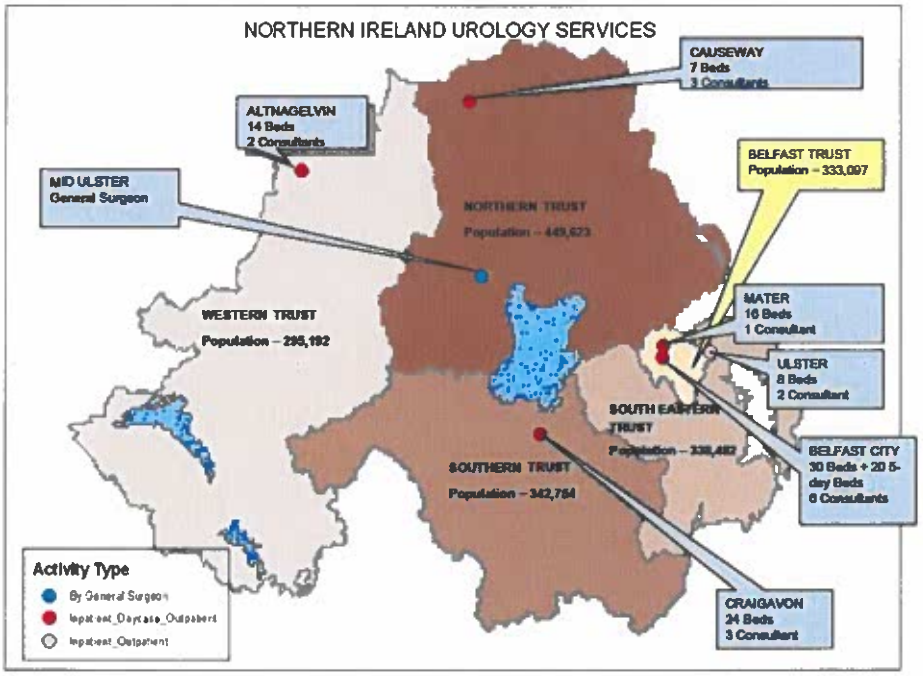
3.1 Consultant led Adult Urology Services are provided in each of the five Trusts. Table 2 below outlines the number of Consultants, Specialist Nurses and Main Hospital bases.

Table 2 – Consultant/Nurse Staffing and Inpatient Units

	Northern	Southern	South Eastern	Western	Belfast	Total
Consultants	3	3	2	2	7	17
Specialist Nurses	3	2	1	3 (2.6 WTE)	3	12 (11.6 WTE)
Hospital Base	Causeway	Craigavon	Ulster	Altnagelvin	BCH/ Mater	

3.2 Figure 2 depicts the five Trusts, their respective resident population, and location and number of Inpatient beds.

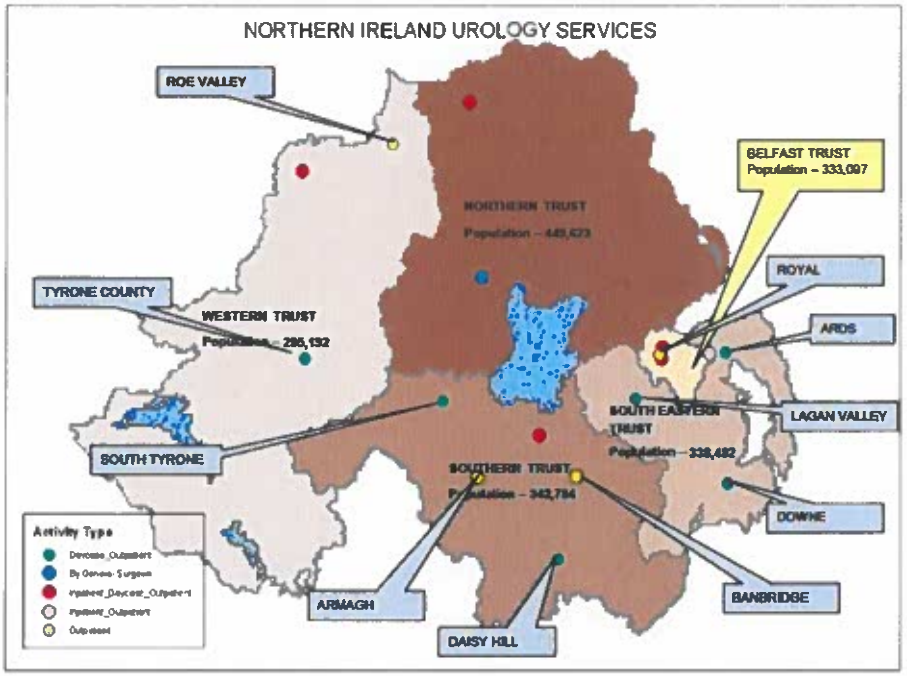
Figure 2 – Urology Services – Inpatient Services



Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

3.3 Figure 3 layers on the additional sites within each Trust which provide a range of Outpatient, and Day Surgical Services.

Figure 3 – Urology Services – Outpatients, Day Surgery



3.4 Figures 2 and 3 identified the resident populations for each of the 5 Trusts, however, the actual catchment populations significantly differ when adult only services and patient flows are considered. Table 3 indentifies the inpatient and day case population served by each Trust/Consultant.

Table 3 – Catchment populations served by each Trust

	Consultant urological surgeons number	Inpatient catchment population	Inpatient catchment population per consultant	Daycase catchment population	Daycase catchment population per consultant
BHSCT	7	873,000	124,700	646,000	92,300
NHSCT	3	218,000	72,700	245,000	82,000
SEHSCT	2	130,000	65,000	321,000	160,000
SHSCT	3	305,000	102,000	287,000	96,000
WHSCT	2	236,000	118,000	262,000	131,000
Total	17	1,762,000	103,000	1,762,000	103,000

3.5 This analysis demonstrates a significant flow of inpatient/day case work (and therefore outpatient/assessment and diagnostic workup) from the Northern Trust area to Belfast. It also demonstrates that although South Eastern Trust services a significant catchment population for day case work (and outpatient, assessment and diagnostics) it serves a smaller proportion of its population with inpatient care. This is due to the fact that a significant volume of outpatients, diagnostics and day surgery is undertaken in the Lagan Valley Hospital by a Consultant Urologist outreached from Belfast. Any subsequent inpatient treatment is then carried out in BCH.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Outpatient (new) Services

3.6 A referral review exercise was held in December 2008, at which a number of primary and secondary care clinicians (5 General Practitioners and 5 Consultant Urologists) and Trust Managers undertook a quantitative and qualitative analysis of all new outpatient referrals received (368) in Urology for a full week in November 2008.

Table 4 - Analysis of Urology Referral Letters

Gender	Belfast	Northern	Western	Southern	SE	Regional
Male	111	39	34	42	55	281
Female	33	13	10	11	18	85
Blank	0	1	1	0	0	2
Total	144	53	45	53	73	368

Age Range	Belfast	Northern	Western	Southern	SE	Regional
0-14	2	0	0	1	0	3
15-30	17	4	5	3	7	36
31-40	19	4	5	8	4	40
41-50	29	9	4	7	5	54
51-60	18	13	9	6	4	50
60+	59	22	22	28	9	140
Blank	0	1	0	0	44*	45
Total	144	53	45	53	73	368

Urgency	Belfast	Northern	Western	Southern	SE	Regional
Red Flag	6	2	3	3	4	18
Urgent	30	11	10	10	12	73
Routine	108	40	32	40	57	277
Blank	0	0	0	0	0	0
Total	144	53	45	53	73	368

Named Cons	Belfast	Northern	Western	Southern	SE	Regional
Y	35	13	6	12	15	81
N	109	40	39	41	58	287
Total	144	53	45	53	73	368

Ref Source	Belfast	Northern	Western	Southern	SE	Regional
Non-GP ref's	15	12	1	5	14	47
GP Refs	129	41	43	48	59	320
Blank	0	0	1	0	0	1
Total	144	53	45	53	73	368

* 44 out of 73 referrals in SET had DOB deleted-therefore not possible to record age range.

** Data on percentages is **Appendix 4**

3.7 Regionally 76% of the referrals were male, which was to be expected. 87% of the referrals were from GPs with the remaining 13% spread across Consultant to Consultant (internal and external), A&E referrals and other sources. 78% of the referrals were referred into Urology as a specialty, with only 22% having a named Consultant. Regionally (excluding SET) 63% of the referrals related to the over 50's age range. Referrals marked by GPs as red flag or urgent represents 25%.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

3.8 A breakdown of the referrals by presenting symptoms/conditions is in Table 5 below. Data on percentages is included in Appendix 5. Clinicians have indicated that this outcome is fairly representative of the nature and type of referrals they receive.

Table 5 - Analysis of presenting symptoms/conditions

Presenting Symptom/Condition		Belfast		Northern		Western		Southern		SE		Regional	
Haematuria (ALL)		**19**		**10**		**10**		**5**		**12**		**56**	
	frank		*11*		*3*		*4*		*2*		*6*		*26*
	microscopic		*6*		*5*		*6*		*2*		*6*		*25*
	blank		*2*		*2*		*0*		*1*		*0*		*5*
Prostate/raised PSA		**14**		**7**		**8**		**9**		**12**		**50**	
Other		**21**		**4**		**5**		**8**		**8**		**46**	
Ncode procedure (All)		**21**		**2**		**1**		**3**		**14**		**41**	
	vasectomy		*11*		*0*		*1*		*1*		*4*		*17*
	foreskin		*1*		*0*		*0*		*2*		*7*		*10*
	epididymal cyst		*3*		*2*		*0*		*0*		*3*		*8*
	hydrocele		*4*		*0*		*0*		*0*		*0*		*4*
	varicocele		*1*		*0*		*0*		*0*		*0*		*1*
	blank		*1*		*0*		*0*		*0*		*0*		*1*
Recurrent UTI's		**17**		**9**		**4**		**6**		**4**		**40**	
LUTS		**11**		**7**		**2**		**5**		**7**		**32**	
Prostate/BPH/prostatitis		**11**		**5**		**4**		**6**		**2**		**28**	
Renal stones/colic/loin pain		**11**		**5**		**1**		**2**		**4**		**23**	
Testicular/ Scrotal lumps or swelling		**8**		**0**		**5**		**0**		**8**		**21**	
Andrology (ALL)		**7**		**2**		**3**		**6**		**2**		**20**	
	erectile dysfunction		*2*		*2*		*0*		*3*		*1*		*8*
	Peyronie's disease		*2*		*0*		*2*		*0*		*0*		*4*
	blood in ejaculate		*3*		*0*		*0*		*0*		*0*		*3*
	ulcer/lesion on gland		*0*		*0*		*1*		*1*		*0*		*2*
	balanitis/discharge		*0*		*0*		*0*		*2*		*0*		*2*
	Blank		*0*		*0*		*0*		*0*		*1*		*1*
Unknown		**3**		**1**		**1**		**2**		**0**		**7**	
Ca Bladder/Kidney		**1**		**1**		**0**		**1**		**0**		**3**	
Blank		**0**		**0**		**1**		**0**		**0**		**1**	
Total		**144**		**53**		**45**		**53**		**73**		**368**	

3.9 The categorisation of patients by presenting symptoms/condition is a useful process and the outcomes of this exercise should assist Urology teams in determining the nature and frequency of assessment and diagnostic clinics. There was an overlap in symptoms for some patients e.g. many patients with enlarged prostate, known benign prostatic hyperplasia (BPH) or prostatitis have a range of lower urinary tract symptoms (LUTS). However, for the purposes of this exercise, if prostatic disease was identified on the referral letter, these patients were recorded as such, whereas patients presenting with just LUTS were categorised as such. Where LUTS

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

services are in place, both of these groups of patients are seen and treated within the same pathway.

3.10 General comments;

- A small number of the referrals (<10) were not for a new outpatient appointment but were asking for a review appointment, which was overdue, to be expedited. In addition, a small number of referrals (<10) were for patients who had been discharged from outpatients due to not responding to a booking letter or had DNA'd and who had subsequently visited their GP and asked for another referral to be processed.

- In overall terms, the quality and appropriateness of the referrals was deemed to be good. Internal referrals (A&E, inpatient etc) were often handwritten and were not as structured as GP referral letters.

- The exercise included looking at the time between the date recorded on the referral letter and the hospital date stamp indicating receipt. A significant variance between these two dates was noted in internal referrals (Consultant to Consultant). There did not appear to be any significant delays with regard to GP referrals.

Recommendation

4.	Trusts must review the process for internal Consultant to Consultant referrals to Urology to ensure that there are no undue delays in the system.

- Consultants indicated that they would routinely upgrade a significant number of routine and urgent referrals (GP) to urgent or red flag. This is particularly relevant when considering the service capacity requirements to assess and investigate potential cancers within cancer standard timescales. This has been confirmed in a recent Cancer Registry, full year analysis of the cancer waiting times database, with a total of 700 red flag GP referrals and 875 referrals which Consultants upgraded to red flag at triage recorded.

- It has been noted that the development of agreed referral guidelines/criteria for suspected Urological cancers is a priority piece of work for the recently formed NICaN Group and this should work should be advanced as soon as possible.

Recommendation

5.	NICaN Urology Group in conjunction with Urology Teams and Primary Care should develop and implement (by September 2009) agreed referral guidelines and pathways for suspected Urological Cancers.

Areas of Urology

3.11 As a specialty, Urology can be sub-divided into a number of special interest areas, most of which also comprise elements of general or 'core' Urology work.

3.12 **Core Urology** includes the assessment, diagnosis, medical treatment and (non complex and/or endoscopic) surgical treatment of diseases/conditions of the kidney,

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

bladder, prostate, penis and scrotum. LUTS, BPH, haematuria, simple stones, erectile dysfunction (ED) and 'N' code work are considered to be core Urology. Urologists in NI, regardless of special interest area, all provide core Urology services. Over 80% of all 'M' and 'N' code inpatient and daycase procedures are peno-scrotal, cystoscopy, TURBT (trans urethral resection of bladder tumour), TURP (trans urethral resection of prostate) and urethral catheterisation.

3.13 **Uro-Oncology.** Around 40% of Urology work is cancer related and most of the assessment, diagnostics and medical/ simple surgical treatments are appropriately undertaken at local level. Less than 10% of Urological cancers require radical/complex surgery. (see section 7).Specialist cancer services are based in BCH, where there are three designated 'cancer' Urologists. One Urologist in Altnagelvin and one/two in Craigavon would also be considered to have a special interest in cancer.

3.14 **Stones/Endourology** includes the management and treatment of renal and ureteric calculi. This involves open surgery, endoscopic intervention or stone fragmentation using multimodal techniques such as laser, lithoclast with or without US (ultrasound) and ESWL (Extracorporeal shock wave lithotripsy). Craigavon has the only fixed-site lithotripter, with BCH and Causeway serviced by a mobile facility on a sessional basis. With regard to special interest Urologists, there are currently two in Belfast Trust and one in each of the other four Trusts.

3.15 **Andrology** includes the treatment of erectile dysfunction, particularly post prostate surgery, penile curvatures and deformities (Peyronie's disease) and other conditions of the male reproductive organs. Currently all Consultants provide andrology services within their commitment to core Urology. The service would benefit from having a specialist Urologist to manage and treat the more complex cases, including penile prostheses work.

3.16 **Reconstruction,** which is often combined with the functional side of Urology, includes reconstruction of urinary continence in men, bladder reconstruction after oncological surgery and in a neuropathic bladder, e.g. spina bifida, spinal cord injury, bladder reconstruction in congenital and developmental LUT pathology (adolescent), urethral reconstruction for strictures and reconstruction prior to transplantation. There are currently two Consultants (one on long term sick leave) in Belfast who specialise in this area, working closely with the Uro-oncology team and with supra regional support provided by University College Hospital London.

3.17 **Female/functional** relates to the management and treatment of incontinence and bladder dysfunction in women, which on some occasions overlaps with reconstruction surgery. Some of this work is undertaken by Urologists however, the majority is undertaken by Uro-Gynaecologists as outlined in section 2. There is a shared view among Urologists that each Urology team should have at least one Urologist with a special interest in female/ functional Urology, and who for this aspect of their work, should work within a multidisciplinary team of Gynaecologists, physiotherapists and nurse practitioners in providing care for urinary incontinence, prolapse and fistula repair.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Recommendation

6.	Deployment of new Consultant posts (both vacancies and additional posts arising from this review) should take into account areas of special interest that are deemed to be required in the service configuration model

Non-Elective Services

3.18 There are approximately 2,500 non-elective FCE's (coded as Urology on admission or discharge) per annum (approximately 7 a day) with little variation in these numbers from year to year.

3.19 In broad terms, non-elective admissions fall into the following categories;

- Testicular torsion/infections
- Renal colic/Acute kidney obstruction
- Infection—recurrent UTI's/ pyelonephritis
- Urinary retention /haematuria

3.20 The majority of admissions fall into urinary retention and renal colic which do not usually require an immediate surgical operation, neither does treatment of infections. Testicular torsion and acute kidney obstruction require emergency (often surgical) intervention.

3.21 There are currently 15 hospitals in NI with A&E Departments (varying opening times) and acute medical and surgical facilities. With the implementation of DBS (Developing Better Services) this position will change in future years. However, for the purposes of this review the profile of services and location of non-elective Urology patients is assumed to be as is at present.

3.22 The majority of non-elective admissions are admitted to the 'presenting' acute hospital and unless it is BCH or CAH are admitted (out of hours) under General Surgery, until transfer to the care/specialty of Urology, if appropriate, on the next working day.

3.23 Even in a redesigned Urology service it is not envisaged that these arrangements will change for the foreseeable future, as it would not be viable to provide 24/7 onsite Urology cover in all 15 hospitals. However, the requirement to have clearly defined protocols and pathways in place for the management of these admissions has been identified.

Recommendations

7.	Urologists, in collaboration with General Surgery and A&E colleagues, should develop and implement clear protocols and care pathways for Urology patients requiring admission to an acute hospital which does not have an acute Urology Unit.

8.	Urologists, in collaboration with A&E colleagues, should develop and implement protocols/care pathways for those patients requiring direct transfer and admission to an acute Urology Unit.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

9.	Trusts should ensure arrangements are in place to proactively manage and provide equitable care to those patients admitted under General Surgery in hospitals without Urology Units (e.g. Antrim, Daisy Hill, Erne). Arrangements should include 7 day week notification of admissions to the appropriate Urology Unit and provision of Urology advice/care by telephone, electronically or in person, also 7 days a week.

ICATS (Integrated Clinical Assessment and Treatment Services)

3.24 ICATS was launched in NI in 2005/06, as one element of the Department's Outpatient Reform Programme and in response to very lengthy waiting times for first outpatient appointments.

3.25 ICATS were designed to provide services, in a variety of primary and secondary care settings by integrated multidisciplinary teams of health service professionals, including GPs with a special interest, specialist nurses and allied health professionals. One of the fundamental elements was that many patients didn't need to be seen or assessed by a hospital Consultant at an outpatient clinic and that quick triage of referral letters and assessment and diagnostics by the most appropriate health care professional within ICATS teams, with onward referral to secondary care, only if required, would divert large numbers of outpatient referrals from hospital consultants. Another fundamental design principle was that non urgent referrals would, in the first instance, go to ICATS to be triaged and that all subsequent flows to secondary care consultants would be from the ICATS team.

3.26 It was agreed that, to begin with, ICATS would be implemented in a small number of core specialities (4) and these were identified based on those specialities with the highest volumes and longest waiting times in 2005/06. Urology was one of the 4 initial specialties identified. Across all ICATS specialties £2m was allocated in 2006/07, increasing to £9m recurrently from 2007/08.

3.27 The design of ICATS included 5 possible next steps/pathways for patients referred into the service-

- to diagnostics,
- for direct treatment on an inpatient/day case list,
- for return to primary care with advice on further management,
- to tier 2 outpatient services (non Consultant assessment and treatment) or
- to hospital (Consultant) outpatients.

3.28 For a variety of reasons, the development of Urology ICATS has been difficult, slower than planned and somewhat fragmented with regard to service model design, which differs significantly in each of the Board areas.

3.29 Table 6 below outlines the progress to date in Urology ICATS.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Table 6 - Urology ICATS - Current Position

Board Area	Current Position	Ring fenced funding/ Investment Made	Comments
NHSSB	Hospital based (Causeway) Nurse specialists undertaking mostly cystoscopies. Consultant led referral triage.	£642K	Original intention to expand nurse service to LUTS/haematuria/prostate clinics and review/follow-up clinics.
SHSSB	GPSI and specialist nurse Tier 2 clinics for haematuria, prostate, LUTS, stones, andrology. ICATS in separate building on Craigavon Area Hospital site. Consultant led referral triage.	£240K	Oncology review and urodynamics clinics being established.
WHSSB	Nurse led clinics (LUTS, prostate) and single visit haematuria clinics with nurse specialists/staff grade in place for some years. Predominately hospital based (Altnagelvin). Consultant led referral triage.	£211K	ICATS plan now approved – expanding diagnostic, LUTS services and involving GPSI'S in referral triage process in order to improve links with primary care and improve referral information and patterns.
EHSSB	SET – plan approved by EHSSB late 2008. Nurse specialist undertaking cystoscopies for some time outwith any ICATS model. BELFAST – no progress but nurse led services in place for some time and single visit haematuria clinic established late 2008. Consultant led referral triage in both SET +Belfast	£350K	GPSI'S appointed some time ago but posts not yet activated.

3.30 It is clear that Urology services have been developing non Consultant delivered outpatient, assessment and diagnostic services, such as haematuria, LUTS, ED, prostate, stones etc for some years prior to the launch of ICATS. These services were/are largely provided by nurse specialists, staff grades and radiology staff in a hospital environment.

3.31 Consultant Urologists unanimously consider that referral triage should be led by Consultants. With over 40% of referrals being cancer related (and with many not red flagged or marked urgent) they believe that they are best placed and skilled to undertake the triage process. They also believe that despite the volume of referrals, this is not a particularly time consuming process.

3.32 They indicate that they are fully committed to developing further non Consultant assessment, diagnostic and some treatment services and supportive of *providing appropriate, safe and sustainable, cost effective care closer to home, so that urology services are delivered in the right setting, with the right equipment, performed by the appropriate skilled person* (NHS, Providing Care for Patients with Urology Conditions- Guidance).

3.33 This approach was evident during the referral review exercise in December 2008, with Consultants readily indicating that patients should be booked straight into diagnostics or nurse led clinics such as LUTS, prostate, haematuria.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

3.34 Consultant Urologists are very clear that the need to ensure that whoever the specialist practitioner is and wherever they work, they should be part of, or affiliated to, the local Urology team, led by a Consultant Urologist.

3.35 In light of the already changing shape of Urology services and the further developments that will arise out of this review, it is appropriate and timely to take stock of ICATS, its design principles and future development and investment. A review of all ICATS Services is planned for the first quarter of 2009/10 year and the outcomes of this review should guide the future direction of travel for ICATS services within Urology .

Recommendation

10.	In undertaking the ICATS review, there must be full engagement with secondary care Urology teams, current ICATS teams, as well as General Practitioners and LCGs. In considering areas of Urology suitable for further development they should look towards erectile dysfunction, benign prostatic disease, LUTS and continence services. The review should also take into account developments elsewhere within the UK and in particular developments within PCTs in relation to shifting care closer to home.

Links with Renal Transplantation

3.36 Renal transplantation is the definitive preferred treatment for end-stage renal failure. Kidneys for transplantation become available from either deceased or live donors. In 2006 the DOH commissioned a Taskforce to investigate and make recommendations to increase the level of organ donation. In 2008/09 the DHSSPS set a target for access to live renal transplantation and investment has been made to increase the live donor programme at Belfast City Hospital.

3.37 There are currently two wte transplant surgeons in post, a long-term locum transplant surgeon and in addition there is 0.2 wte input from an Urologist. The Urologist only undertakes live donor kidney retrieval using laparoscopic techniques, which is an essential quality component for the live donor programme.

3.38 Taskforce recommendations would suggest that cadaveric retrievals and transplantations should be increased to 50 per year (currently approximately 30) and within Priorities for Action there is a target for an additional 20 live donor retrievals and transplantations per year by March 2011. With the increase in laparoscopic live donor retrieval, additional input from Urologists may be needed and the current review of the renal transplantation service will need to take account of this requirement, along with the Urology input required if any reconstruction of the urinary drainage system is needed before transplantation.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

4. CAPACITY, DEMAND AND ACTIVITY

4.1 Urology is a specialty that is categorised by high numbers of referrals for relatively simple initial diagnostics (often to exclude pathology) or surgical procedures. In addition, around 40% of Urology is cancer related and as more elderly patients are referred and treated, there is a need for follow-up services and patient surveillance.

4.2 The increasing demand for Urology services in Northern Ireland is similar to that being experienced in the rest of the UK.

4.3 The Action On Urology Team (March 2005) reported that:

Demand for Urology services is rising rapidly and the pattern of disease is changing.

- *There is an overall rise in demand from an ageing population especially the over 50's who make the heaviest demands upon Urology care.*
- *Prostate disease incidence is rising rapidly and PSA requests are generating further demand.*
- *Haematuria/bladder disease demand is also rising, stimulated by the combined availability of dipsticks and flexible cystoscopes.*
- *Work is shifting away from surgery towards diagnostics and medical treatment.*

4.4 In addition, there has been an increased "medicalisation" of Urology as the pharmacology of the urinary tract has become better understood and the increasing availability and ever improving range of drugs.

Activity/Demand/Capacity Analysis

4.5 During the review detailed analysis was undertaken by SDU and the Boards, and the following represents the most accurate information available at this time.

Outpatients

4.6 New outpatient referrals and attendances (activity) have been increasing year on year. Not all referrals result in attendance as many are removed for "reasons other than treatment" (ROTT) and are appropriately discharged from the system without having been seen.

4.7 The most recent analysis undertaken is estimating an 18% increase in predicted (GP) demand from 2007 to 2008 (2008 ROTT rates applied). This does not however represent a 'true' picture as during this period two Trusts changed their recording/management of activity from General Surgery to Urology. It has been difficult to quantify, with a degree of accuracy, the impact of these changes on the information, as increases, (albeit smaller), in General Surgery are also being estimated. Notwithstanding the above difficulty, it has been accepted that there is a significant increase in demand, which is likely to be between 10 and 15%. It has also been concluded that this increase is likely to be as a result of those factors outlined at the beginning of this section i.e. ageing population, patient expectation and demand with the increased emphasis on men's health, changing pattern of disease, availability of assessment and diagnostic modalities to exclude pathology, along with decreasing waiting times and previously unmet need.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

4.8 A regional referrals management review, led by SDU Primary Care advisors is due to commence in April 2009.

Table 7 - Urology – Service and Budget Agreement Levels and Activity

	SBA [1]	07/08 Outturn[2+4]	Projected 08/09 Outturn [3+4]
Elective Inpatients	4,155	4,937 + 295(IS)	5,823+606(IS)
Non-elective Inpatients	2,109	2,369	2,496
Daycases	8,715	12,416 + 462 (IS)	13,252+1028(IS)
New Outpatients	5,824	7,593 + 571 (IS)	9,984 +519(IS)
Review Outpatients	12,566	15,967	19,224

(1) Information from 4 Boards SBAs
(2) 2007/08 outturn from PAS (includes in-house additional activity)
(3) Projected 2008/09 outturn (including in-house additional activity) based on November 2008 position
(4) IS information provided by EHSSB

4.9 In 2008, the Boards completed a detailed capacity and demand model across a number of specialities, inclusive of Urology. A number of assumptions/estimates were applied and both the recurrent gap against SBA and non-recurrent (backlog) was identified. The recurrent gap does not take account of growth in demand. The backlog (non-recurrent) gap relates to the in-year activity required due to the need to reduce waiting times for inpatient/day cases and outpatients to 13 and 9 weeks respectively by March 2009.

4.10 It has been agreed that the maximum elective access waiting times for 2009/10 will remain at 13 and 9 weeks and with a year of steady state, Trusts and Commissioners will therefore be better placed to assess both the 'real' demand and capacity to treat.

4.11 As part of this review EHSSB undertook further analysis of demand and capacity within urology and identified a significant recurrent gap, against SBA volumes.

Conclusion

4.12 Both the demand and activity in Urology is significantly greater than the current SBA volumes. Some of this is non-recurrent backlog created by the reducing waiting times since 2005/06 and the remainder is recurrent based on 2007/08 demand. Significant non-recurrent funding has been allocated in recent years to ensure Trusts were able to undertake this activity and to meet the elective access waiting times and cancer access standards. Within Trusts large numbers of additional clinics and theatre sessions have been funded non-recurrently and there has also been significant use of the independent sector.

4.13 Both increased and additional capacity to assess and treat patients is urgently required in Urology. However, additional recurrent investment in capacity (resources-human and physical) which is required in this speciality and is detailed later in this report is not the only solution. Trusts will also be required to ensure optimum use and efficiency of their existing capacity and will need to be creative in developing new ways of working and re-designing and modernising services to increase the capacity already in the system and to manage the increasing demand into secondary care.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

4.14 The IEAP (Integrated Elective Access Protocol) provides detailed guidance on tried and tested systems and processes which ensure effective and efficient delivery of elective services, along with improvements to the patient experience. The Scheduled Care Reform Programme (2008-10) includes significant developments such as, pre-op assessment, admission on day of surgery, increasing day surgery rates, reducing cancelled operations, optimising the use and productivity of theatres, booking systems and a management of referral demand exercise. All of these will build/create additional capacity within the system.

Recommendation

11.	Trusts (Urology departments) will be required to evidence (in their implementation plans) delivery of the key elements of the Elective Reform Programme.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

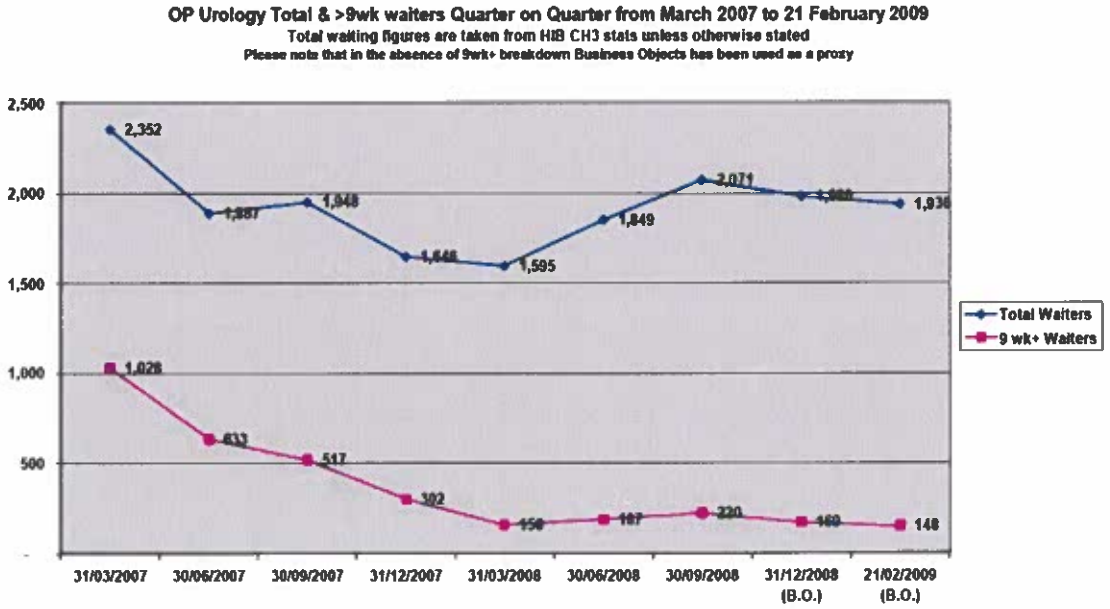
5. PERFORMANCE MEASURES

Elective access waiting times

5.1 There have been significant reductions in waiting times since 2005, in line with PFA (Priorities for action) targets and as a result of the elective reform and modernisation programme.

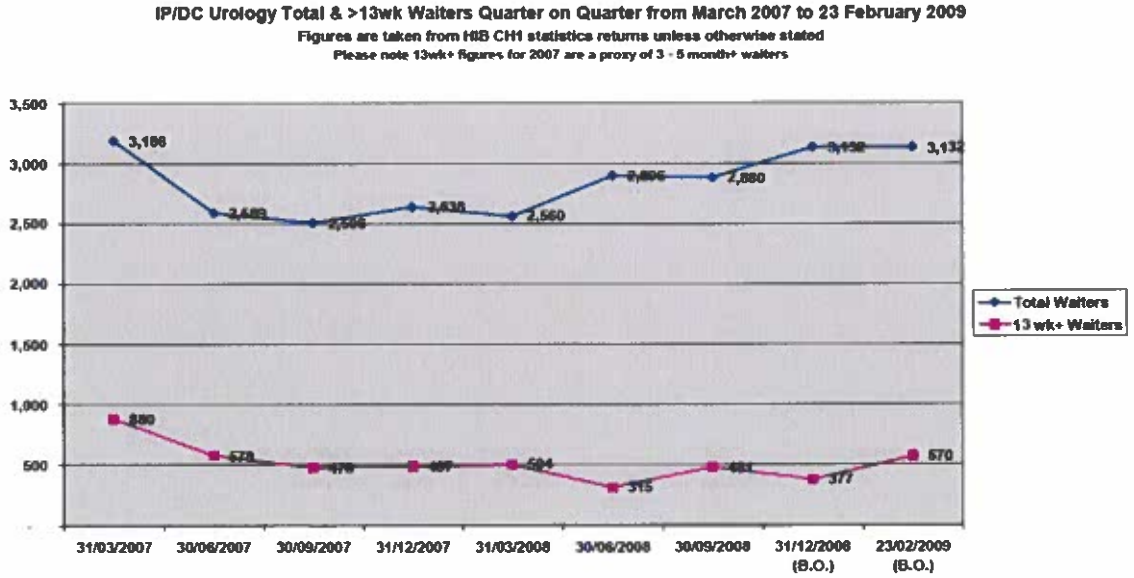
PFA 2008/2009: By March 2009, no patient should wait longer than 9 weeks for first outpatient appointment and/or diagnostics
By March 2009, no patient should wait longer than 13 weeks for Inpatient or daycase treatment.

Figure 4



(B.O. – refers to Business Objects)

Figure 5



Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

5.2 As at February 2009, all Trusts, with the exception of Belfast, are indicating that they will meet the target waiting times for outpatients, diagnostics, Inpatients and daycases. Belfast Trust is reporting in excess of 100 anticipated breaches in Inpatient/daycase work.

Urology Cancer Performance

5.3 The Cancer Access Standards were introduced from April 2007. These introduced waiting times standards for suspected cancer patients both urgently referred by the General Practitioner or those referrals triaged by the Consultant as suspected cancer. It also set standards for those patients diagnosed with cancer and how long they should wait for treatment.

5.4 The 2008/09 Cancer Access Standards were defined as below:

- 98% of patients diagnosed with cancer from decision to treat, should begin their treatment within a maximum of 31 days
- 95% of patients urgently referred with a suspected cancer should begin their first definitive treatment within a maximum of 62 days.

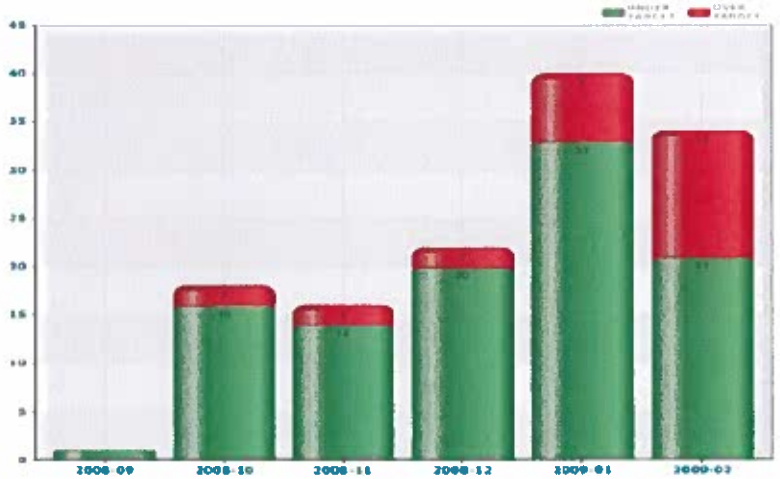
* decision to treat is the date on which the patient and clinician agree the treatment plan.

5.5 It is recognised that a considerable amount of the actions required to achieve the cancer access standards are associated with service improvement. These include the identification and agreement of the suspected cancer patient pathway, the introduction of robust administrative systems or processes and the proactive management of patients.

5.6 The recent cancer access standard performance in relation to the 62 day standard shows that up to 24 February 2009, across all Trusts, the number of Urological cancer patients achieving the 62 day standard is at 62%. This shows that of the 34 confirmed cancers treated up to this date, 13 of these had not been treated within 62 days.

Figure 6

62 Day Completed Waits (Actual) for All Trust, All Hospital Site, Urological Cancer Site



Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

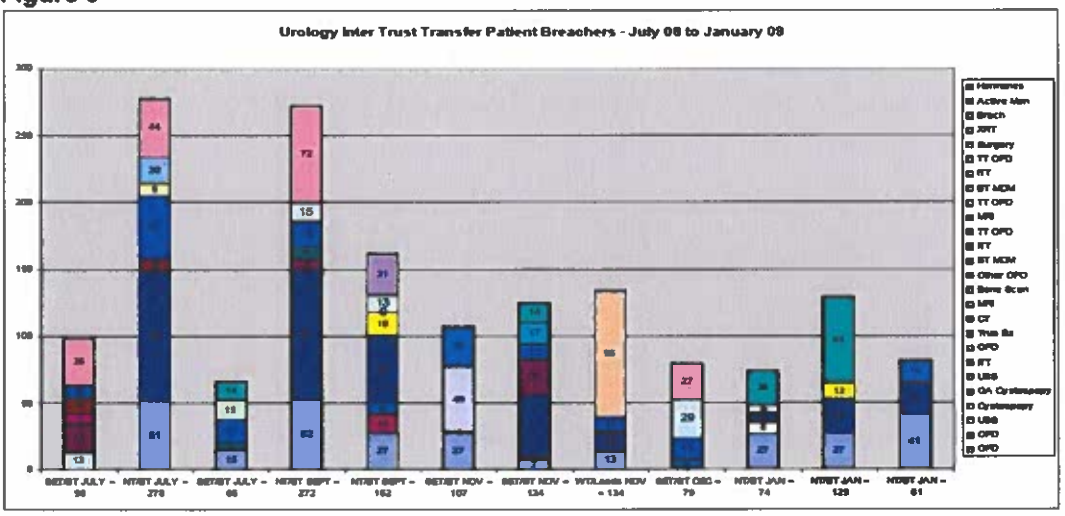
5.7 For the same period in February, the performance in relation to the 31 day standard shows that, only 87% of those Urological cancer patients (63 of 71 patients) were treated within 31 days of the decision to treat. From a sample of 9 patients that breached the 31 day standard in January 2009, they waited on average 50 days from their decision to treat to their first treatment.

Figure 7



5.8 It is accepted that those patients who transfer from one Trust to another for treatment are more likely to breach the target, than those who remain within the one Trust for their complete pathway. These patients are referred to as Inter Trust Transfer (ITT) patients. These ITT patients that breach the target are analysed in more detail. The detail for the period July 2008 to January 2009 is shown on Figure 8 below. This shows that of the suspected 'red flag' cancer patients referred who breached the 62 day target, 12 of these were ITT patients and they waited from 66 to 278 days from referral to their first treatment. It is accepted as a regional standard, for all tumour sites that if the patient is to be transferred for treatment, all diagnostic investigations should be completed and the patient should be ready for transfer by day 28 of the 62 day pathway. From this evidence it shows that this is not happening in the majority of cases.

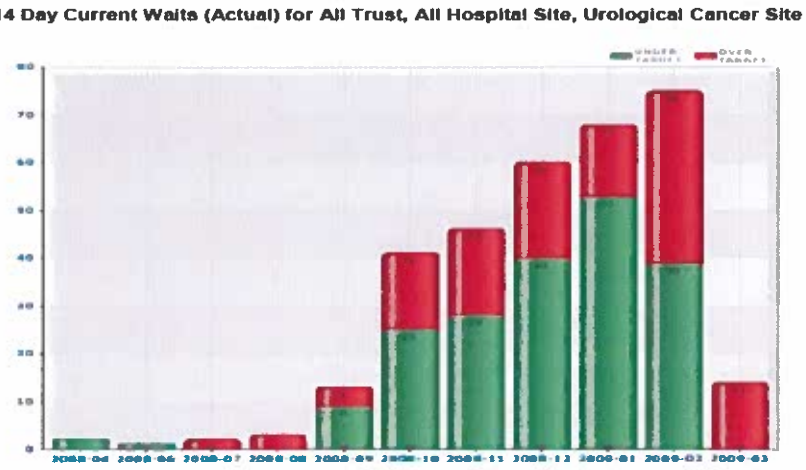
Figure 8



Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

5.9 Whilst this analysis only refers to ITT patients, it is probably representative of the pathway for those patients that breach the target and remain only within the one Trust. For example, for the 'front end' of the patient pathway, the number of days the patient can wait for their initial outpatient appointment and subsequent investigation can be over 150 days. This has improved in recent months, but to achieve the 28 day standard this should be completed within approximately 21 days. This is further evidenced by the analysis of the 14 day waiting times for suspected Urological cancers referrals; this showed that of the referrals seen in February only 52% were seen within 14 days. As highlighted any delay at the front end of the pathway will have an impact on the Trusts ability to achieve the treatment times and the 62 day standard.

Figure 9



5.10 Whilst it is clear that some element of redesign of the pathway is required, the evidence appears to indicate that for the number of suspected 'red flag' cancer referrals received or triaged by the Consultants, additional capacity at the front end to complete timely investigations is required. For example, the introduction of one-stop clinics for investigations such as haematuria can have an impact and reduce the number of days the patient waits for investigations as well as reducing the number of times that the patient has to attend the hospital. This needs to be matched with sufficient Consultant capacity for treatments, including theatre capacity, Oncologists for oncology and radiotherapy.

5.11 All Trusts have reported that Urology is the key tumour site which they are at most risk with and their achievement of the cancer access standards by March 2009. In addition, at a recent ITT Executive Directors Services Steering Group the Belfast Trust reported they estimate 15 to 20 urological patients will breach the cancer access standards. Some of this is due to the late transfer of patients, but also due to a lack of available Consultants and theatre capacity. If the number of patients forecasted breach the target, this will mean that as a region NI will not achieve the cancer access standard.

Recommendation

12.	Trust Urology Teams must as a matter of urgency redesign and enhance capacity to provide single visit outpatient and assessment (diagnostic) services for suspected urological cancer patients.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

NHS Better Care, Better Value Indicators

5.12 A number of better care, better value Indicators are useful performance measures to apply to Urology in assessing levels of efficiency, productivity and patient experience.

5.13 Length of stay (LOS) is one of the greatest variables between Trusts, hospitals and individual Consultants. By reviewing and improving admission and discharge processes, Trusts can improve the patient experience by reducing the number of days spent in hospital, and save bed days thus increasing capacity and saving money.

5.14 Some hospitals would expect to have longer than average LOS if they undertake more complex operations, treat patients with greater co-morbidity and patients with higher levels of social deprivation.

Table 8
Urology Episodic Average Length of Stay (06/07, 07/08, 08/09 - Apr 08 to Nov 08)

	Elective			Non Elective		
	FY2006/2007	FY2007/2008	FY2008/2009*	FY2006/2007	FY2007/2008	FY2008/2009*
Regional average LOS in days	3.7	3.4	3.2	4.8	4.7	4.6

	Elective			Non Elective		
Trust	FY2006/2007	FY2007/2008	FY2008/2009*	FY2006/2007	FY2007/2008	FY2008/2009*
Belfast Health and Social Care Trust	3.9	3.4	3.3	5.5	4.9	5.0
Northern Health and Social Care Trust	2.3	2.9	2.5	4.3	5.4	5.6
South Eastern Health and Social Care Trust	3.8	3.9	3.3	3.9	4.4	3.4
Southern Health and Social Care Trust	3.7	4.0	3.5	4.5	4.8	4.9
Western Health and Social Care Trust	3.6	2.8	3.1	3.9	3.8	3.7
Average LOS in days	3.7	3.4	3.2	4.8	4.7	4.6

	Elective			Non Elective		
Site	FY2006/2007	FY2007/2008	FY2008/2009*	FY2006/2007	FY2007/2008	FY2008/2009*
Altnagelvin Hospitals	3.6	2.8	3.1	3.9	3.8	3.7
Belfast City Hospital	4.1	3.5	3.4	5.5	4.7	5.0
Causeway	2.3	2.9	2.5	4.3	5.4	5.6
Craigavon Area Hospital	3.7	4.0	3.5	4.5	4.8	4.9
Down and Lisburn	1.0	0.0	1.2	0.0	0.0	0.0
Mater Infirmorum Hospital	3.2	2.7	2.5	5.9	6.4	5.0
The Royal Group of Hospitals	0.0	0.0	0.0	0.0	0.0	0.0
Ulster Community and Hospitals	3.8	4.0	3.5	3.9	4.4	3.4
Average LOS in days	3.7	3.4	3.2	4.8	4.7	4.6

*Information for 08/09 is cumulative from 01/04/08 to 30/11/08

5.15 All Trusts have longer average LOS for non elective patients than elective. The Southern Trust has the longest average LOS for elective patients and for elective and non-elective combined. Northern Trust has the shortest elective LOS which reflects their lower levels of major surgery.

5.16 Hospital Episode Statistics (HES) data, which combines elective and non-elective LOS, indicates a reduction in England over a three year period from an average of 3.8 days in 2005/2006 to 3.3 days in 2007/2008. Only South Eastern and Western Trusts have an average (combined) LOS of less than 4 days.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Recommendations

13.	Trusts should implement the key elements of the elective reform programme with regard to admission on the day of surgery, pre-operative assessment and increasing day surgery rates.

14.	Trusts should participate in a benchmarking exercise of a set number of elective (procedure codes) and non-elective (diagnostic codes) patients by Consultant and by hospital with a view to agreeing a target length of stay for these groups of patients.

Day Surgery

5.17 *For any surgical operation there is a large variation in performance throughout the UK with regard to time spent in hospital. Some units favour certain procedures to be performed on a day case basis while others, for the same procedure may regard an overnight stay as the norm. (BADS Directory of Procedures 2007)*

5.18 Hospitals are increasingly focussing on the short stay elective pathway. Carrying out elective procedures as day cases, where clinical circumstances and specialist equipment and training allows, saves money on bed occupancy and nursing care, as well as improving patient experience and outcomes.

5.19 The Audit Commission has identified 25 operations across a number of surgical specialties which could be carried out as day cases and has set a target of an average day case rate of 75% across the 25 procedures. This target has now been adopted within Priorities for Action, to be achieved by March 2011. Three of the procedures specifically relate to Urology (orchidopexy, circumcision, transurethral resection of bladder tumour). BADS (British Association of Day Surgery) identifies another 28 Urology operations (M and N code) which could be done as day surgery. The BADS Directory also suggests a % rate that can be achieved, which is 90% for the majority of the operations.

5.20 Table 9 below identifies the day case rates (% of all elective work undertaken as day case) in Urology by Trust and by hospital. It excludes Independent Sector activity and cystoscopies (M45) and prostrate TRUS, +/- biopsy (M70), both of which are not considered to be 'true' surgical operations and could equally be treated and coded as an outpatient with procedure case.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Table 9 Urology Day Case Rates excluding M45 and M70.3 & Y53.2 (06/07, 07/08, 08/09 - Apr 08 to Nov 08)
Independent Sector Activity has been excluded

	FY2006/2007	FY2007/2008	FY2008/2009*
Regional Total	50.0	48.4	48.7

Trust	FY2006/2007	FY2007/2008	FY2008/2009*
Belfast Health and Social Care Trust	47.1	42.9	46.4
Northern Health and Social Care Trust	31.1	32.6	27.9
South Eastern Health and Social Care Trust	78.0	74.0	69.9
Southern Health and Social Care Trust	43.7	45.4	49.1
Western Health and Social Care Trust	47.1	51.3	42.2

Site	FY2006/2007	FY2007/2008	FY2008/2009*
Altnagelvin Hospitals	47.1	51.3	42.2
Belfast City Hospital	49.9	45.5	48.9
Causeway	31.1	32.6	27.9
Craigavon Area Hospital	43.7	45.4	49.1
Down and Lisburn	98.8	100.0	89.3
Mater Infirmorum Hospital	4.9	4.2	6.9
The Royal Group of Hospitals	100.0	100.0	100.0
Ulster Community and Hospitals	76.6	71.2	66.3

5.21 There is a significant variation in day case rates across the Trusts/hospitals, ranging from 30% in Northern to 70% in South Eastern. Some of this can be explained due to the variation in 'N' code work undertaken by Urologists as opposed to General Surgeons (see Chapter 2). Trusts have also reported that on some sites access to dedicated day surgery facilities is limited and that this hampers the development of short stay elective pathways.

5.22 The CSR (Comprehensive Spending Review) is driving Trusts to reduce inpatient costs and to redesign/remodel their bed stock. This along with day surgery targets in Priorities for Action and the HSC Board's Elective Reform Programme will require Urology services to be creative in the development of day and short stay surgery, ensuring the provision of a safe model of care that provides a quality service to patients.

5.23 Trusts will need to consider procedures currently undertaken using theatre/day surgery facilities and the appropriateness of transferring this work to procedure/treatment rooms, thereby freeing up valuable theatre space to accommodate increased day surgery. Some operations will require specialised equipment and training for clinicians and some require longer recovery or observation times and so are only possible as a true day case if performed on morning sessions. Therefore, the development and expansion of day surgery may require reconfiguration of day surgery/main theatre lists, redesign of clinical pathways and investment in appropriate equipment/technology.

Recommendation

15.	Trusts will be required to include in their implementation plans, an action plan for increasing the percentage of elective operations undertaken as day surgery, redesigning their day surgery theatre facilities and should work with Urology Team in other Trusts to agree procedures for which day care will be the norm for elective surgery.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Outpatients

Table 10

Urology Outpatient Attendances - Consultant Led (06/07, 07/08, 08/09 - Apr 08 to Nov 08) - New : Review ratios

Independent Sector has been excluded

	FY2006/2007	FY2007/2008	FY2008/2009*
Regional new to review ratio	1.93	2.04	1.93

Trust	FY2006/2007	FY2007/2008	FY2008/2009*
Belfast Health and Social Care Trust	1.68	2.14	1.97
Northern Health and Social Care Trust	1.97	1.74	1.46
South Eastern Health and Social Care Trust	1.15	1.10	1.09
Southern Health and Social Care Trust	4.04	3.27	3.85
Western Health and Social Care Trust	2.34	2.21	2.78
Average new to review ratio	1.93	2.04	1.93

Site	FY2006/2007	FY2007/2008	FY2008/2009*
Altnagelvin Hospitals	2.34	2.21	2.78
Belfast City Hospital	1.84	2.90	2.44
Causeway	1.97	1.74	1.46
Craigavon Area Hospital	4.04	3.27	3.84
Down and Lisburn	1.06	1.18	1.24
Mater Infirmorum Hospital	1.63	1.11	1.47
The Royal Group of Hospitals	0.83	0.91	0.88
Ulster Community and Hospitals	1.19	1.07	1.01
Average new to review ratio	1.93	2.04	1.93

*Information for 08/09 is cumulative from 01/04/08 to 30/11/08

5.24 Regionally, there is an average new: review ratio of 1:2, with little variation from year to year. English HES data for 2006/07 reports a 1:2.4 new: review ratio. Variations are to be expected between hospitals and individual Consultants when case mix and complexity are taken into account e.g. BCH, due to a more complex case mix and Lagan Valley/RGH due to the fact that only day surgery is undertaken on these sites.

5.25 Craigavon Hospital is an outlier with regard to review ratios, with Altnagelvin Hospital having the second highest ratio.

5.26 It is disappointing to note that at the time of this review Trusts have reported a total of 9,386 patients for whom the (intended) date of their review has past (some by many months). This is referred to as a review backlog and if most of these patients had been seen within the same 2008/09 timeframe for the data above, then the new: review ratios would have been higher, particularly in Belfast and Southern Trusts. (Backlog; Belfast 5,599, Southern 2,309, Northern 668, South Eastern 431, Western 379). All Trusts have submitted action plans to address the review backlog that has arisen across a number of specialties.

Recommendations

16. Trusts should review their outpatient review practice, redesign other methods/staff where appropriate and subject to casemix/complexity issues reduce new:review ratios to the level of peer colleagues.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

17.	Trusts must modernise and redesign outpatient clinic templates and admin/booking processes to ensure they maximise their capacity for new and review patients and to prevent backlogs occurring in the future.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

6. CHALLENGES AND OPPORTUNITIES

6.1 At an early stage in the Review, an extensive round of meetings/discussion sessions were held with the various stakeholder organisations and staff to scope the challenges and opportunities of service delivery.

Challenges

6.2 A number of key themes were articulated and are summarised below:

- Increasing demand and workload pressures which were understood to be as a result of an ageing population along with people living longer, increased cancer detection and shorter waiting times arising from the elective access targets and cancer access standards, which is generating a previously unmet need in assessment and diagnostics.

- Capacity pressures (staffing), with a workforce struggling to cope with the increasing workload and meet the current targets and quality/clinical standards. This has resulted in significant reliance on independent sector and large numbers of additional clinics and theatre sessions being held internally. Both of these have been funded non-recurrently, year on year and are not sustainable in the future.

- Capacity pressures (infrastructure), on some sites, with regard to access to theatres and day surgery sessions which again results in transfer of work to independent sector. Access to elective Urology beds, in times of emergency admissions pressures, was also an issue for some sites.

- The challenges presented by the operation of 2 to 3 person Consultant teams outside of Belfast and the impact this has on on-call/cross cover arrangements, attraction and retention of clinical staff and the opportunity to develop sub specially interests and expertise. The size of the team is directly linked to its catchment population and the viability and sustainability of Urology services is dependent on a critical mass of work, of sufficient variety of conditions and treatments, to attract both training and substantive posts. The arrangements for the management and admission of acute Urological patients, particularly out of hours, in some Trusts, and the impact that the lack of such a service has on other sites was also raised as an issue.

- Impact of junior doctors hours, EWTD (European Working Time Directive) and in particular, changes to the training programme have resulted in a reduction in "the medical workforce", a shift from Consultant led services to Consultant delivered services and additional requirements on Consultants to directly provide and supervise training opportunities.

- Challenges around the cancer agenda and in particular, compliance with IOG (Improving Outcomes Guidance) and preparing for the Peer Review Exercise in 2010.

- Concerns were expressed about how service development tends to take place within and is restricted by Trust/Organisational boundaries. Also about inconsistent access/pathways for patients.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Opportunities

6.3 Within the various service and staff groups there was a strong desire and commitment to making significant improvements to Urology services in Northern Ireland.

6.4 There was general acceptance that additional investment was not the only solution: Making better use of the existing resources was also necessary and that the review of Urology services created significant opportunities to develop and re-design services, provide high quality, timely and cost effective services to patients and the community and to support and develop the individual and teams within this important specialty.

6.5 There was also a strong sense of wanting to do things differently and of the need to change and adapt to a changing landscape in terms of public expectations, targets and standards, changing pattern of disease and treatment, new technologies and techniques and employment and training legislation and entitlement.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

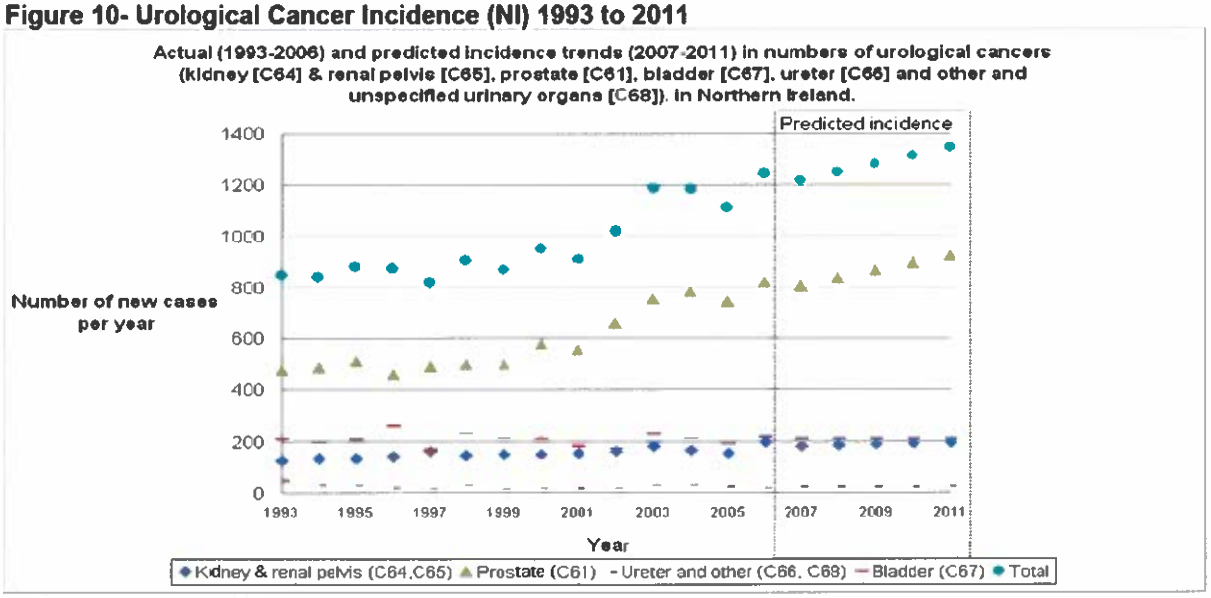
7. UROLOGICAL CANCERS

7.1 Around 40% of Urology work is cancer related and in addition to intensive assessment, diagnostics and treatment requirements, there is also a requirement for considerable patient follow-up, support and surveillance services. Cancer becomes more common with increasing age with almost 2 out of every 3 cancers diagnosed in people aged 65 and over.

7.2 Cancer of the prostate, testis, penis, kidney and bladder as a group has the highest volume of cancer incidence than any other specialty, with 1,246 incidence recorded on the cancer registry for 2007. The next highest is breast, followed by colorectal and lung.

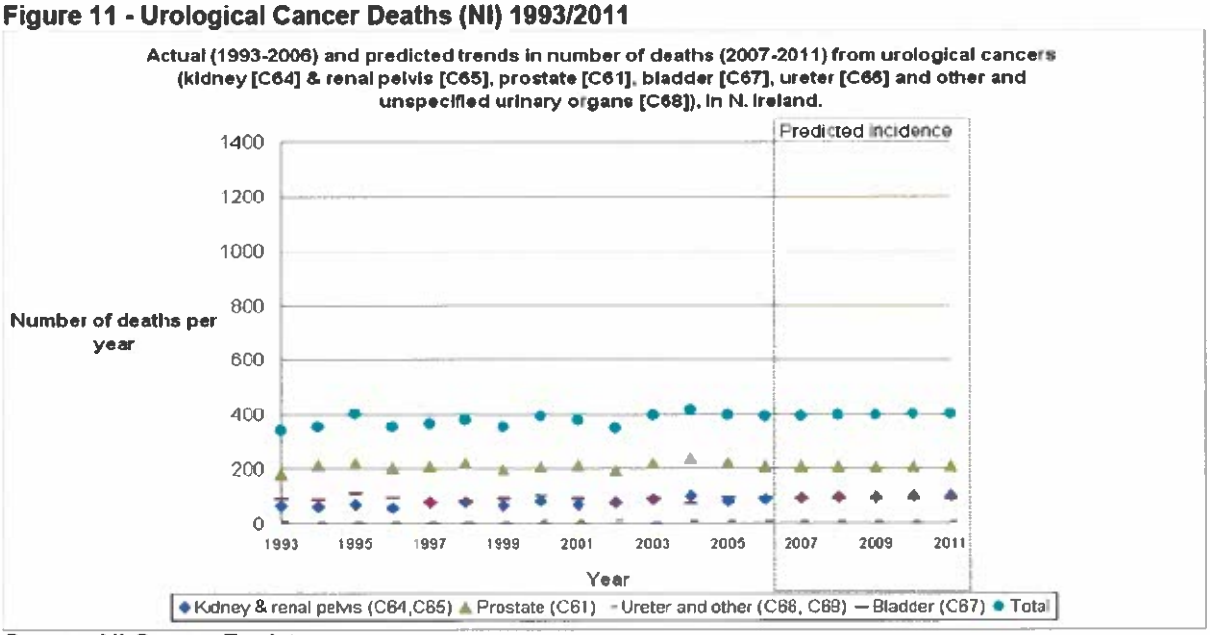
Cancer Incidence and Mortality

Figure 10- Urological Cancer Incidence (NI) 1993 to 2011



Source: NI Cancer Registry

Figure 11 - Urological Cancer Deaths (NI) 1993/2011



Source: NI Cancer Registry

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

7.3 Bladder and ureter incidence has been and is likely to remain stable (approximately 230).

7.4 Kidney cancer incidence has increased by almost 50% between 1993 and 2006 (196 in 2006), with a corresponding rise in deaths. By 2011, there could be further slight increases.

7.5 Prostate cancer incidence increased by 70% between 1993 and 2006 (817 in 2006). By 2011, it is predicted to increase by a further 20% compared with current incidence, but the number of deaths remains stable.

7.6 Prostate cancer is the second most frequently diagnosed cancer among men of all ages; testicular cancer, although relatively infrequent, is nevertheless the most common cancer in men under 45 years of age. Cancer of the penis, by contrast, is rare. Cancers of the kidney and bladder are roughly twice as common among men.

7.7 The main presenting symptoms of primary urological tumours fall into 3 groups:

- Lower urinary tract symptoms
- Haematuria and
- Suspicious lumps.

7.8 Haematuria is the most common symptom of both bladder and kidney cancer, although kidney cancer is often asymptomatic until it reaches a later stage.

7.9 Early, asymptomatic prostate cancer is being diagnosed more in recent years due to increase use of PSA testing and men's health awareness programmes.

Guidance and Standards

7.10 The NI Report "Cancer Services: Investing in the Future" (The Campbell Report) published in 1996 recommended that delivery of cancer services should be at three levels: Primary Care, Cancer Units and the Cancer Centre. The 2000 Review of Urological Services in Northern Ireland endorsed the principles of the Campbell Report and took account of them in their recommendations.

7.11 In 2002, NICE published guidance on cancer services-"Improving Outcomes in Urological Cancers-The Manual" (IOG).

7.12 The key recommendations from IOG are in Appendix 6. The recommendations relate to the requirement to have dedicated, specialist, multidisciplinary Urological cancer teams, making major improvements in information and support for patients and carers, with nurse specialist having a key role in these services, and having specific arrangements in place to undertake radical surgery for prostate and bladder cancer.

7.13 In 2008, under the auspices of NICaN (Northern Ireland Cancer Network) a new Urological tumour group was set up and has to date met on three occasions. Mr H Mullen chairs this group with Mr P Keane, Consultant Urologist, Belfast Trust, serving as the lead clinician. Mr Keane is also a member of the Review Steering

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Group (as a NICAN lead) along with Dr D Hughes, NICaN Medical Director and Mrs B Tourish, NICaN, Clinical Network Co-ordinator.

7.14 The NICaN Group has agreed priority areas of work, based on IOG, including the development and implementation of formal dedicated MDTs / MDMs, implementing referral guidelines and agreed pathways for diagnostics and treatment of each of the cancers, developing patient information and guidance and ensuring suitable arrangements are in place prior to the Peer Review planned for 2010.

Recommendation

18. The NICaN Group in conjunction with each Trust and Commissioners should develop and implement a clear action plan with timelines for the implementation of the new arrangements/enhanced services in working towards compliance with IOG.

7.15 A key element of IOG is the requirement to undertake radical pelvic surgery on a single site, serving a population of 1 million or more, in which a specialist team carries out a cumulative total of at least 50 such operations (prostatectomy (M61)and cystectomy (M34) per annum.

7.16 Tables 11 and 12 outline the number of radical pelvic operations carried out in 2006/07 and 2007/08 by Trust and Consultant.

Table 11 – Radical Pelvic Surgery 2006/07

Trust	Consultant	M34 Bladder	M61 Prostate	Total
BHSCT	Cons A	3	11	*14*
	Cons B	8	14	*22*
	Cons C	9	11	*20*
	Cons D	5	0	*5*
Total		25	36	*61*
SHSCT	Cons A	3	1	*4*
	Cons B	8	5	*13*
	Cons C	2	5	*7*
Total		13	11	*24*
WHSCT	Cons A	3	17	*20*
Total		3	17	*17*
Grand Total		41	64	*105*

Table 12 – Radical Pelvic Surgery 2007/08

Trust	Consultant	M34 Bladder	M61 Prostate	Total
BHSCT	Cons A	6	12	*18*
	Cons B	7	18	*25*
	Cons C	20	12	*32*
	Cons D	3	0	*3*
	Cons E	1	0	*1*
Total		37	42	*79*
SHSCT	Cons A	0	1	*1*
	Cons B	3	1	*4*
	Cons C	5	3	*8*
	Cons D	0	3	*3*
Total		8	8	*16*
WHSCT	Cons A	0	7	*7*
Total		0	7	*7*
Grand Total		45	57	*102*

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

7.17 The Northern and South Eastern Trust do not undertake such operations and patients requiring/choosing radical surgery are referred to BCH.

7.18 In 2007/08 77% of radical pelvic operations were undertaken in Belfast Trust (BCH). Neither the Southern or Western Trust (separately or together) undertake the required number (50) of such operations. Four of the existing Consultants undertake small (<5) numbers of each of the procedures. With a total of just over 100 procedures a year, a population less than 2 million and, with the potential for this activity to reduce with the implementation of a brachytherapy service in the next year, a single site for radical pelvic surgery is considered to be the appropriate way forward if IOG compliance is to be achieved.

Recommendations

19.	By March 2010, at the latest, all radical pelvic surgery should be undertaken on a single site, in BCH, by a specialist team of surgeons. The transfer of this work should be phased to enable BCH to appoint appropriate staff and ensure infrastructure and systems are in place. A phased implementation plan should be agreed with all parties.

20.	Trusts should ensure that surgeons carrying out small numbers (<5 per annum) of either radical pelvic operation, make arrangements to pass this work on to more specialised colleagues, as soon as is practicably possible, (whilst a single site service is being established).

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

8. CLINICAL WORKFORCE REQUIREMENTS

Consultant staffing

8.1 In 1996, BAUS (British Association of Urological Surgeons) recommended a Consultant: Population ratio of 1:80,000 by 2007. In 1999 the ratio in Northern Ireland was 1:167,000 population reducing to 1:103,000 population at the time of the review in 2009, with a funded establishment of 17 wte Consultants.

8.2 In the 2000 "Report of a working group on Urological Services in Northern Ireland" a ratio of 1:100,000 population was recommended due to Northern Ireland's younger age profile. BAUS had indicated that the demand for Urological Services is related to the age structure of the population and specifically with the proportion of 65 years.

8.3 In 1996, the percentage of those aged 65 years and over in Northern Ireland was 12.85% and at this time was considerably lower than in England (15.8%) and Wales (15.2%). By 2007 Northern Ireland's percentage of over 65 had risen to 14.1% and is predicted to rise further to 16.7% by 2018.

8.4 A total population of 1.76 million in 2008 and a Consultant to population ratio of 1:80,000, would equate to a funded establishment of 22 wte Consultant Urologists.

8.5 The NI Urology SAC (Specialist Advisory Committee), in estimating the number of higher specialist trainees required by 2018, have used a Consultant Urologist workforce of 38 wte by 2018. In projecting future staffing, SAC took account of "Developing a Modern Surgical Workforce" published by the Royal College of Surgeons in England (2005) and subsequent interim review of October 2006. The Royal College suggests that for a population of 1 million the requirement will be 8-9 specialist surgeons and 8-10 generalists.

8.6 Based on an average age of retirement of 60 years of age, the anticipated retirements in Urology between 2009 - 2018 is four. Taking this into account along with the Royal Colleges projected future staffing requirements, SAC have recommended an increase in the number of higher specialist trainees from the current 8 at ST3+ (year 3 and above) to up to 15 by 2018.

8.7 SAC have confirmed that they are content, at this time, with the Consultant to population ratio proposals within this review i.e. 1:80,000.

Consultant Programme

8.8 Guidelines for a Consultant job plan (agreed by the Royal College of Surgeons and adopted by the Association of Surgeons of Great Britain and Ireland) are based on a commitment of 10 notional half days.

8.9 The traditional Consultant contract has 6 + 1 (special interest) fixed sessions with 3 flexible sessions. BAUS Council recommend a 5 + 1 fixed session contract with 4 flexible sessions for Consultant Urologists.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

"A Quality Urologist Service for Patients in the New Millennium - Guidelines on Workload, Manpower and Standards of Care" (BAUS 2000) recommends a typical job plan as outlined below:

Operating Theatre	3 NHD
Outpatient Clinics	2 NHD
Specialist Interest	1 NHD
Ward Round plus on-call	1 NHD
Post Graduate Education:	1NHD

To Include:

- Audit, teaching
- Pathology and X-ray meetings
- Clinical Governance
- Quality Assurance
- Mortality and Morbidity meetings

Flexible commitment	2 NHD

On-call rota 1:5

- *Special interest sessions may be used to provide additional operating, specific outpatient clinics, uro dynamics, lithotripsy or to supervise the research activities of the Department.*
- *Involvement in clinical management, audit and clinical governance will occupy significant clinical time and provision must be made for these activities within the job plan, as should participation in MDM's for all Urologists.*
- *Flexible sessions cover duties, which may be performed at different times, over different weeks and even sometimes outside standard working hours. These will include clinic administration, travel, inter-departmental referral and continuing clinical responsibility. They will also include time spent after operating sessions and clinics "tidying the desk", talking to patients relatives, visiting patients on the ward prior to operation, reviewing patient notes, results and ensuring that these are made known to patients and to the relevant medical practitioners.*

Workloads

8.10 Both BAUS and The Royal College of Surgeons outline similar workloads/activity that can be expected from a Consultant's working week, based on a 42 week working year.

8.11 **Outpatients (new and review)** - A Consultant working alone should see between 1176 and 1680 patients per annum. *Consultants with a major sub specialty interest e.g. oncology, will see significantly fewer patients due to case complexity and a need to allocate more time to each patient. Teaching, particularly under graduates and house officers, will also reduce the number of cases per clinic.*

8.12 To allow sufficient time for proper assessment and counselling, it is accepted practice to allow approximately 20 minutes for a new patient consultation and 10 minutes for a follow-up consultation. Therefore in a standard clinic an Urologist, working on his own should see 7 new patients and 7 follow-up patients. This can be

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

adjusted locally depending on case complexity up to a maximum of 20 patients (new and review) per clinic.

8.13 **In patient/day case activity** - *The average Consultant Urological Surgeon, and his team, should be performing between a 1000 and 1250 inpatient and day patient FCEs per annum. The exact number will depend on sub specialty interest, case mix, the number of operating sessions in the job plan and whether the Urologist has an obligation to train a specialist registrar. For example, some specialists in oncology, who perform lengthy complex procedures, would be expected to have fewer FCEs than their generalist counterparts.*

8.14 The activity analysis outlined in section 4 of the report outlines projected activity of 21,571 episodes in 2008/09. This figures includes in-house additional activity provided by Trusts but excludes activity sent out to the Independent Sector. With no further reduction in elective waiting times in 2009/10, it will be possible to make a more robust assessment of recurrent demand during the year.

8.15 The activity delivered by Trusts in 2008/09 equates to 21.5 wte consultant staff, taking account of the average workload figures above. However, due to complexity/casemix issues not all Consultants will perform the average number of FCEs. For example, with the creation of single site for radical pelvic surgery there will be a requirement for an additional Uro-oncology Consultant at the BCH.

Recommendation

21.	To deliver the level of activity from 2008/09 and address the issues around casemix and complexity it is recommended that the number of Consultant Urologists is increased to 23 wte.

8.16 This level of investment in staffing infrastructure will allow Urology services to be recurrently provided at 2008/09 outturn levels. In terms of future proofing, Trusts will be required to look at further efficiencies within existing capacity with a view to increasing the average workload per Consultant to the higher level in the context of changing demographics with an older population which will place additional demands on Urology services over the coming years. This is particularly relevant to the Northern and Southern Trusts where Consultant workloads are significantly below their peer colleagues and BAUS guidelines.

Recommendation

22.	Urology Teams must ensure that current capacity is optimised to deliver the number FCEs by Consultant as per BAUS guidelines (subject to casemix and complexity). This may require access to additional operating sessions up to at least 4 per week (42 weeks per year) and an amendment to job plans.

Nurse Staffing

8.17 The additional nursing and support staff requirements to support the additional clinics and theatre sessions that will be implemented with the appointment of new Consultants are included in the estimated costing in Appendix 7.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

8.18 To ensure high quality nursing services and effective and efficient use of highly specialised equipment and instruments it is essential that nurses working in Urology wards, theatres and other departments are fully trained and competent in the field of Urology.

8.19 Specialist nurses and practitioners have a key and expanding role to play in a modern Urology Service. There are many examples of nurses, within and outwith ICATS teams, undertaking assessment, diagnostic, treatment and follow-up of areas of Urology such as erectile dysfunction, LUTS (Lower Urinary Tract Symptoms), haematuria clinics, stones etc.

8.20 Specialist (Uro-Oncology) nurses must be dedicated, fully participating members of any cancer MDT, actively represent the patient's interests at MDM's and have a key role to play in carrying out detailed assessment of patients needs in order to provide, or coordinate good care. They have a particular role to play at "results" clinics and in assisting patients and carers in making informed decisions and choices regarding treatment options, the management of and living with the symptoms and consequences of their cancer and the treatments/interventions.

8.21 Under the auspices of NICaN, in collaboration with the senior nurses for cancer services across the Northern Ireland and English networks, a number of cancer site specific, clinical nurse specialist benchmarking censuses have been completed. There are a total of 12 specialist nurses in Urology in Northern Ireland at this time. However, few of these staff are solely dedicated to cancer care and therefore an estimate of the wte (whole time equivalent) has been made. In November 2008 there were estimated to be 4 wte oncology nurse specialists -1.5 in BCH, 2 in Altnagelvin and .5 in the Ulster.

8.22 Table 13 below outlines the results of a benchmarking exercise completed in November 2008, in which each of the cancer networks identified the incidence of cancer and calculated an average caseload per Clinical Nurse Specialist (CNS).

Table 13 - CNS caseload benchmarking data

	Lung	Breast	Urology	Colo-rectal	Gynae	Upper GI	Haem	Skin	Head & Neck	Brain
Cancer incidence	845	1,031	1,246	995	450	562	411	208	127	109
Total no CNS in post 2008	7.5	14	4	3	2	1	3	3	2	1
NI mean caseload	112	73	311	331	225	562	137		63	109
England mean caseload	122	81	131	89	77	98	70		66	81
Additional nos needed	3	2	5	4	4	3.5	5	1	2.5	1
Future NI mean caseload	80	64	138	142	75	125	52		51	54.5

8.23 There are higher numbers of Urological cancer incidences than in any other speciality and these CNSs have the third highest (upper GI is the highest at 562) mean caseload at 311, which is more than double the English mean caseload.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

8.24 This shortfall will need to be addressed if significant improvements are to be made in the cancer pathways, waiting times, support and follow-up for Urology patients in Northern Ireland.

Recommendation

23.	At least 5 Clinical Nurse Specialists (cancer) should be appointed (and trained). The deployment of these staff within particular teams will need to be decided and Trusts will be required to develop detailed job plans with caseload, activity and measurable outcomes agreed prior to implementation. A further review and benchmarking of cancer CNSs should be undertaken in mid 2010.

Radiology Staffing

8.25 The assessment and diagnostics of Urological diseases/conditions involves intensive and high volumes of radiology services across a broad range of modalities-ultrasound (KUB, TRUS), IVP, CT and MRI scans, along with the provision of an interventional radiology service. As Urology services are redesigned and streamlined, radiology services will be required to respond and adapt to the new service models and pathways and in particular accommodate more single visit haematuria, LUTS, prostate and stones clinic.

8.26 In addition to any further investment, radiology services will be required to ensure optimum and enhanced use of current available capacity by modernising and reforming the systems and processes currently in place.

8.27 In recognition of the significant capacity gap in Urology to meet the growing demand, a number of additional Consultants will be appointed and a significant number of additional patients will need to be assessed and treated internally. Additional radiology staffing to support these appointments (included in the estimated costs in Appendix 7) has been calculated using the Adenbrookes formula of .3 wte Consultant Radiologist per wte Consultant Urologist and a ratio of 6 wte band 5 Radiographers per wte Radiologist.

Pathology and Radiotherapy Services

8.28 It is recognised with the volumes of Urological cancers, the Urology service is a high user of both pathology and radiotherapy services. However, given the work being undertaken by NICaN, within the Cancer Services Framework and the supporting cancer investment plan, and the Pathology Services Review, published in December 2007, it was agreed that the current Urology review would not include a detailed assessment of these services. Investment in an additional band 7, BMS is however included in the estimated costs in appendix 7, in recognition of the increased diagnostic workload associated with growing PSA work and the centralisation of radical pelvic surgery on the BCH site.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

9. SERVICE CONFIGURATION MODEL

9.1 In section 6 the key challenges currently being faced by the service were outlined. In summary, these related to the capacity to deliver a modern, quality service and the ability to achieve and sustain long term stability and viability, with a stable workforce that can continue to attract the necessary expertise across all of the professions.

9.2 It has been recognised that investment in additional capacity and staff will not on its own resolve the challenges relating to long term service stability. This will require a reconfiguration of teams/services into more sustainable units thus enabling the service to make the best use of any investment made.

9.3 A number of models (6) for future service delivery were developed. These ranged from 5 teams in NI, with each Trust having its own discrete urology service and its staffing and workload based on its current catchment population, to 2 teams in NI.

9.4 A sub group of clinicians, Trust and Board Managers developed criteria and a weighted scoring system against which each of the models could be assessed. The 5 criteria (Appendix 8) were:

- Service stability/sustainability (population, team size, dedicated skilled radiology and nursing staff, rotas and EWTD.
- Feasibility (ease and speed of implementation).
- Compliance with DHSSPS policy/strategy, commissioner intent/support, compatibility with Trusts strategic development plans and impact on other services.
- Inpatient accessibility.
- Organisational complexity.

9.5 At the Steering Group meeting on 20 January 2009, each of the 6 models was evaluated against the agreed criteria. Model 3 (Appendix 9) was agreed as the preferred model and was deemed to be the most appropriate way forward for urology services.

Recommendation

24.	Urology services in Northern Ireland should be reconfigured into a 3 team model, to achieve long term stability and viability.

9.6 Model 3 comprises 3 teams, which for ease of description are called Team North, Team South and Team East. Table 14 below outlines the main elements of each of these teams.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Teams	Geographical Area/ Catchment Population	Consultant Staffing/Suggested Special Interest Areas**	Arrangements for Elective and Non Elective Services
Team North	Upper2/3rd of Northern* and Western integrate to form one Team/Network. Catchment population circa 480,000	Six wte All core Urology Uro-oncology – 2 Stones/endourology – 2* Functional/female Urology – 1 Andrology – 1	One on-call rota (1:6). One local MDT/MDM.*** Main acute elective and non elective inpatient unit in Altnagelvin Approximately 7 elective beds in Causeway(Selected minor/intermediate cases) Day surgery – Altnagelvin, Causeway, Tyrone County Outpatients – Altnagelvin, Causeway, Tyrone County, Roe Valley May wish to consider outreach outpatient and/or day case diagnostics in Mid-Ulster *Mobile ESWL (Lithotripter) on Causeway site
Team South	Lower 1/3rd Western (Fermanagh) and all of Southern integrate to form one Team/Network. Catchment population circa 410,000	Five wte All core Urology Uro-oncology – 2 Stones/endourology – 2* Functional/female Urology – 1	One on-call rota (1:5). One local MDT/MDM.*** Main acute elective and non elective inpatient unit in Craigavon Day surgery – Craigavon, South Tyrone, Daisy Hill Outpatients – Craigavon, South Tyrone, Daisy Hill, Banbridge, Armagh May wish to consider outreach outpatients and/or day case diagnostics in Erne/ Enniskillen *Static/fixed ESWL (lithotripter) on Craigavon site.
Team East	SET + Belfast integrate to form one Team/Network-continue to provide service to patients from Southern sector of Northern Trust (Newtownabbey, Carrickfergus, Larne, ?Antrim). Catchment population circa 870,000 Complex cancer catchment 1.76m	Twelve Wte All core Urology Uro-oncology/cancer centre – 4 Stones/endourology – 3* Functional/female Urology – 2 Reconstruction – 3	One on-call rota (1:12) (may wish to consider 2nd tier on-call). One local MDT/MDM plus regional/specialist MDM.*** Main acute elective and non elective unit in BCH, with elective also in Mater and Ulster Day surgery – BCH, Mater, Lagan Valley, Ards, Downe Outpatients – BCH, Ulster, Mater, Royal, MPH, Ards, Lagan Valley, Downe Should provide outreach outpatient, day case diagnostics and day surgery in Antrim and/or Whiteabbey/Larne *Mobile ESWL lithotripter on BCH site.

Table 14 Elements and Arrangements in Three Team Model

*Population estimates for local District Council areas in Appendix 10. Precise catchment 'lines' on map to be clarified.

** Suggested special interest areas derived from discussions with clinicians and from BAUS guidelines.

*** MDM reconfiguration has been approved by NICaN Group

WIT-50852

9.7 In response to concerns expressed at the Steering Group Meeting in January 2009, Speciality Advisor (local and 'Island of Ireland') advice was sought around the issue of a single handed Consultant doing on-call from home covering elective and non elective patients on different sites. The advice has confirmed that such arrangements are possible and that a similar situation exists in other specialties e.g. Trauma and Orthopaedics.

9.8 Urologists have advised that there are very few occasions when a Consultant's presence is required, out of hours, to deal with an elective post operative complication/event. Equally, as described in the previous section of this report, the vast majority of non elective admissions, out of hours, do not require a Consultant's intervention. However, surgeons undertaking elective inpatient surgery on a site other than the main acute unit should use morning lists so as to further ameliorate the impact of out of hour's events. They can minimise the impact further through careful choice of the nature and type of surgery undertaken.

Recommendations

25.	Teams North and East (Northern, Western, Belfast and South Eastern Trusts) should ensure that prior to the creation of the new Teams, there are clear, unambiguous and agreed arrangements in place with regard to Consultant on-call and out of hours arrangements.

26	Each Trust must work in partnership with the other Trust/s within the new team structure to determine and agree the new arrangements for service delivery, including inter alia, governance, employment and contractual arrangements for clinical staff, locations, frequency and prioritisation of outreach services, areas of Consultant specialist interest based on capacity and expertise required and catchment populations to be served.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

10. IMPLEMENTATION ISSUES

10.1 To implement the review recommendations a recurrent (full year) investment of £2.875m has been estimated (Appendix 7). Commissioners will need to consider the method of allocating funding to support the full implementation of the recommendations, particularly with regard to aligning the allocation to the additional Consultant distribution profile.

10.2 Trusts and Commissioners will need to take forward discussions with General Practitioners around referral pathways and patient flows in the context of the proposed three team model.

10.3 Trusts will be required to submit detailed business cases prior to funding being released.

10.4 Trusts and Commissioners will need to agree timescales and the measurable outcomes in terms of additional activity, improved performance, a phased reduction in Independent Sector usage and service reform and modernisation plans.

10.5 The implementation of the recommendations of the review may/ will require capital investment to put in place additional physical infrastructure such and to fund equipment associated with technologically driven sub-specialty areas. e.g. endo-urology, reconstruction, laser surgery. Where capital requirements are identified, Trusts should process these bids through their normal capital and business planning cycle.

10.6 The new Teams (Trust partnerships) will be required to submit project plans for implementation of the new arrangements which is envisaged to be on a phased and managed basis. The new Health and Social Care Board will establish an Implementation Board to oversee the process.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

GLOSSARY OF TERMS/ABBREVIATIONS

BADS- British Association of Day Surgery

BPH – Benign Prostatic Hyperplasia
A non –cancerous condition in which an overgrowth of *prostate* tissue pushes against the *urethra* and the bladder, restricting or blocking the normal flow of urine. Also known as benign prostatic hypertrophy. This condition is increasingly common in older men.

Biopsy
Removal of a sample of tissue or cells from the body to assist in diagnosis of a disease.

Bladder reconstruction
A surgical procedure to form a storage place for urine following a *cystectomy*. Usually, a piece of bowel is removed and is formed into a balloon-shaped sac, which is stitched to the *ureters* and the top of the urethra. This allows urine to be passed in the usual way.

Brachytherapy
Radiotherapy delivered within an organ such as the prostate.

CNS
Clinical Nurse Specialist

Cystectomy
Surgery to remove all or part of the bladder.

Cystoscope
A thin, lighted instrument used to look inside the bladder and remove tissue samples or small tumours.

Cystoscopy
Examination of the bladder and *urethra* using a *cystoscope*.

ED
Erectile dysfunction

EWTD
European Working Time Directive

Genital
Referring to the external sex or reproductive organs.

Haematuria
The presence of blood in the urine. Macroscopic haematuria is visible to the naked eye, whilst microscopic haematuria is only visible with the aid of a microscope.

HES/Hospital Episode Statistics
HES is the national statistical data warehouse for England of the care provided by NHS hospitals and NHS hospital patients treated elsewhere.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Incontinence
Inability to control the flow of urine from the bladder (urinary) or the escape of stool from the rectum (faecal)

IVP – Intravenous Pyelogram
An x-ray examination of the kidneys, ureters and urinary bladder that uses iodinated contrast material injected into veins.

KUB
Kidney, Ureter, Bladder (Ultrasound)

Laparascopic surgery
Surgery performed using a laparascope; a special type of endoscope inserted through a small incision in the abdominal wall.

LUTS
Lower Urinary Tract Symptoms

MRI - Magnetic resonance imaging
A non-invasive method of imaging which allows the form and metabolism of tissues and organs to be visualised (also known as nuclear magnetic resonance).

MDMs
Mutli-disciplinary meetings

MDTs
Mutli-disciplinary teams

NICaN
Northern Ireland Cancer Network

Oncology
The study of the biology and physical and chemical features of cancers. Also the study of the causes and treatment of cancers.

Prostatectomy
Surgery to remove part, or all of the *prostate gland*. Radical prostatectomy is the removal of the entire *prostate gland* and some of the surrounding tissue.

Prostate gland
A small gland found only in men which surrounds part of the urethra. The prostate produces semen and a protein called *prostate specific antigen (PSA)* which turns the semen into liquid. The gland is surrounded by a sheet of muscle and a fibrous capsule. The growth of prostate cells and the way the prostate gland works is dependent on the male hormone *testosterone*.

PSA – Prostate Specific Antigen
A protein produced by the *prostate gland* which turns semen into liquid. Men with prostate cancer tend to have higher levels of PSA in their blood (although up to 30% of men with prostate cancer have normal PSA levels). However, PSA levels may also be increased by conditions other than cancer and levels tend to increase naturally with age.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Radical treatment
Treatment given with curative, rather than *palliative* intent.

Radiologist
A doctor who specialises in creating and interpreting pictures of areas inside the body. The pictures are produced with x-rays, sound waves, or other types of energy.

Radiotherapy
The use of radiation, usually x-rays or gamma rays, to kill tumour cells. Conventional external beam radiotherapy also affects some normal tissue outside the target area. Conformal radiotherapy aims to reduce the amount of normal tissue that is irradiated by shaping the x-ray beam more precisely. The beam can be altered by placing metal blocks in its path or by using a device called a multi-leaf collimator. This consists of a number of layers of metal sheets which are attached to the radiotherapy machine; each layer can be adjusted to alter the shape and intensity of the beam.

Renal
Of or pertaining to the Kidneys.

Resection
The surgical removal of all or part of an organ.

Scrotum
The external sac that contains the testicles.

Testicle or testis (plural testes)
Egg shaped glands found inside the scrotum which produce sperm and male hormones.

TRUS Tran-rectal ultrasound (TRUS)
An *ultrasound* examination of the prostate using a probe inserted into the rectum.

Trans-uretharal resection (TUR)
Surgery performed with a special instrument inserted through the urethra.

Trans-urethral resection of the prostate (TURP)
Surgery to remove tissue from the prostate using an instrument inserted through the urethra. Used to remove part of the tumour which is blocking the urethra.

Ultrasound
High-frequency sound waves used to create images of structures and organs within the body.

Ureters
Tubes which carry urine from the kidneys to the bladder.

Urethra
The tube leading from the bladder through which urine leaves the body.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Urogenital system
The organs concerned in the production and excretion of urine, together with the organs of reproduction.

Urologist
A doctor who specialises in diseases of the urinary organs in females and urinary and sex organs in males.

Urology
A branch of medicine concerned with the diagnosis and treatment of diseases of the urinary organs in females and the urogenital system in males.

Uro-oncologist
A doctor who specialises in the treatment of cancers of the urinary organs in females and urinary and sex organs in males.

Vasectomy
Surgery to cut or tie off the two tubes that carry sperm out of the *testicles*.

WTE
Whole Time Equivalent

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

APPENDICES

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Appendix 1

Regional Urology Steering Group

Membership

Mr Hugh Mullen (Chair)	SDU, Director of Performance and Provider Development
Mr Mark Fordham	External Advisor, Consultant Urologist
Ms Catherine McNicholl	SDU, Programme Director (Project Manager)
Mr Paul Cunningham	SDU, Performance Manager
Dr Hubert Curran	SDU, Primary Care Advisor
Dr Windsor Murdock	SDU, Primary Care Advisor
Dr Miriam McCarthy	DHSS&PS, Director Secondary Care
Dr Dermot Hughes	NICaN, Medical Director
Mr Patrick Keane	Belfast Trust, Lead Clinician NICaN Urology Group
Dr Diane Corrigan	SHSSB, Consultant Public Health
Dr Janet Little	EHSSB, Acting Director Public Health
Dr Christine McMaster	EHSSB, Specialist Registrar, Public Health
Dr Adrian Mairs	NHSSB, Consultant Public Health
Mr Alan Marsden	NHSSB, Elective Care Commissioning Manager.
Dr Bill McConnell	WHSSB, Director Public Health
Mrs Rosa McCandless	WHSSB, Information Manager
Mrs Karen Hargan	Western Trust, Assistant Director Surgery/Acute Services
Mr Colin Mulholland	Western Trust, Consultant Urologist
Ms Carmel Leonard	Western Trust, Lead Nurse Surgery
Mr Paul Downey	Northern Trust, Consultant Urologist
Mr Martin Sloan	Northern Trust, Director Elective and

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

	Acute Services
Dr Brian Armstrong	Belfast Trust, Co-Director Specialist Services
Mr Chris Hagan	Belfast Trust, Consultant Urologist
Mr Brian Duggan	Belfast Trust, Consultant Urologist
Mr Brian Best	South Eastern Trust, Consultant Urologist
Mr John McKnight	South Eastern Trust, Consultant Urologist
Mrs Diane Keown	South Eastern Trust, Assistant Director Surgery.
Ms Joy Youart	Southern Trust, Acting Director Acute Services
Mr Michael Young	Southern Trust, Consultant Urologist
Mrs Jenny McMahon	Southern Trust, Nurse Specialist.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Appendix 2

Regional Review of Adult Urology Services

Terms of Reference

Overall Purpose

To develop a modern, fit for purpose in the 21st century, reformed service model for Adult Urology services which takes account of relevant Guidelines (NICE, Good Practice, Royal College, BAUS, BAUN). The future model should ensure quality services are provided in the right place, at the right time by the most appropriate clinician, through the entire pathway from Primary Care to Intermediate to Secondary and Tertiary Care.

It is anticipated that the Review Report will be available for submission to the Department in December 08, subject to Steering Group approval. A multi-disciplinary, key stakeholder Steering Group, chaired by Mr Hugh Mullen will meet to consider and approve the review findings and proposals.

The Review will include the following;

1. Baseline assessment of current service model identifying what is provided where, by whom, performance against access standards and the current profile of investment.

2. Expand on the current capacity/demand modelling exercise to take account of case mix with a view to identifying capacity gaps and informing future investment plans.

3. Develop a service model with agreed patient pathways which informs the distribution of services. The model will also outline proposals for optimising safe, effective and efficient Urology services which meet both access and quality standards/outcomes. The following aspects of the service will be considered;

    - Management of referrals and diagnostics including urodynamics.
    - Development and use of ICATS services
    - Management of acute urological admissions
    - Core Urology (secondary care) Services
    - Andrology Services
    - Interventional Uro-Radiology
    - Endourology/Stone Service
    - Uro-oncology Services
    - Relationship with Uro-gynaecology Services
    - Reconstruction and Neurourology Service
    - Acute Urological management of nephrology patient

4. Make recommendations, as appropriate, on the relationship with the Transplant service and waiting time targets for live donor transplantations.

5. Review workforce planning and training / development needs of the service group and ensure any proposals take account of the need to comply with EWTD (European Working Time Directive.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Appendix 3

UROLOGY REPORTS/ REVIEWS

Northern Ireland Review Reports

Report of the EHSSB Sub Group on Urological Cancer	Sept 1997
Report of the Working Group on Urology Services in Northern Ireland	May 2000
Update on Urology Cancer Services in the EHSSB	Oct 2001
External Review of Urology Services for Craigavon Area Hospital Group	Aug 2004
Draft Service Framework for Cancer Prevention, Treatment and Care – (Urology section)	Version 7 June 2008

National Reports

BAUS – A Quality Urological Service for Patients in the New Millennium	Oct 2000
BAUS – The Provision of Urology Services in the UK	Feb 2002
NICE – (Guidance on Cancer Services) Improving outcomes in Urological Cancers	Sept 2002
Modernisation Agency – Action on Urology – Good Practice Guide	Mar 2005
Providing Care for Patients with Urological Conditions: guidance and resources for commissioners (NHS)	2008
NICE – Urinary Incontinence: the management of urinary incontinence in women	2006
NICE – Prostate Cancer: diagnosis and treatment	2008
NICE – (Urological) Referral guidelines for suspected cancer	2005

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Appendix 4

GP REFERRAL EXERCISE - PERCENTAGES

Gender	Belfast	Northern	Western	Southern	SE	Regional Average
Male	77	74	76	79	75	76
Female	23	25	22	21	25	23
Blank	0	2	2	0	0	1
Total	100	100	100	100	100	100
Age Range	**Belfast**	**Northern**	**Western**	**Southern**	**SE**	**Regional Average**
0-14	1	0	0	2	0	1
15-30	12	8	11	6	10	10
31-40	13	8	11	15	5	11
41-50	20	17	9	13	7	15
51-60	13	25	20	11	5	14
60+	41	42	49	53	12	38
Blank	0	2	0	0	60*	12
Total	100	100	100	100	100	100
Urgency	**Belfast**	**Northern**	**Western**	**Southern**	**SE**	**Regional Average**
Red Flag	4	4	7	6	5	5
Urgent	21	21	22	19	16	20
Routine	75	75	71	75	78	75
Blank	0	0	0	0	0	0
Total	100	100	100	100	100	100
Named Cons	**Belfast**	**Northern**	**Western**	**Southern**	**SE**	**Regional Average**
Y	24	25	13	23	21	22
N	76	75	87	77	79	78
Total	100	100	100	100	100	100
Ref Source	**Belfast**	**Northern**	**Western**	**Southern**	**SE**	**Regional Average**
Non-GP ref's	10	23	2	9	19	13
GP Ref's	90	77	96	91	81	87
Blank	0	0	2	0	0	0
Total	100	100	100	100	100	100

* 44 out of 73 referrals in SET had DOB deleted-therefore not possible to record age range.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Appendix 5

GP REFERRAL EXERCISE – PRESENTING SYMPTOMS (PERCENTAGES)

Presenting Symptom/Condition		Belfast		Northern		Western		Southern		SE		Regional	
Haematuria (ALL)		13		19		22		9		16		15	
	frank		58		30		40		40		50		46
	microscopic		32		50		60		40		50		45
	blank		11		20		0		20		0		9
Prostate/raised PSA		10		13		18		17		16		14	
Other		15		8		11		15		11		13	
Ncode procedure (All)		15		4		2		6		19		11	
	vasectomy		52		0		100		33		29		41
	foreskin		5		0		0		67		50		24
	epididymal cyst		14		100		0		0		21		20
	hydrocele		19		0		0		0		0		10
	varicocele		5		0		0		0		0		2
	blank		5		0		0		0		0		2
Recurrent UTI's		12		17		9		11		5		11	
LUTS		8		13		4		9		10		9	
Prostate/BPH/prostatitis		8		9		9		11		3		8	
Renal stones/colic/loin pain		8		9		2		4		5		6	
Testicular/ Scrotal lumps or swelling		6		0		11		0		11		6	
Andrology (ALL)		5		4		7		11		3		5	
	erectile dysfunction		29		100		0		50		50		40
	peyronie's disease		29		0		67		0		0		20
	blood in ejaculate		43		0		0		0		0		15
	ulcer/lesion on gland		0		0		33		17		0		10
	balanitis/discharge		0		0		0		33		0		10
	blank		0		0		0		0		50		5
Unknown		2		2		2		4		0		2	
Ca Bladder/Kidney		1		2		0		2		0		1	
Blank		0		0		2		0		0		0	
Total		100		100		100		100		100		100	

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Appendix 6

NICE – Improving outcomes in Urological Cancers (IOG) – The Manual (2002)

Key Recommendations

The key recommendations highlight the main organisational issues specific to urological cancers that are central to implementing the guidance. As such, they may involve major changes to current practice.

- All patients with Urological cancers should be managed by multidisciplinary Urological cancer teams. These teams should function in the context of dedicated specialist services, with working arrangements and protocols agreed throughout each cancer network. Patients should be specifically assured of:
    - Streamlined services, designed to minimise delays;
    - Balanced information about management options for their condition;
    - Improved management for progressive and recurrent disease.
- Members of Urological cancer teams should have specialised skills appropriate for their roles at each level of the service. Within each network, multidisciplinary teams should be formed in local hospitals (cancer units); at cancer centres, with the possibility in larger networks of additional specialist teams serving populations of at least one million; and at supra-network level to provide specialist management for some male genital cancers.
- Radical surgery for prostate and bladder cancer should be provided by teams typically serving populations of one million or more and carrying out a cumulative total of at least 50 such operations per annum. Whilst these teams are being established, surgeons carrying out small numbers (five or fewer per annum) of either operation should make arrangements within their network to pass this work on to more specialist colleagues.
- Major improvements are required on information and support services for patients and carers. Nurse specialist members of urological cancer teams will have key roles in these services.
- There are many areas of uncertainty about the optimum form of treatment for patients with urological cancers. High-quality research studies should be supported, with encouragement of greater rates of participation in clinical trials.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Appendix 7

Estimated Cost of Implementation of Recommendations.

Staffing	Number	Band/Grade	Unit Cost	Total
Consultant Urologist	6	Consultant	Commercially Sensitive Information redacted by the USI	
Consultant Anaesthetist @ 0.6 wte per Con. Urologist	3.6	Consultant		
Consultant Radiologist @ 0.3 wte per Con. Urologist	1.8	Consultant		
Radiographer @ 6 per wte Con Radiologist	10.8	Band 5		
Nursing @ 1.8 wte per Con. Urologist	10.8	Band 5		
Nursing @ 0.46 wte per Con. Urologist	2.7	Band 3		
Specialist Nursing	5	Band 7		
Nursing @ 0.64 wte (day surgery)	0.64	Band 5		
Pers. Secretary @ 0.5 wte per consultant urologists	3	Band 4		
Admin support to radiologists at 0.5 wte per Radiologist	1	Band 3		
Admin Support to Specialist Nurses @ 0.5 wte per Nurse	3	Band 3		
Medical Records support 0.5 per unit	2.5	Band 4		
MLSO – Bio-medical Science	1	Band 7		
Support Costs				
Surgical G&S Commercially Sensitive Information redacted by USI per Con. Urologist	X 6			
Theatre Goods/Disposables @ Commercially Sensitive Information redacted by USI per Con.Urologist	X 6			
Radiology G&S per Con. Urologist	X 6			
CSSD @ Commercially Sensitive Information redacted by USI per Con. Urologist	X 6			
Outpatients Clinics @ 2 per Con. Urologist	X 12			
Sub Total				
Less Consultant funded in 2008				
Sub Total				
Less 2008/09 Cancer Funds				
FINAL TOTAL				

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Appendix 8

Evaluation Criteria

Criteria	Definitions
1. Service Stability / Sustainability	This is the criterion of the highest priority/value. The long term stability and hence viability and success of the service depends on a stable workforce – a workforce that can develop the service further and continue to attract the necessary expertise across all its professions. The criterion is sub-divided into four closely related sub-categories. a. Population – smaller catchment populations restrict the generation of a critical mass of work (cancer and non cancer). Using BAUS recommendations of 1 consultant per 80,000, each team should serve a catchment population of no less than 400,000. b. Team Size – A team of at least five to six consultants is preferred. This will improve long term attractiveness of each team in terms of recruitment and retention. It will also enable at least 2-3 to sub specialise, with dedicated sessions in the sub specialty e.g. uro-oncology, endourology/stones, female urology c. On site interventional radiology and trained urological nursing – These are key quality aspects. On site radiology to ensure timely access to interventions for emergency and urgent cases and sufficient total activity to justify 24 hour urology nursing experience in wards and theatres. This is to enhance multi-disciplinary working and support the development of nurse-led services. d. Commitment to Rotas and Working Time Directive – The service must be capable of sustaining adequate and acceptable on-call arrangements (elective and emergency), compliance with EWTD and equitable provision of emergency care.
2. Feasibility (ease and speed of implementation)	This criterion concerns the need to maximise the use of existing capital infrastructure (beds, theatres, equipment, clinic accommodation). The additional activity required and the appointment of additional Consultants and Nurse Specialists will require additional access to clinical facilities (as described above). It is assumed that the more new capital development is required, the longer the lead in time for starting new teams, and the longer the reliance on the independent sector. Preference will be given to those models that require the least capital resources and restructuring of premises. Consideration of the availability of trained staff will also be given. A particular model will lose points if it is unlikely that trained staff will be available in the numbers required to fill necessary posts.
3. Compliance with DHSSPS Strategy / Commissioner Support / Compatibility with Trust Strategic Plans/impact on other services	A model will lose points if it does not reflect specific regional health and wellbeing strategies/policies – DBS (the location of major hospitals with inpatient care), Cancer Framework (location of cancer units and Cancer Centre). Models should also attract commissioner support. Alignment with Trust Strategic Plans and impact on other services should also be considered.
4. Accessibility for Inpatient Elective Care	It is assumed that each model will be able to facilitate the flexible locating of outpatient and diagnostic service and will therefore be difficult to discriminate scores on this basis. Agreed pathways for emergency care is also assumed. Variation in local provision of elective inpatient care is more discriminatory. A model will lose points if it requires significantly greater travel time (from the do nothing case) for a substantial number of patients.
5. Organisational Complexity	A service should have unambiguous clinical and managerial leadership and accountability arrangements. Some potential models will need to transcend Trust organisational boundaries. This criterion concerns how complicated such arrangements are likely to be and weights each model accordingly – the more complicated the fewer the points awarded.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

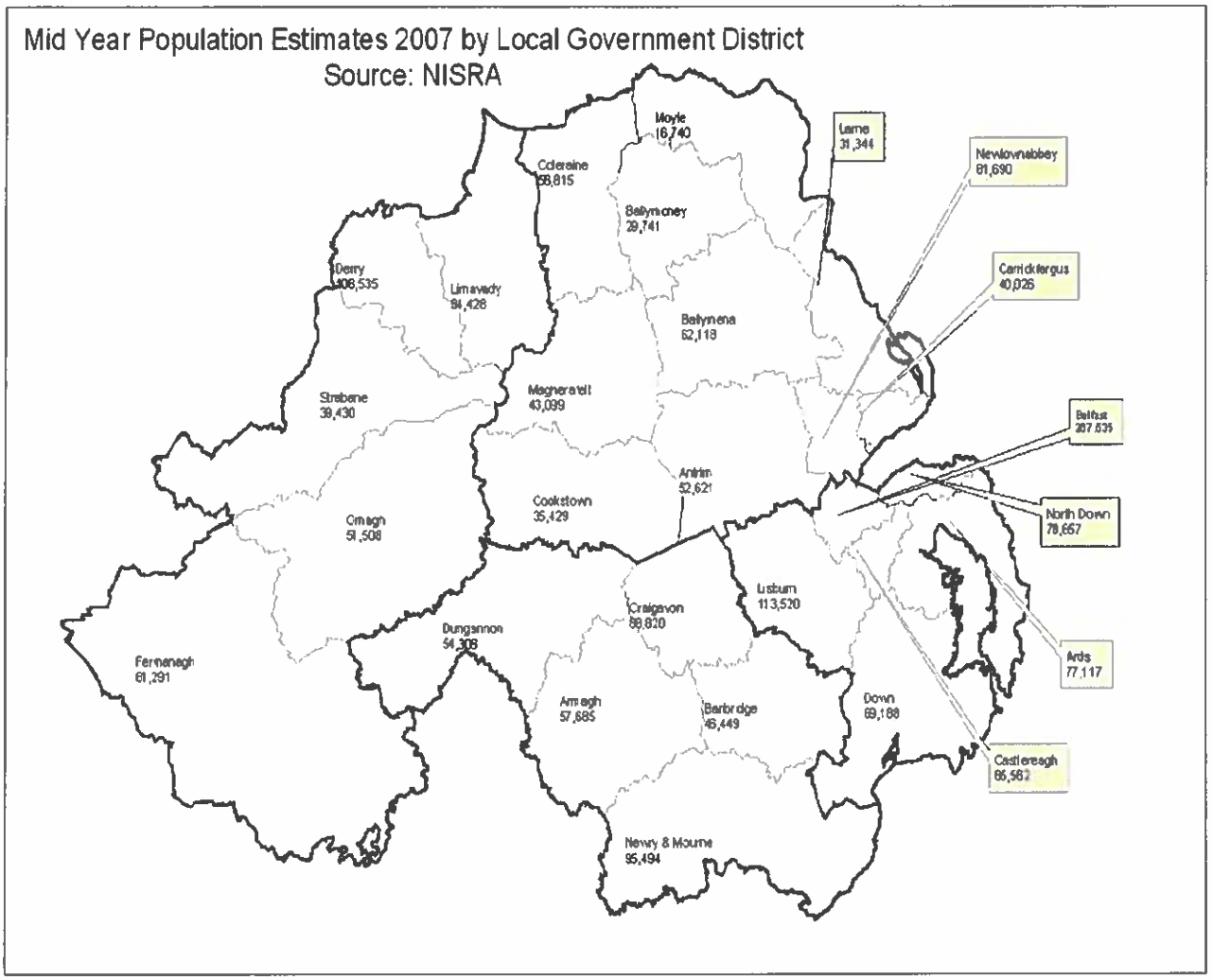
Appendix 9

Model 3: Three Teams/Networks

Team North and West:	• Upper 2/3rds of Northern and Western integrate to form one Team/Network
	• Main base Hospital - Altnagelvin
	• Potential for small number of inpatient beds in Causeway Hospital to be used for selected elective work subject to satisfactory arrangements for the post-operative management of these patients
Team South and West:	• Lower 1/3rd of Western (Fermanagh) and all of Southern integrate to form one Team/Network
	• Main base Hospital – Craigavon
Team East:	• SET and Belfast integrate to form one Team/Network
	• Continue to provide services to the southern sector of Northern population by outreach – Outpatient/Diagnostics/Day Surgery in Antrim and Whiteabbey hospitals with inpatients going to Belfast

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Appendix 10



Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

SUBMISSION

From: Jim McComish

Cancer Services, Diagnostics and Specialist Drugs Unit

Date: 3 March 2010

To:

1. David Galloway
2. Dr Miriam McCarthy
3. Departmental Board members

REVIEW OF ADULT UROLOGY SERVICES IN NORTHERN IRELAND

Issue:	**Review of Adult Urology Services in Northern Ireland.**
Decision sought:	**Endorsement of recommendations of Review of Adult Urology Services, prior to being forwarded to Minister for his approval.**
Financial implications:	**£3.2m – already identified from within the HSC Board's existing funding.**
HR implications:	**Increase in number of urologists and clinical nurse specialists.**
Timing:	**Routine.**
Presentational Issues:	**There may be local media interest.**
Legislative issues:	**None**
Statutory duties:	**None**

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

FOI Implications: **May not be disclosed under the terms of exemption 35 - formulation and development of government policy.**

Recommendation: **That the Departmental Board approve the recommendations and agree to the HSC Board implementing these as quickly as possible during 2010/11.**

Background

1. During 2008/09, the former Service Delivery Unit was asked to undertake a regional review of adult urology services in response to service concerns regarding the ability to manage growing demand, meet cancer and elective waiting times, maintain quality standards and provide high quality elective and emergency services. The Review group was chaired by Hugh Mullen and the report was submitted to the Department for consideration in March 2009. A summary of the recommendations of the Review is attached at **Annex A**.

2. The Minister launched the consultation on the Review on 23 September 2009. To ensure a comprehensive consultation, the Regional Health and Social Care Board (the Board) wrote to a wide variety of stakeholders to ensure they were aware of the consultation.

3. The respondents were asked to denote if they agreed or disagreed with the recommendations. A free text box was included to further elaborate on those recommendations that they did not agree on. The consultation formally closed on Friday 18 December; on this date, a total of 26 responses had been received by the Board. A late response was received from the Northern Trust.

Summary of responses

4. In general, there were very few comments on the Review. A table showing each of the respondents is shown below; this also indicates if their overall comments

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

were for/supportive, against or neutral in relation to the recommendations in the Review.

Table 1: Summary of Responses

External Bodies/Charities/Voluntary Sector	For	Against	Neutral
Royal College of Surgeons (Edinburgh)			
Royal College of Nursing (Northern Ireland)			
Press Enquiry - BBC Radio Foyle			
Disability Action			
Cancer Registry			
The Prostate Cancer Charity			
Cancer Choices			
Political Parties	**For**	**Against**	**Neutral**
Councillor D Barbour			
DUP - Mr Philip Weir			
Gregory Campbell MP/MLA			
Trust Management/Exec Directors	**For**	**Against**	**Neutral**
Southern Trust			
South Eastern Trust			
Belfast Trust			
Northern Trust			
Urologists	**For**	**Against**	**Neutral**
Southern Trust - Mr M Young			
Northern Trust - Irrelevant Personal Information			
Northern Trust -			
Northern Trust Staff	**For**	**Against**	**Neutral**
Urology Specialist Nurse - Irrelevant Personal Information			
Urology Specialist Nurse -			
Consultant Surgeon - Irrelevant Personal Information			
Consultant Rheumatologist Irrelevant Personal Information			
Consultant Gynaecologist -			
Consultant Gynaecologist -			
Consultant Paediatrician -			
Consultant Haematologist -			
Consultant Nephrologists -			
Consultant Neonatologist -			

5. As shown, the Board received seven responses from external bodies including charities, and voluntary agencies; these both welcomed the Review and were supportive of the Review recommendations. The President of the Royal College of Surgeons Edinburgh, agreed with the recommendation that there should be a single centre for radical pelvic surgery, but felt this recommendation was

compromised by the recommendation that surgeons carrying out small numbers of radical pelvic surgery should make arrangements to pass this work on to more specialised colleagues, as soon as practicably possible, whilst a single site service is being established.

6. The Royal College of Nursing supported the proposals outlined in the Review but wished to ensure the appropriate investment is made in securing the right numbers of specialist nurses. The Cancer Registry, Cancer Choices, The Prostate Cancer Charity were all supportive of the Review and reinforced the need to focus on the outcomes for urology patients. Some provided useful information to be taken into account during the implementation of the recommendations. Disability Action provided only comment on the consultation process and has been included as neutral, as has the press enquiry from BBC Radio Foyle.

7. The Board received three responses from political parties and/or political representatives. These have been summarised as against the Review recommendations, however, their main comments relate to the service reconfiguration into teams, a perceived loss of services at the Causeway Hospital and for residents in the Coleraine area – which is not the case.

8. The Board received responses from four of the five Trusts; all four Trust responses supported the review, the three team reconfiguration and the remaining recommendations. They each highlighted specific issues which will need to be resolved as part of the implementation process. The Northern Trust highlighted specific issues in relation to the Board's decision to withdraw the funding (£642k) for the ICATS service within the Trust which was not implemented effectively and other the unfunded services including two staff grades and the lithotripter service at Causeway Hospital. The Trust highlighted concerns in relation to the provision of junior medical staff and the arrangements for on-call. It is expected that the specific detail of these arrangements and the

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

patient pathway across the each of the teams will be resolved as part of the agreements reached through the implementation process.

9. The Review showed that 17 consultant urologists are employed across Northern Ireland; from these the Board received three responses from consultant urologists (17% of the urologists). They each highlight individual concerns in relation to the team model and the consolidation of complex surgery within one team. Many of these issues were fully discussed during the clinical development of the Review recommendations and the evaluation of the clinical evidence at this time.

Northern Health and Social Care Trust staff

10. The most responses not supporting the Review recommendations were received from Northern Trust clinical staff, 10 in total (excluding the two consultant urologists). They highlighted concerns in relation to the lack of beds and particular a lack of access to urology consultation at Antrim Hospital. At the present time there are no urology beds at Antrim hospital and the Review has not changed the configuration of beds, the seven elective beds at Causeway Hospital will remain. It is planned that the provision of urology outpatient and consultation services at Antrim will be provided from Team East. Also two of the clinical nurse specialists appointed to provide the ICATS service responded, expressing their concerns at the loss of the funding for the service.

11. The Northern Trust was represented by an urologist and an executive director, who were both members of the Urology Review Steering Group. The responses from the Northern Trust clinicians were welcomed; they have highlighted a number of very important issues which will need to be resolved as part of the implementation process.

12. Since the retirement of two general surgeons with an interest in urology, the provision of urology input to Antrim has been more limited in recent years. As explained, many of their concerns are related to a lack of appreciation or

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

misunderstanding of the expected urological presence to be provided on the Antrim site as a result of implementing the recommendations. As highlighted, the Northern Trust was represented on the Urology Steering Group; it is evident from the comments received that the communication within the Trust could have been improved.

13. The implementation process will agree the arrangements for patient pathways, in particular, the arrangements for out of hours, the admission/assessment processes for acute patients and access to a urological consultation. The decision of the Board's northern office to withdraw the funding for the ICATS service at the Northern Trust due to the failure to provide the service commissioned by the Board is a matter for ongoing discussion with the Trust. However, this issue will continue to be discussed during the implementation of the review and may require the Board to prioritise further resources for the reinstatement of an assessment and diagnostic service model within Team East and North.

Planned next steps in responses to consultation

14. In light of the responses received to the consultation, the Board has arranged to meet individually with each of the political party/political representatives to explain the current service configuration and the expected outcome from the implementation of the review. Also meetings are been arranged with each of the clinical staff who responded from the Northern Trust to discuss their concerns and ensure these issues are included in the actions required to implement the project. In addition, it is planned for a formal meeting to be arranged with all these clinicians to discuss their concerns.

15. Mr Mark Fordham, consultant urologist and external advisor on the Review, has agreed to participate in this session. It is expected that this meeting will allow the Board to explain the intended model of service and how the implementation of the Review recommendations will see an improved service to Antrim Hospital. As explained earlier, many of the concerns or comments received from the

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

consultation relate to a lack of appreciation of the specific details of the patient pathway, the actual operational service provision, which will be resolved through the implementation process. This process should not delay the Departmental Board or Minster endorsing the Review recommendations.

Position

16. The Board discussed the results of the urology review consultation at the Board meeting on 28 January, and recommended that the Minister endorse all the recommendations from the Review.

17. It has not been possible for four of the five Trusts to achieve the Ministerial waiting time targets for urology patients, with some waiting up to 17 weeks for an outpatient appointment and 26 weeks for inpatient or day case treatment. This is in context that the Board has from April to December 2009 spent approximately £3.5m in the independent sector for urology patients.

Recommendation

18. Prior to being forwarded to Minister for consideration, it is recommended that the Departmental Board endorse the recommendations of the Review of Adult Urology Services in Northern Ireland and approve the HSC Board to proceed with the implementation of these as quickly as possible during 2010/11.

Jim McComish

Ext Personal Information redacted by

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Annex A

SUMMARY OF RECOMMENDATIONS

- Unless urological procedures (particularly operative 'M' code) constitute a substantial proportion of a surgeon's practice, (s)he should cease undertaking any such procedures. Any surgeon continuing to provide such urology services should do so within a formal link to a urology unit/team.

- Trusts should plan and consider the implications of any impending retirements in general surgery, particularly with regard to the transfer of "N" Code work and the associated resources to the urology team.

- A separate review of urinary continence services should be undertaken, with a view to developing an integrated service model in line with NICE Guidance.

Current Service Profile

- Trusts must review the process for internal consultant to consultant referrals to urology to ensure that there are no undue delays in the system.

- Northern Ireland Cancer Network (NICaN) Urology Group, in conjunction with urology teams and primary care, should develop and implement agreed referral guidelines and pathways for suspected urological cancers.

- Deployment of new consultant posts (both vacancies and additional posts arising from this review) should take into account areas of special interest that are deemed to be required in the service configuration model.

- Urologists, in collaboration with general surgery and A&E colleagues, should develop and implement clear protocols and care pathways for urology patients requiring admission to an acute hospital which does not have an acute urology unit.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

- Urologists, in collaboration with A&E colleagues, should develop and implement protocols/care pathways for those patients requiring direct transfer and admission to an acute urology unit.

- Trusts should ensure arrangements are in place to proactively manage and provide equitable care to those patients admitted under general surgery in hospitals without urology units (e.g. Antrim, Daisy Hill, Erne). Arrangements should include seven day week notification of admissions to the appropriate urology unit and provision of urology advice/care by telephone, electronically or in person, also seven days a week.

- In undertaking the ICATS review, there must be full engagement with secondary care urology teams, current ICATS teams, as well as general practitioners and LCGs. In considering areas of urology suitable for further development they should look towards erectile dysfunction, benign prostatic disease, LUTS and continence services. The review should also take into account developments elsewhere within the UK and in particular developments within PCTs in relation to shifting care closer to home.

Capacity, Demand and Activity

- Trusts (urology departments) will be required to evidence (in their implementation plans) delivery of the key elements of the elective reform programme.

Performance Measures

- Trust urology teams must, as a matter of urgency, redesign and enhance capacity to provide single visit outpatient and assessment (diagnostic) services for suspected urological cancer patients.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

- Trusts should implement the key elements of the elective reform programme with regard to admission on the day of surgery, pre-operative assessment and increasing day surgery rates.

- Trusts should participate in a benchmarking exercise of a set number of elective (procedure codes) and non-elective (diagnostic codes) patients by consultant and by hospital with a view to agreeing a target length of stay for these groups of patients.

- Trusts will be required to include in their implementation plans, an action plan for increasing the percentage of elective operations undertaken as day surgery, redesigning their day surgery theatre facilities and should work with urology team in other Trusts to agree procedures for which day care will be the norm for elective surgery.

- Trusts should review their outpatient review practice, redesign other methods/staff (telephone follow-up/nurse) where appropriate and subject to case mix/complexity issues reduce new:review ratios to the level of peer colleagues.

- Trusts must modernise and redesign outpatient clinic templates and admin/booking processes to ensure they maximise their capacity for new and review patients and to prevent backlogs occurring in the future.

Urological Cancers

- The NICaN group, in conjunction with each Trust and commissioners, should develop and implement a clear action plan with timelines for the implementation of the new arrangements/enhanced services in working towards compliance with IOG.

- By March 2010, at the latest, all radical pelvic surgery should be undertaken on a single site, in BCH, by a specialist team of surgeons. The transfer of this work

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

should be phased to enable BCH to appoint appropriate staff and ensure infrastructure and systems are in place. A phased implementation plan should be agreed with all parties.

- Trusts should ensure that surgeons carrying out small numbers (<5 per annum) of either radical pelvic operation, make arrangements to pass this work on to more specialised colleagues, as soon as is practicably possible, (whilst a single site service is being established).

Clinical Workforce Requirements

- To deliver the level of activity from 2008/09 and address the issues around case mix and complexity it is recommended that the number of consultant urologists is increased to 23 wte.

- Urology teams must ensure that current capacity is optimised to deliver the number FCEs by consultant as per BAUS guidelines (subject to case mix and complexity). This may require access to additional operating sessions up to at least four per week (42 weeks per year) and an amendment to job plans.

- At least five clinical nurse specialists (cancer) should be appointed (and trained). The deployment of these staff within particular teams will need to be decided and Trusts will be required to develop detailed job plans with caseload, activity and measurable outcomes agreed prior to implementation. A further review and benchmarking of cancer CNS's should be undertaken in mid 2010.

Service Configuration Model

- Urology services in Northern Ireland should be reconfigured into a three team model, to achieve long term stability and viability.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

- Teams North and East (Northern, Western, Belfast and South Eastern Trusts) should ensure that prior to the creation of the new teams, there are clear, unambiguous and agreed arrangements in place with regard to consultant on-call and out of hours arrangements.

- Each Trust must work in partnership with the other Trust/s within the new team structure to determine and agree the new arrangements for service delivery, including inter alia, governance, employment and contractual arrangements for clinical staff, locations, frequency and prioritisation of outreach services, areas of Consultant specialist interest based on capacity and expertise required and catchment populations to be served.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

From:	suzanne.beaney Personal Information redacted by the USI
To:	Galloway, David; Secondary Care; Banks, Caroline; Garrett, Elizabeth
Cc:	McCarthy, Miriam; Secondary Care; McCormick, Andrew; McKee, Christine; Adair, Anne; Baxter, Clare; Magill, Jenny; Gaughran, Aine; Private Office DHSSPS; Devlin, Linda
Subject:	Submission: SUB/226/2010 REVIEW OF ADULT UROLOGY SERVICES IN NORTHERN IRELAND
Date:	15 March 2010 11:50:08
Attachments:	Sub.226.2010.doc

DEPARTMENT OF HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

Routine

From: Suzanne Beaney
Private Office
To: Galloway David (Mr)
Date: 15/03/2010

Action Copy: McCarthy Miriam (Dr)
McCormick Andrew
Baxter Clare (Ms)
Magill Jenny
Gaughran Aine
Office Copy

SUB/226/2010:REVIEW OF ADULT UROLOGY SERVICES IN NORTHERN IRELAND

The Minister has read your submission of 05/03/2010. Minister has approved subject to letters from clinicians regarding support as discussed with David Galloway on 12th March 2010.

Many thanks.

Suzanne Beaney (Private Office)

Room C5.4 Castle Buildings Tel: Personal Information redacted by

OffName

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

SUBMISSION

From: David Galloway
Secondary Care Directorate

Date: 4 March 2010

To:

1. Dr McCarthy-*agreed/MMcC/4.3.10*
2. PS Minister

REVIEW OF ADULT UROLOGY SERVICES IN NORTHERN IRELAND

Issue:	**The HSC Board has forwarded the outcome of the consultation on the Review of Adult Urology Services.**
Timing:	**Routine.**
Presentational Issues:	**There may be local media interest.**
FOI Implications:	**May not be disclosed under the terms of exemption 35 - formulation and development of government policy.**
Recommendation:	**That you approve the recommendations and agree to the HSC Board implementing these as quickly as possible during 2010/11.**

Background

1. During 2008/09, the former Service Delivery Unit was asked to undertake a regional review of adult urology services in response to service concerns regarding the ability to manage growing demand, meet cancer and elective waiting times, maintain quality standards and provide high quality elective and emergency services. The Review group was chaired by Hugh Mullen and the

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

report was submitted to the Department for consideration in March 2009. A summary of the recommendations of the Review is attached at **Annex A**.

2. You launched the consultation on the Review, which was carried out by the Regional Health and Social Care Board (the Board), on 23 September 2009, with a closing date of 18 December 2009.

3. The Board has now evaluated the responses and is formally asking that you endorse the recommendations and give approval for their implementation.

Consultation process

4. To ensure a comprehensive consultation, the Board wrote to a wide variety of stakeholders to ensure they were aware of the consultation.

5. The respondents were asked to denote if they agreed or disagreed with the recommendations. A free text box was included to further elaborate on those recommendations that they did not agree on. The consultation formally closed on Friday 18 December; on this date, a total of 26 responses had been received by the Board. A late response was received from the Northern Trust.

Summary of responses

6. In general, there were very few comments on the Review. A table showing each of the respondents is shown below; this also indicates if their overall comments were for/supportive, against or neutral in relation to the recommendations in the Review.

Table 1: Summary of Responses

External Bodies/Charities/Voluntary Sector	For	Against	Neutral
Royal College of Surgeons (Edinburgh)			
Royal College of Nursing (Northern Ireland)			
Press Enquiry - BBC Radio Foyle			
Disability Action			
Cancer Registry			
The Prostate Cancer Charity			

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Cancer Choices			
Political Parties	**For**	**Against**	**Neutral**
Councillor D Barbour			
DUP - Mr Philip Weir			
Gregory Campbell MP/MLA			
Trust Management/Exec Directors	**For**	**Against**	**Neutral**
Southern Trust			
South Eastern Trust			
Belfast Trust			
Northern Trust			
Urologists	**For**	**Against**	**Neutral**
Southern Trust - Mr M Young			
Northern Trust - Irrelevant Personal Information			
Northern Trust -			
Northern Trust Staff	**For**	**Against**	**Neutral**
Urology Specialist Nurse - Irrelevant Personal Information			
Urology Specialist Nurse -			
Consultant Surgeon - Irrelevant Personal Information			
Consultant Rheumatologist Irrelevant Personal Information			
Consultant Gynaecologist -			
Consultant Gynaecologist -			
Consultant Haematologist -			
Consultant Paediatrician -			
Consultant Nephrologists -			
Consultant Neonatologist -			

7. As shown, the Board received seven responses from external bodies including charities, and voluntary agencies; these both welcomed the Review and were supportive of the Review recommendations. The President of the Royal College of Surgeons Edinburgh, agreed with the recommendation that there should be a single centre for radical pelvic surgery, but felt this recommendation was compromised by the recommendation that surgeons carrying out small numbers of radical pelvic surgery should make arrangements to pass this work on to more specialised colleagues, as soon as practicably possible, whilst a single site service is being established.

8. The Royal College of Nursing supported the proposals outlined in the Review but wished to ensure the appropriate investment is made in securing the right numbers of specialist nurses. The Cancer Registry, Cancer Choices, The

Prostate Cancer Charity were all supportive of the Review and reinforced the need to focus on the outcomes for urology patients. Some provided useful information to be taken into account during the implementation of the recommendations. Disability Action provided only comment on the consultation process and has been included as neutral, as has the press enquiry from BBC Radio Foyle.

9. The Board received three responses from political parties and/or political representatives. These have been summarised as against the Review recommendations, however, their main comments relate to the service reconfiguration into teams, a perceived loss of services at the Causeway Hospital and for residents in the Coleraine area – which is not the case.

10. The Board received responses from four of the five Trusts; all four Trust responses supported the review, the three team reconfiguration and the remaining recommendations. They each highlighted specific issues which will need to be resolved as part of the implementation process. The Northern Trust highlighted specific issues in relation to the Board's decision to withdraw the funding (£642k) for the ICATS service within the Trust which was not implemented effectively and other the unfunded services including two staff grades and the lithotripter service at Causeway Hospital. The Trust highlighted concerns in relation to the provision of junior medical staff and the arrangements for on-call. It is expected that the specific detail of these arrangements and the patient pathway across the each of the teams will be resolved as part of the agreements reached through the implementation process.

11. The Review showed that 17 consultant urologists are employed across Northern Ireland; from these the Board received three responses from consultant urologists (17% of the urologists). They each highlight individual concerns in relation to the team model and the consolidation of complex surgery within one team. Many of these issues were fully discussed during the clinical development

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

of the Review recommendations and the evaluation of the clinical evidence at this time.

Northern Health and Social Care Trust staff

12. The most responses not supporting the Review recommendations were received from Northern Trust clinical staff, 10 in total (excluding the two consultant urologists). They highlighted concerns in relation to the lack of beds and particular a lack of access to urology consultation at Antrim Hospital. At the present time there are no urology beds at Antrim hospital and the Review has not changed the configuration of beds, the seven elective beds at Causeway Hospital will remain. It is planned that the provision of urology outpatient and consultation services at Antrim will be provided from Team East. Also two of the clinical nurse specialists appointed to provide the ICATS service responded, expressing their concerns at the loss of the funding for the service.

13. The Northern Trust was represented by an urologist and an executive director, who were both members of the Urology Review Steering Group. The responses from the Northern Trust clinicians were welcomed; they have highlighted a number of very important issues which will need to be resolved as part of the implementation process.

14. Since the retirement of two general surgeons with an interest in urology, the provision of urology input to Antrim has been more limited in recent years. As explained, many of their concerns are related to a lack of appreciation or misunderstanding of the expected urological presence to be provided on the Antrim site as a result of implementing the recommendations. As highlighted, the Northern Trust was represented on the Urology Steering Group; it is evident from the comments received that the communication within the Trust could have been improved.

15. The implementation process will agree the arrangements for patient pathways, in particular, the arrangements for out of hours, the admission/assessment

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

processes for acute patients and access to a urological consultation. The decision of the Board's northern office to withdraw the funding for the ICATS service at the Northern Trust due to the failure to provide the service commissioned by the Board is a matter for ongoing discussion with the Trust. However, this issue will continue to be discussed during the implementation of the review and may require the Board to prioritise further resources for the reinstatement of an assessment and diagnostic service model within Team East and North.

Planned next steps in responses to consultation

16. In light of the responses received to the consultation, the Board has arranged to meet individually with each of the political party/political representatives to explain the current service configuration and the expected outcome from the implementation of the review. A meeting has already been held with the clinical staff who responded from the Northern Trust to discuss their concerns. The meeting was well attended and successful in assuring clinicians that the issues they raised have been taken account of in the actions required to implement the project. The clinicians from Antrim were content that the proposed urology support for Antrim Area Hospital and access for their acute patients into the Belfast City Hospital would provide a much enhanced service to that which they have currently. Their position could now be very much considered as supporting the review recommendations.

17. Mr Mark Fordham, consultant urologist and external advisor on the Review, has agreed to participate in this session. It is expected that this meeting will allow the Board to explain the intended model of service and how the implementation of the Review recommendations will see an improved service to Antrim Hospital. As explained earlier, many of the concerns or comments received from the consultation relate to a lack of appreciation of the specific details of the patient pathway, the actual operational service provision, which will be resolved through the implementation process. This process should not delay the Departmental Board or Minster endorsing the Review recommendations.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Position

18. The Board discussed the results of the urology review consultation at the Board meeting on 28 January, and recommended that the Minister endorse all the recommendations from the Review.

19. It has not been possible for four of the five Trusts to achieve the Ministerial waiting time targets for urology patients, with some waiting up to 17 weeks for an outpatient appointment and 26 weeks for inpatient or day case treatment. This is in spite of considerable investment from the Board which has seen some £3.5m spent on urology procedures in the independent sector between April and December 2009.

Presentational Issues

20. This review has attracted media and public interest and we would expect issue of the final recommendations to also attract interest. You may wish to issue a press release announcing your endorsement of the recommendations, which we will draft for your consideration.

Recommendation

20. It is recommended that you endorse the recommendations of the Review of Adult Urology Services in Northern Ireland and approve the HSC Board to proceed with their implementation; a draft letter for issue by Dr McCarthy, is attached at Annex B.

David Galloway

Ext Personal Information redacted by

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Annex A

SUMMARY OF RECOMMENDATIONS

- Unless urological procedures (particularly operative 'M' code) constitute a substantial proportion of a surgeon's practice, (s)he should cease undertaking any such procedures. Any surgeon continuing to provide such urology services should do so within a formal link to a urology unit/team.

- Trusts should plan and consider the implications of any impending retirements in general surgery, particularly with regard to the transfer of "N" Code work and the associated resources to the urology team.

- A separate review of urinary continence services should be undertaken, with a view to developing an integrated service model in line with NICE Guidance.

Current Service Profile

- Trusts must review the process for internal consultant to consultant referrals to urology to ensure that there are no undue delays in the system.

- Northern Ireland Cancer Network (NICaN) Urology Group, in conjunction with urology teams and primary care, should develop and implement agreed referral guidelines and pathways for suspected urological cancers.

- Deployment of new consultant posts (both vacancies and additional posts arising from this review) should take into account areas of special interest that are deemed to be required in the service configuration model.

- Urologists, in collaboration with general surgery and A&E colleagues, should develop and implement clear protocols and care pathways for urology patients requiring admission to an acute hospital which does not have an acute urology unit.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

- Urologists, in collaboration with A&E colleagues, should develop and implement protocols/care pathways for those patients requiring direct transfer and admission to an acute urology unit.

- Trusts should ensure arrangements are in place to proactively manage and provide equitable care to those patients admitted under general surgery in hospitals without urology units (e.g. Antrim, Daisy Hill, Erne). Arrangements should include seven day week notification of admissions to the appropriate urology unit and provision of urology advice/care by telephone, electronically or in person, also seven days a week.

- In undertaking the ICATS review, there must be full engagement with secondary care urology teams, current ICATS teams, as well as general practitioners and LCGs. In considering areas of urology suitable for further development they should look towards erectile dysfunction, benign prostatic disease, LUTS and continence services. The review should also take into account developments elsewhere within the UK and in particular developments within PCTs in relation to shifting care closer to home.

Capacity, Demand and Activity

- Trusts (urology departments) will be required to evidence (in their implementation plans) delivery of the key elements of the elective reform programme.

Performance Measures

- Trust urology teams must, as a matter of urgency, redesign and enhance capacity to provide single visit outpatient and assessment (diagnostic) services for suspected urological cancer patients.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

- Trusts should implement the key elements of the elective reform programme with regard to admission on the day of surgery, pre-operative assessment and increasing day surgery rates.

- Trusts should participate in a benchmarking exercise of a set number of elective (procedure codes) and non-elective (diagnostic codes) patients by consultant and by hospital with a view to agreeing a target length of stay for these groups of patients.

- Trusts will be required to include in their implementation plans, an action plan for increasing the percentage of elective operations undertaken as day surgery, redesigning their day surgery theatre facilities and should work with urology team in other Trusts to agree procedures for which day care will be the norm for elective surgery.

- Trusts should review their outpatient review practice, redesign other methods/staff (telephone follow-up/nurse) where appropriate and subject to case mix/complexity issues reduce new:review ratios to the level of peer colleagues.

- Trusts must modernise and redesign outpatient clinic templates and admin/booking processes to ensure they maximise their capacity for new and review patients and to prevent backlogs occurring in the future.

Urological Cancers

- The NICaN group, in conjunction with each Trust and commissioners, should develop and implement a clear action plan with timelines for the implementation of the new arrangements/enhanced services in working towards compliance with IOG.

- By March 2010, at the latest, all radical pelvic surgery should be undertaken on a single site, in BCH, by a specialist team of surgeons. The transfer of this work

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

should be phased to enable BCH to appoint appropriate staff and ensure infrastructure and systems are in place. A phased implementation plan should be agreed with all parties.

- Trusts should ensure that surgeons carrying out small numbers (<5 per annum) of either radical pelvic operation, make arrangements to pass this work on to more specialised colleagues, as soon as is practicably possible, (whilst a single site service is being established).

Clinical Workforce Requirements

- To deliver the level of activity from 2008/09 and address the issues around case mix and complexity it is recommended that the number of consultant urologists is increased to 23 wte.

- Urology teams must ensure that current capacity is optimised to deliver the number FCEs by consultant as per BAUS guidelines (subject to case mix and complexity). This may require access to additional operating sessions up to at least four per week (42 weeks per year) and an amendment to job plans.

- At least five clinical nurse specialists (cancer) should be appointed (and trained). The deployment of these staff within particular teams will need to be decided and Trusts will be required to develop detailed job plans with caseload, activity and measurable outcomes agreed prior to implementation. A further review and benchmarking of cancer CNS's should be undertaken in mid 2010.

Service Configuration Model

- Urology services in Northern Ireland should be reconfigured into a three team model, to achieve long term stability and viability.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

- Teams North and East (Northern, Western, Belfast and South Eastern Trusts) should ensure that prior to the creation of the new teams, there are clear, unambiguous and agreed arrangements in place with regard to consultant on-call and out of hours arrangements.

- Each Trust must work in partnership with the other Trust/s within the new team structure to determine and agree the new arrangements for service delivery, including inter alia, governance, employment and contractual arrangements for clinical staff, locations, frequency and prioritisation of outreach services, areas of Consultant specialist interest based on capacity and expertise required and catchment populations to be served.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Annex B

Mr Hugh Mullan
Director of Performance Management
and Service Improvement Directorate
Regional Health and Social Care Board
12-22 Linenhall Street
Belfast
BT2 8BS

March 2010

REVIEW OF ADULT UROLOGY SERVICES

Thank you for your letter of 15 February 2010, forwarding the results of the consultation on the Review of Adult Urology Services.

The Minister has now had the opportunity to consider the responses to the consultation and am pleased to advise you that he is content to endorse the recommendations. I would therefore be grateful if you could make arrangements for the implementation of the recommendations as soon as possible, which I understand are being funded from within the Board's existing allocation to address elective and access issues.

The Minister would like to acknowledge the commitment and dedication of the Urology Review Group in taking forward work to improve both the quality and accessibility of services within this specialty area.

Yours Sincerely

Dr Miriam McCarthy

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

From:	caroline.white Personal Information redacted by the USI
To:	Galloway, David; Secondary Care; Banks, Caroline; Garrett, Elizabeth
Cc:	McCarthy, Miriam; Secondary Care; McCormick, Andrew; McKee, Christine; Adair, Anne; Baxter, Clare; Magill, Jenny; Gaughran, Aine; Private Office DHSSPS; Devlin, Linda
Subject:	Submission: SUB/284/2010 REVIEW OF ADULT UROLOGY SERVICES IN NORTHERN IRELAND
Date:	29 March 2010 15:44:39
Attachments:	Sub.284.2010.doc

DEPARTMENT OF HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

Routine

From: Caroline White
Private Office
To: Galloway David (Mr)
Date: 29/03/2010

Action Copy: McCarthy Miriam (Dr)
McCormick Andrew
Baxter Clare (Ms)
Magill Jenny
Gaughran Aine
Office Copy

SUB/284/2010:REVIEW OF ADULT UROLOGY SERVICES IN NORTHERN IRELAND

The Minister has read and agreed your submission of 19/03/2010 and asked for press release to go Tuesday, 30/3/2010

Press office to arrange press release Tuesday 30/3/2010

Many thanks.

Caroline White (Private Office)

Castle Buildings Tel: Personal Information redacted by

OffName

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

SUBMISSION

From: David Galloway
Secondary Care Directorate

Date: 18 March 2010

1. Dr M McCarthy – [*Agreed 19/3/10*]
2. PS Michael McGimpsey

REVIEW OF ADULT UROLOGY SERVICES IN NORTHERN IRELAND

Issue:	**You have agreed the recommendations of the urology review be taken forward but had asked that we seek confirmation of clinician support for those recommendations. Letters of support for the review recommendations have now been received from clinicians at Antrim Area Hospital and from the Medical Director of the Northern Trust.**
Timing:	**Routine.**
Presentational Issues:	**There may be local media interest.**
FOI Implications:	**May not be disclosed under the terms of exemption 35 - formulation and development of government policy.**
Recommendation:	**That you agree to proceed with an announcement of the review recommendations. Press release attached at Tab C.**

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Background

1. During 2008/09, the former Service Delivery Unit was asked to undertake a regional review of adult urology services in response to service concerns regarding the ability to manage growing demand, meet cancer and elective waiting times, maintain quality standards and provide high quality elective and emergency services. The Review group was chaired by Hugh Mullen and the report was submitted to the Department for consideration in March 2009.

2. You have agreed (Sub 226/2010) that the recommendations should be accepted subject to confirmation that clinicians in the Northern Trust were able to confirm their support for these proposals as indicated to you in that submission.

3. In light of the responses received to the consultation, the Board has arranged to meet individually with each of the political party/political representatives to explain the current service configuration and the expected outcome from the implementation of the review.

4. A meeting has already been held with the clinical staff who responded from the Northern Trust to discuss their concerns. The meeting was well attended and successful in assuring clinicians that the issues they raised have been taken account of in the actions required to implement the project. The clinicians from Antrim were content that the proposed urology support for Antrim Area Hospital and access for their acute patients into the Belfast City Hospital would provide a much enhanced service to that which they have currently. Their position could now be very much considered as supporting the review recommendations.

5. Since you were last briefed on this issue, letters have been received from clinicians at Antrim Area Hospital and from the Medical Director of the Northern Trust expressing their support and that of colleagues for the review recommendations. Copies of these letters are provided at Tab A.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Presentational Issues

20. This review has attracted media and public interest and we would expect issue of the final recommendations to also attract interest. You may wish to issue a press release announcing your endorsement of the recommendations, draft attached at Tab C for your consideration.

Recommendation

6. It is recommended that you now agree to the issue of a letter to the HSC Board asking that the Board proceeds with the implementation of the recommendations. A draft letter for issue by Dr McCarthy, is attached at Tab B.

David Galloway

Ext Personal Information redacted by

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

TAB A

Northern Health and Social Care Trust

15 March 2010

Mrs Beth Malloy
Assistant Director, Scheduled Services
Performance Management and Service Improvement Directorate
Health and Social Care Board
Templeton House
411 Holywood Road
Belfast
BT4 2LP

Dear Beth

RE: FINAL RESPONSE OF NORTHERN TRUST CLINICIANS TO UROLOGY CONSULTATION

Many thanks for facilitating a meeting between the Urology "Team East" and clinicians from Antrim Hospital on Wednesday, 3 March 2010. I am writing to confirm that we have been reassured by the information that we received from Mr Chris Hagan and colleagues regarding cover for patients in the southern sector of NHSCT. We are now happy for the Urology Review's proposals for Antrim Hospital to go ahead. The next stage for us as clinicians will be to work through some of the details with Team East and we are keen to collaborate on this work as soon as possible. I can confirm that I have discussed this with my surgical and gynaecological colleagues and that they are in agreement also.

Yours sincerely

Personal Information redacted by the USI

OLIVIA DORNAN
CLINICAL DIRECTOR MEDICINE AND EMERGENCY MEDICINE
NHSCT

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

cc Dr Adele Kennedy, Secretary, Antrim Medical Staff
Mr Colm Donaghy, Chief Executive, NHSCT
Dr Peter Flanagan, Medical Director, NHSCT
Mrs Valerie Jackson, Director Acute Hospital Services, NHSCT
Mr Chris Hagan, Clinical Director Urology, BHSCT

Mrs Beth Malloy
Assistant Director, Scheduled Services
Performance Management and Service Improvement Directorate
Health and Social Care Board
Templeton House
411 Holywood Road
Belfast
BT4 2LP

16th March 2010 **Our Ref:** **Your Ref:**

Dear Beth,

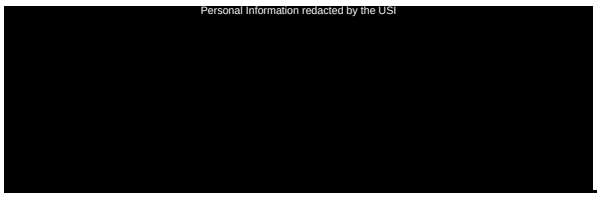
UROLOGY REVIEW TEAM NORTH WEST

I refer to previous correspondence regarding Urology Services in Causeway Hospital. I am pleased to see there is now stability within key areas of the urology service which had been provided for a number of years without recurrent funding.

You will be aware we are about to embark on a journey with colleagues from the Western Trust to implement the recommendations of the Urology Review in our locality. Our first meeting is scheduled for 1 April 2010.

I can confirm that clinical and managerial staff are committed to working collaboratively with the Western Trust and the commissioner to agree and implement a model of Urology services that will benefit our patients now and in the future.

Yours sincerely,



Dr Peter Flanagan
Director of Medicine & Governance

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

TAB B

Mr Hugh Mullan
Director of Performance Management
and Service Improvement Directorate
Regional Health and Social Care Board
12-22 Linenhall Street
Belfast
BT2 8BS

March 2010

REVIEW OF ADULT UROLOGY SERVICES

Thank you for your letter of 15 February 2010, forwarding the results of the consultation on the Review of Adult Urology Services.

The Minister has now had the opportunity to consider the responses to the consultation and am pleased to advise you that he is content to endorse the recommendations. I would therefore be grateful if you could make arrangements for the implementation of the recommendations as soon as possible, which I understand are being funded from within the Board's existing allocation to address elective and access issues.

The Minister would like to acknowledge the commitment and dedication of the Urology Review Group in taking forward work to improve both the quality and accessibility of services within this specialty area.

Yours Sincerely

Dr Miriam McCarthy

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

TAB C

PRESS RELEASE

Health Minister, Michael McGimpsey today, after a 12 week public consultation exercise, announced the implementation of the recommendations of a review of adult urology services in Northern Ireland.

The main recommendations of the review, which aim to improve capacity for the delivery of urology services, include:

- An increase in consultant urologists from 17 to 23;
- All radical pelvic surgery to be carried out in BCH;
- At least 5 clinical nurse specialists should be employed;
- An Increase the proportion of elective surgeries undertake as day cases; and
- Reconfigure the service into a three team model, covering northern, southern and eastern areas respectively.

Speaking today the Minister said: “Urology services face increasing demand due to an aging population, increased patient expectations, men’s health initiatives and availability of better assessment and diagnosis. These recommendations will I believe ensure that capacity will meet future demands and I am happy to endorse their implementation. I am particularly pleased to note that these recommendations have the support of the clinical leadership of the Trusts involved”

Notes to Editors:

1. The Regional Review of Urology Services was completed in March 2009.
2. A 12 week public consultation of the Review was conducted by the Regional Health and Social Care Board.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

3. The speciality of urology predominantly covers the assessment, diagnosis and treatment of urogenital conditions involving diseases of the kidney, bladder, prostate, penis, testis and scrotum.
4. Around 40% of urology work is cancer related.
5. The consultation can be accessed online.
6. Media queries to DHSSPS Press Office on 028 9052 0571 or out of hours contact the Duty Press Officer via pager number 076 9971 5440 and your call will be returned.

DEPUTY SECRETARY
HEALTH CARE POLICY GROUP
Dr Miriam McCarthy



Department of
Health, Social Services and Public Safety
www.dhsspsni.gov.uk

AN ROINN
Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí

MÄNNYSTRIE O
Poustie, Resydènter Heisin an Fowk Siccar

Mr Hugh Mullen
Director of Performance Management and Service Improvement Directorate
Regional Health and Social Care Board
12-22 Linenhall Street
Belfast
BT2 8BS

Castle Buildings
Room D4.17
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: DH1/10/56565
Date: 2 April 2010

Dear Mr Mullen

REVIEW OF ADULT UROLOGY SERVICES

Thank you for your letter of 15 February 2010, forwarding the results of the consultation on the Review of Adult Urology Services.

The Minister has now had the opportunity to consider the responses to the consultation and am pleased to advise you that he is content to endorse the recommendations. I would therefore be grateful if you could make arrangements for the implementation of the recommendations as soon as possible, which I understand are being funded from within the Board's existing allocation to address elective and access issues.

The Minister would like to acknowledge the commitment and dedication of the Urology Review Group in taking forward work to improve both the quality and accessibility of services within this specialty area.

Yours Sincerely

[Signed]

MIRIAM McCARTHY

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

From:	Beth Malloy
To:	Duffin, Richard
Subject:	RE: URGENT: FW: Update on Modernising Endoscopy
Date:	12 December 2011 11:45:25

"This email is covered by the disclaimer found at the end of the message."

Richard

Please see some notes below, please contact me if you need further clarification

Thanks
Beth

Endoscopy

The Modernising Endoscopy Programme was established to support Trusts to improve endoscopy services in preparation of Bowel Cancer Screening. Following the successful introduction of BCS, the Modernising Endoscopy Programme led by the PHA and NICaN was formally stood down in December 2010. However, improving and reducing waiting times for endoscopy services is a priority for the Board and PHA. The need for timely access to endoscopy is an important factor in the continuing roll-out of the Bowel Cancer Screening Programme which is due to be completed by the end of 2011/12. To this end, the Board and PHA have worked with Trusts and a number of actions have been agreed to reduce the maximum waiting time for endoscopy to 13 weeks by March 2012. These include the expansion of core capacity, short–term use of the independent sector and improved productivity through enhanced booking and scheduling processes. As a result, the number of patients waiting longer than 13 weeks for endoscopy has reduced in October. This trend is expected to continue during the remainder of 2011/12 and all Trusts have confirmed that they expect to achieve the 13-week maximum waiting time by March 2012.

Progress towards achievement of the 13-week maximum waiting time by March 2012, delivery of core capacity, and of in-house and IS waiting list plans, is being monitored at the fortnightly elective care monitoring meetings.

Urology Review

The implementation of the recommendations of the Regional Review of Adult Urology Services is currently well underway. The Board has agreed the volumes of activity associated with the introduction of the three Urology Teams and has approved the funding for the appointment of new consultants and the associated support staff. A number of these staff have now been appointed and the recruitment process is underway for the remaining staff. Trusts are expected to deliver the full volumes of activity from April 2012.

Mrs Beth Malloy
Assistant Director Scheduled Services
Performance Management and Service Improvement Directorate
Health and Social Care Board

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Personal Information redacted by the USI

-----Original Message-----
From: Duffin, Richard [mailto: Personal Information redacted by the USI
Sent: 08 December 2011 15:56
To: Beth Malloy
Subject: RE: URGENT: FW: Update on Modernising Endoscopy

Beth,

My number is Personal Information redacted by the USI. I left a message on your mobile

Richard

-----Original Message-----
From: Beth Malloy [mailto: Personal Information redacted by the USI]
Sent: 08 December 2011 15:50
To: Duffin, Richard
Subject: RE: URGENT: FW: Update on Modernising Endoscopy

“This email is covered by the disclaimer found at the end of the message.”

_____

Richard
Please could we speak - what is your phone number?
Beth

Mrs Beth Malloy
Assistant Director Scheduled Services
Performance Management and Service Improvement Directorate
Health and Social Care Board
Personal Information redacted by the USI

-----Original Message-----
From: Duffin, Richard [mailto: Personal Information redacted by the USI]
Sent: 08 December 2011 09:48
To: Beth Malloy
Subject: URGENT: FW: Update on Modernising Endoscopy

Beth

We now urgently need this briefing now on the endoscopy modernization

Could I have you briefing by close of play today?

Richard

-----Original Message-----
From: Beth Malloy [mailto: Personal Information redacted by the USI
Sent: 28 November 2011 10:30
To: Duffin, Richard
Subject: RE: Update on Modernising Endoscopy

“This email is covered by the disclaimer found at the end of the message.”

Richard
Do you still need an update?

Beth

Mrs Beth Malloy
Assistant Director Scheduled Services
Performance Management and Service Improvement Directorate
Health and Social Care Board
Personal Information redacted by the USI

-----Original Message-----
From: Duffin, Richard Personal Information redacted by the USI
Sent: 22 November 2011 14:18
To: Beth Malloy
Cc: Brown, Helena
Subject: FW: Update on Modernising Endoscopy

Beth,

We have been asked to provide urgent briefing on the modernising endoscopy project. Can you provide an update on progress and the latest position regarding the modernising endoscopy programme. Could I have the details by close Friday 25th?

Many thanks

Richard

From: Magee, Joe
Sent: 22 November 2011 14:10
To: Duffin, Richard
Subject: RE: Update on Modernising Endoscopy

Beth Malloy and Brian Godfrey

Joe

DBS and Strategic Development
Room 14
Annex 1
Castle Buildings
Stormont
Belfast
BT4 3SQ
Tel: Personal Information redacted by the USI
Mob Personal Information redacted by the USI

“The information contained in this email and any attachments is confidential and intended solely for the attention and use of the named addressee(s). No confidentiality or privilege is waived or lost by any mistransmission. If you are not the intended recipient of this email, please inform the sender by return email and destroy all copies. Any views or opinions presented are solely those of the author and do not necessarily represent the views of HSCNI. The content of emails sent and received via the HSC network may be monitored for the purposes of ensuring compliance with HSC policies and procedures. While HSCNI takes precautions in scanning outgoing emails for computer viruses, no responsibility will be accepted by HSCNI in the event that the email is infected by a computer virus. Recipients are therefore encouraged to take their own precautions in relation to virus scanning. All emails held by HSCNI may be subject to public disclosure under the Freedom of Information Act 2000.”

“The information contained in this email and any attachments is confidential and intended solely for the attention and use of the named addressee(s). No confidentiality or privilege is waived or lost by any mistransmission. If you are not the intended recipient of this email, please inform the sender by return email and destroy all copies. Any views or opinions presented are solely those of the author and do not necessarily represent the views of HSCNI. The content of emails sent and received via the HSC network may be monitored for the purposes of ensuring compliance with HSC policies and procedures. While HSCNI takes precautions in scanning outgoing emails for computer viruses, no responsibility will be accepted by HSCNI in the event that the email is infected by a computer virus. Recipients are therefore encouraged to take their own precautions in relation to virus scanning. All emails held by HSCNI may be subject to public disclosure under the Freedom of Information Act 2000.”

“The information contained in this email and any attachments is confidential and intended solely for the attention and use of the named addressee(s). No confidentiality or privilege is waived or lost by any mistransmission. If you are not the intended recipient of this email, please inform the sender by return email and destroy all copies. Any views or opinions presented are solely those of the author and do not necessarily represent the views of HSCNI. The content of emails sent and received via the HSC network may be monitored for the purposes of ensuring compliance with HSC policies and procedures. While HSCNI takes precautions in scanning outgoing emails for computer viruses, no responsibility will be accepted by HSCNI in the event that the email is infected by a computer virus. Recipients are therefore encouraged to take their own precautions in relation to virus scanning. All emails held by HSCNI may be subject to public disclosure under the Freedom of Information Act 2000.”

From:	darren.magee[redacted]
To:	Johnston, Jackie (DHSSPS); Magee, Aisling
Cc:	Mooney, Eugene; Tullin, Frances; Secondary Care; Daly, Catherine; Boyd, Linda (SSI); Magee, Joe; Jeynes, Alison; Johnston, Jackie (DHSSPS); Magee, Aisling; Hardy, Joan; Mooney, Eugene; Thompson, Julie; Allen, Sharon (DHSSPS); Scarlett, Mary; Stewart, Bill; Monteith, Roberta; Community Information Branch; HIB Questions; Montgomery, Erin; Rodgers, Heidi; Workforce Statistics; Carson, Philip (DHSSPS); Megaw, Malcolm; QOF Data Enquiries; Tullin, Frances; Browne, Fiona; Private Office DHSSPS; Devlin, Linda; Scullion, Sean; Bill, Jonathan; Baxter, Pamela; Bailie, Marc; Henry, Ronan; Cairns, Joyce; Wallace, Doreen; Daly, Catherine; Boomer, Linda; Nesbitt, John; Anderson, Gail; McGeown, Paula (DHSSPS); Hodgen, Tracy; McAteer, Kieran; Corbett, Patricia; Ferguson, Katherine; Green, Carol
Subject:	CLOSING AQ -- Ref. Number: AQW 30818/11-15 : To ask the Minister of Health, Social Services and Public Safety (i) to outline the reasons for the eight month waiting list at the urology department of the Causeway Hospital; (ii) how many people are curre...
Date:	19 February 2014 11:18:55
Attachments:	30818.DOCX 30818.pdf

CLOSING - AQ

Reference: AQW 30818/11-15
Raised By: Oliver McMullan

Subject: To ask the Minister of Health, Social Services and Public Safety (i) to outline the reasons for the eight month waiting list at the urology department of the Causeway Hospital; (ii) how many people are currently on the waiting list; and (iii) whether he will provide the additional resources needed to meet demand. AQW 30818/11-15

Answer:

Copied To For Input:
Mooney Eugene (Dr)

Copied To For Information:
Secondary Care; IAD (Information & Analysis Directorate); Office Copy; HEnry Ronan; HRD

DEPARTMENT OF HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

DATE FOR ANSWER: **14 February 2014**

PRIORITY WRITTEN NO: **AQW 30818/11-15**

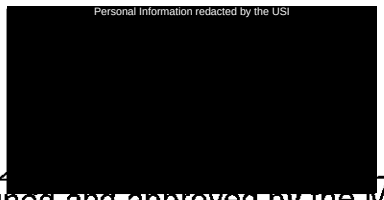
Oliver McMullan (East Antrim): To ask the Minister of Health, Social Services and Public Safety (i) to outline the reasons for the eight month waiting list at the urology department of the Causeway Hospital; (ii) how many people are currently on the waiting list; and (iii) whether he will provide the additional resources needed to meet demand. AQW 30818/11-15

Edwin Poots

(i) The Northern Health and Social Care Trust has been experiencing difficulty in meeting demand for urological services at the Causeway Hospital. This has been due to the inability to fill a vacancy and long term sick leave within the surgical team. I am advised that due to confidentiality reasons, numbers of those patients waiting over eight months cannot be disclosed because of the small number, less than five, involved.

(ii) The latest validated figures indicate that in the Northern HSC Trust at 30th September 2013, 31.3% (187 out of 598) of patients were waiting over 9 weeks for a first consultant-led outpatient appointment in the urology specialty, with 64 (10.7%) waiting over 18 weeks. At 30th September 2013, 34.6% (214 out of 619) of patients were waiting over 13 weeks for inpatient admission in the urology specialty, with 36 (5.8%) waiting over 30 weeks.

(iii) In recent weeks the position regarding the staff complement at the Northern HSC Trust has improved though full capacity has not yet been achieved. The HSC Board and the Trust are working closely together to resolve any difficulties in ensuring prompt access to urology services at the Causeway Hospital.



Signed and approved by the Minister for Health, Social Services and Public Safety Date: 17/2/14

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

DEPARTMENT OF HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

DATE FOR ANSWER: 11 March 2013

ORDINARY WRITTEN No: AQW 31320/11-15

Alban Maginess (Belfast North): To ask the Minister of Health, Social Services and Public Safety how long patients in the Belfast Health and Social Care Trust have to wait for an appointment for the urology day procedure clinic; and, excluding cancer cases, what differentiation is made between routine and urgent urological cases.

Edwin Poots

The waiting times for day case admission in the Urology specialty in the Belfast Health and Social Care (HSC) Trust, at 31st December 2013, the most recent quarter for which official statistics are available, is outlined in the table below.

Patients waiting for day case admission in the Urology specialty, at 31st December 2013, by weeks waiting

	Length of Time Waiting (weeks)						Total Waiting
Belfast HSC Trust	0-6	>6-13	>13-21	>21-26	>26-30	>30	
	1,106	291	274	130	81	379	2,261

Source: DHSSPS Inpatient Waiting Times Dataset

The Belfast HSC Trust has advised that all patients are triaged by their consultant on the basis of their clinical need, with urgent and routine patients treated chronologically within their respective category of triage. Waiting time standards differ markedly between the two categories and maximum waiting times would be monitored closely for both groups of patients, with all available resources utilised to achieve the required waiting time standards as far as reasonably practicable.

Personal Information redacted by the USI

Date: 11/03/13

Signed and approved by the Minister for Health Social Services and Public Safety

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

DEPARTMENT OF HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

DATE FOR ANSWER: **13 March 2014**

ORDINARY WRITTEN No: **AQW 31453/11-15**

Roy Beggs (East Antrim): To ask the Minister of Health, Social Services and Public Safety how many people are currently on the waiting list for a day procedure in urology departments in each Health and Social Care Trust.

Edwin Poots

Waiting times for day case admission in the Urology specialty each Health and Social Care Trust, at the 31st December 2013, the most recent quarter for which official statistics are available, can be found at the link below:

http://www.dhsspsni.gov.uk/northern_ireland_waiting_times_qe_december_2013.xls

Personal Information redacted by the USI

Date: 10/3/14

Signed and approved by the Minister for Health Social Services and Public Safety

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

DEPARTMENT OF HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

DATE FOR ANSWER: **13 March 2014**

ORDINARY WRITTEN No: **AQW 31454/11-15**

Roy Beggs (East Antrim): To ask the Minister of Health, Social Services and Public Safety to detail the number of people waiting over (i) nine; and (ii) eighteen weeks for a first consultant led outpatient appointment in the urology departments, broken down by Health and Social Care Trust.

Edwin Poots

Waiting times for a first consultant-led appointment in the Urology specialty in each Health and Social Care Trust, at 31st December 2013, the most recent quarter for which official statistics are available, can be found at the link below:

http://www.dhsspsni.gov.uk/northern_ireland_waiting_times_qe_december_2013.xls

Personal Information redacted by the USI

Date: 10/3/14

Signed and approved by the Minister for Health Social Services and Public Safety

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

DEPARTMENT OF HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

DATE FOR ANSWER: **19 March 2014**

ORDINARY WRITTEN NO: **AQW 31612/11-15**

Judith Cochrane (East Belfast): To ask the Minister of Health, Social Services and Public Safety to outline (i) the number of patients who have been on the waiting list for urology day procedures within the Belfast Health and Social Care Trust for more than 52 weeks; (ii) the criteria which the Belfast Trust applies in giving Red Flag priority status to urology day procedure patients; (iii) whether additional criteria are used in prioritising those patients whose cases are not given Red Flag status; and (iv) the actions which he will take to ensure that the Belfast Trust responds to concerns raised by local GPs regarding urology day procedure waiting lists.

Edwin Poots

(i) The most recent statistics relating to waiting times for day case admission in the urology specialty in each Health and Social Care Trust can be found at the link below: http://www.dhsspsni.gov.uk/northern_ireland_waiting_times_qe_december_2013.xls

I am advised that due to confidentiality reasons, numbers of those patients waiting over 52 weeks for urology day procedures at the Belfast HSC Trust cannot be disclosed because of the small number, less than five, involved.

(ii) Every suspected cancer referral in Northern Ireland is considered to be red flag and is assessed according to the Northern Ireland Guidance for Suspected Cancer which reflects recommended best practice. The guidance was developed by NICaN's Tumour Groups and Primary Care Group and builds on existing NICE guidance. The guidance can be found at:
http://www.cancerni.net/search/node/guidance

(iii) All non red-flag referrals which have a low suspicion of cancer are triaged based on the information provided on the referral according to their clinical symptoms such as age, prostate specific antigen (PSA) etc. These referrals may still be regarded as urgent and can be upgraded to red flag status by consultants.

(iv)To help improve the current provision of urology services, the Health and Social Care Board is undertaking a clinically led stock take of the 'Review of Adult Urology Services' which was completed in 2009. This exercise will help to identify the current challenges which have directly impacted on the service provision and will make recommendations to improve patient access and reduce waiting times across the region.

[redacted] Personal information redacted by the USI

Date: 19/3/14

Signed and approved by the Minister for Health, Social Services and Public Safety

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

DEPARTMENT OF HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

DATE FOR ANSWER: **31 March 2013**

ORDINARY WRITTEN No: **AQW 32050/11-15**

Alban Maginess (Belfast North): To ask the Minister of Health, Social Services and Public Safety pursuant to AQW 31320/11-15, what action his Department is taking to reduce the number of patients who have to wait more than twelve weeks for an appointment for a urology day procedure

Edwin Poots

To help improve the current provision of urology services, the Health and Social Care Board is undertaking a regional clinically led stock take of the 'Review of Adult Urology Services' which was completed in 2009. This exercise will help to identify the current challenges which have directly impacted on service provision and will make recommendations to improve patient access and reduce waiting times across the region.

Personal Information redacted by the USI

Date: 21/3/14

Signed and approved by the Minister for Health Social Services and Public Safety

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

HEALTH AND WELLBEING 2026

DELIVERING TOGETHER



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

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

CONTENTS

	FOREWORD BY MICHELLE O'NEILL, MLA	**3**
1	**THE CHALLENGE**	**4**
	Organisational	6
	Workforce	6
	The Needs of a Rapidly Changing and Ageing Population	7
	Health Inequalities	8
	Our Opportunity	9
2	**THE AMBITION**	**10**
3	**THE CHANGE NEEDED**	**12**
	Build capacity in communities and in prevention	12
	Enhancing support in primary care	14
	Reforming our community and hospital services	15
	Organising ourselves to deliver	18
4	**THE APPROACH**	**19**
	Partnership Working	19
	Improving Quality and Safety	21
	Investing in our Workforce	22
	Leadership and Culture	22
	Ehealth and Care	23
5	**THE ACTIONS**	**24**

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

WIT-50920

FOREWORD



The World Health Organisation defines health as "a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity". That is the health outcome I want to deliver for all our people.

But without new approaches and in the face of ever growing demand - often driven by successful interventions and improving life expectancy - we will increasingly struggle.

Change is quite simply essential to deliver the world class service - free at the point of delivery and based on need - that is our collective commitment.

We must move beyond simply managing illness and instead ensure that our health service supports people to stay well; physically, mentally and emotionally.

In other words, we need to rethink how we deliver our health and social care service.

My predecessor, Simon Hamilton, asked a panel led by the internationally recognised expert, Professor Rafael Bengoa, to help us identify how to tackle the challenges in our Health and Social Care system.

Their report tells us clearly that we need to re-organise how we do things - and that we need to do this in partnership with the people who use the service and those who work in it. Critically, we must prioritise prevention and early intervention to ensure that people stay well. This approach will produce better health and wellbeing outcomes and it will reduce demand on our over stretched acute services. It will also help us tackle what the Expert Panel Report calls "striking health inequalities" in our society.

This document, Health and Wellbeing 2026: Delivering Together, is the outworking of the Expert Panel's recommendations. It sets out a commitment to tackle the issues we face in our Health and Social Care system through decisive political leadership. We are determined to move beyond short-term approaches and crisis management.

This Executive is united as never before in its commitment to take the right, perhaps difficult, decisions. But we know this is the only way to deliver better outcomes for our people.

We are facing into a time of change for our health system but it is change that must happen. This document sets out a direction of travel that I hope all of our society can embrace and support in the challenging but exciting time ahead.

Michelle O'Neill, MLA
Minister of Health

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

WIT-50921

1 THE CHALLENGE

My desire for world class health and social care is based on firm foundations - we have a health and social care system staffed with many talented and dedicated people working extremely hard to deliver high quality services to those in need. But increasingly those efforts are frustrated by a system which is clearly under mounting pressure. This is impacting on both those within the system and those it serves. Without radical change there is no doubt the situation will further deteriorate. That is why I am convinced that change is needed now.

Before I set out the case for change, it is important to acknowledge and celebrate where Health and Social Care, in collaboration with wider government, is making a real difference to our health and wellbeing.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

WIT-50922

Standardised
CIRCULATORY DEATH RATE
in under 75s
decreased by a fifth over the last 5 years

ENGAGEMENT WITH EDUCATION TRAINING OR EMPLOYMENT FOR THOSE AGED 16-21 WHO ARE IN CARE OR HAVE LEFT CARE HAS RISEN 5.7% IN THE PAST YEAR

SMOKING PREVALANCE FELL
from 26% in 2004/05
to 22% in 2014/15

7677
CARERS RECEIVED SUPPORT FROM TRUSTS IN 2015 COMPARED TO 1414 IN 2011

Over **1 in 3** adults (36%) reported that they ate the recommended **5 PORTIONS** of fruit & veg a day (2014/15)
increased by a third over the last 10 years

FAMILY SUPPORT HUBS
In 2015/16, **4522 families with children** were referred to Family Support Hubs, a **72% increase** on the previous year. Of the 5346 children referred to Hubs in 2015/16, **around 18% were children with a disability**

BOWEL CANCER DECREASE
Since **bowel cancer screening** was introduced, the percentage of people diagnosed with early stage disease has increased from **14% to 22%** thereby **improving their life chances**

LOOKED AFTER CHILDREN
achieving Key Stage 1: Level 2 or above
in English
7.5% INCREASE
in Maths
7% INCREASE

INCREASE IN ADOPTIONS
Between 2014/15 and 2015/16, there has been a **24% INCREASE** in the adoptions of Looked After Children

LIFE EXPECTANCY
over the last 5 years life expectancy has increased
1.3 YEARS
for males
(78 years)
1 YEAR
for females
(82.3 years)

Standardised
RESPIRATORY DISEASE DEATH RATE
in under 75s
decreased by a fifth
over the last 5 years

MMR VACCINE
over 95% of children received the MMR Vaccine which means we have not seen the outbreaks of measles that have occurred elsewhere

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

WIT-50923

At the heart of the many successes of the Health and Social Care (HSC) system is the hard work and dedication of all staff, in every grade and role, who are delivering care at higher levels than ever before.

However, while there is much to celebrate, we must recognise the challenges in the current system. The reality is that we increasingly cannot properly meet people's needs with our current structures. In the past, and for a range of reasons, it has not been possible to achieve the whole system transformation at the scale and with the pace we need to meet the evolving health needs of our people. More and more the impact of this is felt on a daily basis and takes its toll on both those who use services and those working in the sector.

Our Health and Social Care System faces a number of significant challenges:

Organisational

In many past reviews, professionals and staff have expressed their frustration at the limitations of our current arrangements and their desire for change, most recently in the Expert Panel report. The 20th century configuration of our services is simply not optimised to meet the needs of 21st century care.

The point has now been reached where maintaining the current delivery models is having increasingly negative impacts on the quality and experience of care for many service users, while constraining the ability of the system itself to transform to meet today's health needs.

While staff work increasingly hard to mitigate these structural issues, the overall impact is experienced by service users and their families every day in every part of the system. Regrettably, delays in accessing services and unacceptable waiting times for treatment are commonplace. The quality of our service, and the experience of those providing and receiving it, is not as good as it should be.

Modern research shows that outcomes for patients requiring complex or specialist treatment improves where high levels of specialist expertise is available and these teams are able to keep pace with innovation. The current spread of such HSC resources, too often committed to buildings rather than outcomes for patients, is a central challenge we must address.

If we persist with our current models of care, even with the best efforts of all staff and more investment year on year, waiting lists will continue to grow, our expertise will continue to be diluted, and the best possible outcomes for patients will not be realised. This is both unsustainable and unacceptable.

In addition, the way we are organised means that opportunities are being missed to create sustainable employment, drive economic investment, and maximise the contribution of the HSC to the economic goals of the Executive. For example, the life and health sciences sector provides 10% of all of the North's exports. Closer working between the HSC, our world class universities and life and health science organisations and maximising the potential for growth in this high value sector, is fundamentally dependent on centres of clinical excellence with the right level of expertise and the necessary capacity.

Workforce

A further challenge relates to the workforce itself. People who work in health and social care are its greatest strength, working ever harder to provide the care needed by patients and service users. Year on year, investment has been directed to front line services in an effort to meet the ever growing need for treatment and care.

However, if we accept, as a whole range of reviews have, that our services are not best configured for our needs, then it follows that recruiting additional staff alone to prop up outdated service models, is not the answer. We must be able to provide safe and high quality care which keeps up with the fast pace of innovation and health and social care developments. I recognise that staff need the opportunity to develop their skills and expertise in an environment which allows for a greater degree of specialisation, whilst maintaining personalised compassionate care.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

WIT-50924

It has also become clear that even when resources are made available to recruit additional staff, it has simply not been possible to fill all vacant posts. This in turn puts additional pressure on already hardworking staff and has seen our service become increasingly reliant on short term solutions such as locums and agency staff. This creates additional expense with negative implications for the quality of care. It has become a vicious circle which we must stop.

We must invest in our staff and provide the environment to allow them to do what they do best - provide excellent high quality care. This means providing opportunities to develop their skills and find suitable career paths at all levels. Where necessary, we will increase the numbers we train and consider ways of delivering care more effectively through the development of new roles and skills.

I am determined that we will make the health and social care system an employer of choice in the north of Ireland.

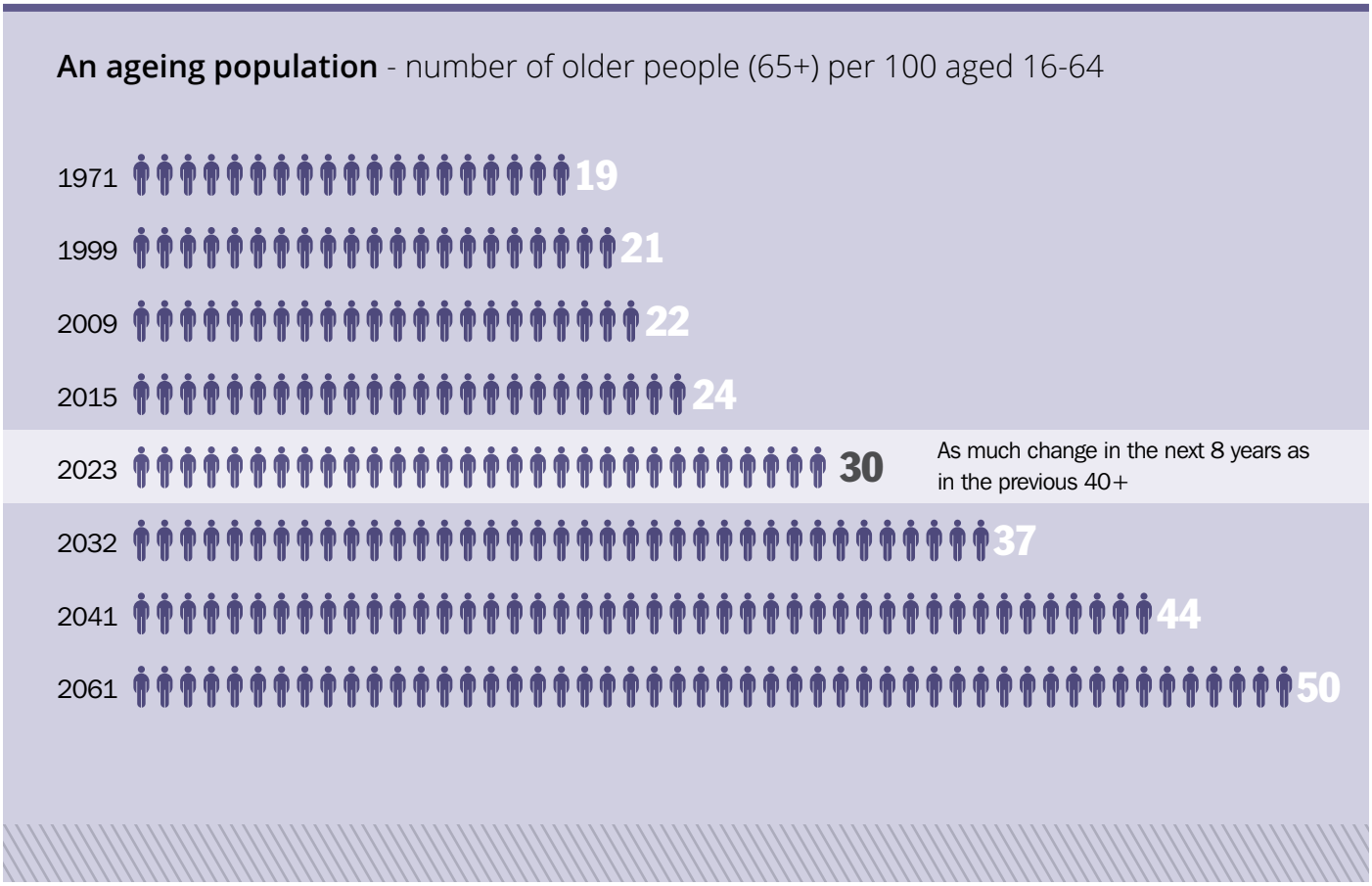
The Needs of a Rapidly Changing and Ageing Population

Our society is getting older: people are living longer, often with long-term health conditions, and we are having fewer children. Estimates indicate that by 2026, for the first time, there will be more over 65s than under 16s.

By 2039, the population aged 65 and over will have increased by 74% compared to the position in 2014. This will mean that one in four people will be aged 65 and over.

Similarly, the population aged 85 and over will increase by 157% over the same period, which will see their share of the population increase from 1.9 % to 4.4%.

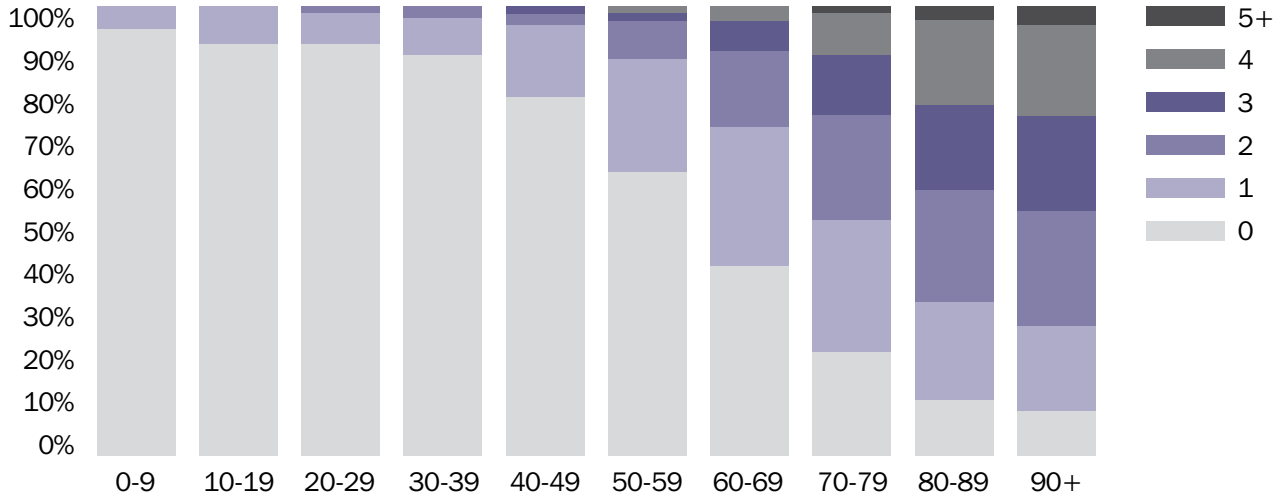
By any analysis, this is a massive success to which our health and social care service has made a significant contribution. That said, it does present a huge and growing challenge in terms of the demands and pressures on health and social care services.



Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

WIT-50925

Percentage of patients in each age band with the indicated number of morbidities



Developments in how conditions can be treated and managed mean that as we get older we are much more likely to develop and live with one or more long term conditions. The table above demonstrates that as we get older, the likelihood of having more than one condition at the same time increases dramatically, and with that the care and treatment that we require becomes much more complex.

Furthermore, people's health and social care needs have changed, and their expectations are rightly higher than at any other time before. In the past, for many conditions, where there was an effective treatment available, it often required hospital attendance or an in-patient stay. Increasingly, such treatments are available in the community, or can be provided on a day care basis; which in many instances is more appropriate to the needs of people with longer-term chronic conditions.

People today want to lead full and productive lives, staying independent for longer. In line with wider societal changes, we all expect improved access, choices and control when it comes to public services.

Health Inequalities

Despite people living longer, health inequalities continue to divide our society. The differences in health and wellbeing outcomes between the most and least deprived areas are still very stark, and completely unacceptable.

For example, men in the least deprived areas live 7.5 years longer than men in the most deprived areas. For women, the difference is over four years. In the most deprived areas, 30% of people report a mental health problem - double the rate in least deprived areas. Rates of suicide are also higher, and leave a devastating impact on people, families and those communities.

Birth weight is an important indicator of foetal and neonatal health, and a low birth weight has a strong association with poor health outcomes in infancy, childhood and throughout someone's life. Between 2010 and 2014, the proportion of babies born at a low birth weight was 44% higher in the most deprived areas than in the least deprived areas.

In 2013/14, the rate of obesity among children in Primary 1 was 71% higher in the most deprived areas than those in the least deprived areas. 42% of Looked After Children (LAC) come from the most deprived areas in the North. Being looked after is associated with poorer socio-economic outcomes in adulthood.

It is clear that economic, social and environmental factors, and experiences early in life, play a major role in determining not just the health outcomes at an individual and community level, but also their social, educational, economic and other outcomes. There is also growing evidence that children who experience adversity in childhood are far more likely to experience health issues in adult life. Specifically, these children are more likely

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

WIT-50926

to adopt health harming behaviours during adolescence which can lead to mental health illness and diseases such as cancer, heart disease and diabetes later in life. Adversity in childhood also means that children are more likely to perform poorly in school, more likely to be involved in crime and more likely to experience poverty and disadvantage in adult life.

Our future health and social care system needs to not only treat people who become sick or need support now, but also needs to do much more to ensure that the next generation is more healthy with more equitable life opportunities for all.

Our Opportunity

The problem and the compelling case for change is not in itself new, and has been made repeatedly by experts, staff and patients over many years. The Expert Panel's Report "Systems, not Structures: Changing Health and Social Care" once again reaffirms this. But despite the overwhelming evidence, the opportunity has thus far not been grasped. However, both as Minister and as an Executive we believe there is now no alternative but to transform how we design and deliver health and social care services.

The political summit hosted by the Expert Panel in February 2016 secured a political mandate for the need for change and the principles to underpin it, and I look forward to all parties engaging with and supporting the HSC to make the difficult decisions required to improve our population's health, and build a sustainable health and social care system. This is the time for political leadership.

The advent of a new outcomes based approach in the draft Programme for Government puts an onus on us all to work together, across traditional silos and boundaries to deliver the best outcomes for the people of the North. Now is the time for us to work collectively to deliver a world class health service.

Across this island, the health and social care fabric of both jurisdictions face the same challenges. We have the opportunity to work more collaboratively with colleagues to address those challenges, and deliver services in a way that improves care for our population as a whole. There are many good examples of where this is already working well, such as cancer and cardiac services in the north west or the partnership with Dublin for children's heart surgery. There are many more such opportunities, including the transplantation of organs and rare diseases, and we have developed a programme of work with the Department of Health in the South to identify areas of mutual benefit.

Staff, clinicians and professionals from right across our health and social care system are telling us loud and clear that change is now necessary. If we do not grasp this opportunity change will happen anyway but in a reactive and unplanned way, with more potential for detrimental impacts on those who use and deliver our services.

In addition, the HSC itself is a huge contributor to the economy in many ways, through skills development, spending power and employment practices.

As the single biggest employer in the North, we have a real opportunity and responsibility to make a tangible and positive contribution to the health and wellbeing of our staff, and society as a whole. We will be an employer of choice, leading by example and investing in the wellbeing of our staff. Despite the demand, resource and service pressures being experienced, I am committed to ensuring the wellness dimensions of being an employer of this scale will be better achieved across the HSC.

In the way we operate, we have the opportunity to promote a new way of working with the community and voluntary sectors through the innovative use of social procurement clauses, and commissioning services based on social value rather than simply on the basis of lowest cost.

Working with our world class universities, skilled graduates and world leading companies, we can grow our life and health sciences sector, creating new jobs. This will mean access to cutting edge technology and therapies, and the dual benefit of improving care and economic growth. To do so requires further collaboration between HSC, academia and industry. The HSC can only play its part if it can provide the centres of expertise and excellence that will continue to attract partners, and support the recruitment and retention of experts in their fields.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

2 THE AMBITION

Health is a human right. I am deeply committed to the principle of universal health care, free at the point of delivery to those in need.

Aligned with the aspirations the Executive set out in the draft Programme for Government, my overarching ambition is for every one of us to **lead long, healthy and active lives**.



Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

WIT-50928

Therefore, we want to see a future in which:

- people are supported to keep well in the first place with the information, education and support to make informed choices and take control of their own health and wellbeing;
- when they need care, people have access to safe, high quality care and are treated with dignity, respect and compassion;
- staff are empowered and supported to do what they do best; and
- our services are efficient and sustainable for the future.

All of these aims are of great importance and must be addressed if we are to meet the future needs for our population.

They will underpin a new model of **person-centred care** focussed on prevention, early intervention, supporting independence and wellbeing. This will enable the focus to move from the treatment of periods of acute illness and reactive crisis approaches, towards a model underpinned by a more holistic approach to health and social care.

We will create the circumstances for people to stay healthy, well, safe and independent in the first place. We will anticipate the needs of individuals for support and care and this new model of person-centre care will intervene early to avoid deterioration.

This model will be designed for and with people and communities rather than by organisations and services. Instead of thinking about buildings and hospitals as the only place to deliver services, we will deliver care and support in the most appropriate setting, ideally in people's homes and communities. In most instances people should only have to go to hospital when they need treatment that can't be provided in their community.

The way we design and deliver services will be focussed on providing continuity of care in an organised way. To do so we will increasingly work across traditional organisational boundaries, to develop an environment characterised by trust, partnership and collaboration.



Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

WIT-50929

3 THE CHANGE NEEDED

If we are to support everyone to lead long, healthy, and active lives, we need to change the focus of our services, and how and where those services are delivered. The Expert Panel has clearly said that 'something very different has to happen at the delivery of care level'.

We must:

- **Build capacity in communities and in prevention** to reduce inequalities and ensure the next generation is healthy and well;
- **Provide more support in primary care** to enable more preventive and proactive care, and earlier detection and treatment of physical and mental health problems;
- **Reform our community and hospital services** so that they are organised to provide care when and where it is needed;
- **Organise ourselves to deliver** by ensuring that the administrative and management structures make it easier for staff to look after the public, patients and clients.

Build capacity in communities and in prevention

We will work with communities to support them to develop their strengths and use their assets to tackle the determinants of health and social wellbeing.

We will support the development of thriving and inclusive communities, through the work of the HSC working closely with Executive colleagues and other providers such as councils, schools, police, housing and transport.

In particular, the HSC will become better at tapping into the innovative ideas and energies in communities themselves, and in the community and voluntary sectors. In all communities, every child and young person should have the best start in life, people should have a decent standard of living, and all citizens should be supported to make healthier and better informed life choices.

We will invest in HSC community development resources to work alongside all communities to enable social inclusion and tackle health inequalities and the underlying contributory factors including poverty, housing, education and crime.

It will take time to realign and grow the community development resource, and as a first step we will review existing capacity and then invest to meet any gaps, including a programme of training.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

WIT-50930

Alongside this, we will link social care more strongly with improving and safeguarding the wellbeing of individuals, families and communities. We will strengthen the social work profession by fully implementing my Department's Improving and Safeguarding Social Wellbeing Strategy.

To give every child and young person the best start in life, we will further increase the support we provide to children, young people and families from before birth to adulthood. The universal Health Visiting and School Nursing service will enable and support children and young adults to be successful healthy adults through the promotion of health and wellbeing; this will include the full delivery of the Healthy Child, Healthy Future programme. This will support the implementation of the Executive's Public Health Framework "Making Life Better" and its ambition to give every child the best start.

I will work with other Ministers to build on the success of the Early Intervention Transformation Programme and enhance early intervention services and the Family Support Hub network by exploring ways to build on the capacity of the hub model. This would include both better coordination of existing early intervention services and increasing the assessment capacity of the Hubs. This will enable us to respond quickly and flexibly to meet the needs of families early on before the problems they face become more intractable and severe. By increasing our early support to families we will reduce the need for later intervention, such as the need for children to come into care.

For children who are in the care system we will work to improve their life chances. Looked After Children experience much worse health, social, educational, and employment outcomes than other children. We will honour our corporate parenting responsibilities to the fullest extent and will be as ambitious for children in care as we are for our own children.

The range of placement options available to Looked After Children will be expanded. Through service redesign and, if necessary, new legislation we will better meet the individual needs of each child and put in place more effective supports for their caregivers, including kinship carers and families who adopt children from care. By working with the courts we will secure permanence for them more quickly helping their mental and emotional wellbeing, educational attainment and health in particular. Support will also be extended so that they are better prepared for independent living in adult life.

FAMILY SUPPORT HUBS

Family Support Hubs provide an accessible, flexible and responsive point of contact for families in need of support.

As of June 2016, 29 family support hubs were operational, providing full regional coverage across the North.

The engagement of local communities in the planning and commissioning of local services has been a key component to the successful delivery of Family Support Hubs.

In 2015/16 there were 4522 families referred through family support hubs, an increase of 1887 compared with 2014/15.

In 2015/16 a total of 5346 children were referred, 953 of which were children with a disability.



Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

WIT-50931

PRACTICE BASED PHARMACISTS

This initiative will see pharmacists working as an integral part of the GP surgery practice team. This means we can use their skills and experience to improve patient outcomes through reviewing their medication and reducing errors.

Practice Based Pharmacists (PBP) can help to alleviate some of the pressures faced by general practice through triaging patients to appropriate services and in some instances undertaking the diagnosis and initiation of treatment and follow-up appointments in patients with long term conditions.This will enable GPs to spend more time with patients with complex needs.

By December 2016, it is anticipated that 54 PBPs will have been placed in GP practices across the North with further PBPs appointed and in place over the period January-May 2017.



Enhancing support in primary care

Primary care is the bedrock of our health and social care system and provides around 95% of the care people need throughout their life. General Practitioners (GPs) and multidisciplinary primary care teams have a key role to play in improving population health and wellbeing, as well as developing care pathways and services to meet the population needs.

Our primary care service is still largely based on GPs working independently with some input from other disciplines. In future, the focus of our system will be increasingly on keeping people healthy and well in the first place. The World Health Organisation defines good health as a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity. In the future we need a model that provides fully integrated multidisciplinary care, not just medical or nursing care.

Our future model of primary care is to be based on multidisciplinary teams embedded around general practice. The teams will work together to keep people well by supporting self management and independence, providing proactive management of high risk patients. They will identify and respond earlier to problems that emerge whether related to health or social circumstances or the conditions in which people live, providing high quality support treatment and care throughout life.

These teams will include GPs, Pharmacists, District Nurses, Health Visitors, Allied Health Professionals and Social Workers, and new roles as they develop, such as Advanced Nurse Practitioners and Physician Associates. There will be capacity and skills to proactively support individuals to address the lifestyle choices that impact upon their health and wellbeing. They will have the right tools and skills to diagnose, treat and coordinate the majority of care for their practice. They know the people they serve, and understand their needs better than anyone.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

WIT-50932

These teams will work in a more integrated way with all other community services and development work in their area, including Community Pharmacy. Community Pharmacy is an important part of primary care and can help to reduce pressure on other parts of the HSC. We must use them better, especially to support improved public health and engaging in with the public to ensure medicines are being used appropriately.

This model is radically different from what we have at present. It will require significant change in the way staff across the HSC are organised and deployed, and in the way GPs and other members of the new teams work together. This new model will therefore be rolled out incrementally over the next 5 years, learning and addressing gaps in staffing as we proceed. The roll-out of Practice Based Pharmacists will be completed by March 2021. GP surgeries will have named health visitors and named district nurses to work with by the end of March 2017. In addition, the way that core district nursing is delivered will be transformed, and a District Nursing Framework will be published by the end of this year.

We will maximise the potential for developing social prescribing models in the multidisciplinary primary care teams, through the embedding of social workers and building linkages to the range of early support services available to service users, such as Mental Health Hubs and other early help initiatives.

Additional funding for primary care will be focussed on developing these teams, with more funding for mental health interventions in primary care and funding to test the impact that specialist allied health professionals, such as physiotherapists, can have when working alongside the primary care team. Training for the first Advanced Nurse Practitioners for primary care and a new Physician Associate post-graduate degree programme have been developed and will start in early 2017. We will work closely with GPs and other professionals on the roll-out and evaluation of this model.

Together, the enhanced community capacity, the focus on prevention based approaches and the multidisciplinary teams in primary care will provide much greater capability to keep individuals and communities well.

Reforming our community and hospital services

Sometimes, the primary care or community care teams cannot fully meet a patient's needs but it isn't appropriate for them to be admitted to a hospital.

With developments in treatments and technology, we are able to do so much more without the need to admit people to hospital. Therefore in future we want to build on new services and models which are already emerging, and ensure that these are implemented across our health and social care system, working in partnership with those who deliver and use these services.

Acute Care at Home is an example of this type of service. Patients, often frail and elderly, are treated in their own homes by doctors, nurses and other staff. Conditions such as chest infections, urinary tract infections and dehydration can all be safely treated without the need to go to hospital, which can be a worrying and anxious experience for many. Patients have, within their own home environment, the same access to specialist tests as hospital inpatients and receive consultant led assessment and treatment.

We will make Acute Care at Home available to the whole population. We will better integrate it with social care and ensure it is supported by other services, including short stay hospital services, GPs and palliative care. This new model of care will be rolled out to all areas within the next three years.

We are committed to the further development of **Ambulatory Assessment and Treatment Centres**, to provide a more joined up, 1-stop service. Evidence from here and elsewhere shows there are significant benefits to be gained from this approach. Our current model is based on the traditional outpatient model of care where a GP refers a patient to the specialty the GP believes most closely relates to the possible cause of the person's symptoms. But as people live longer and develop more problems, diagnosis and treatment becomes more complex. So the traditional model is no longer fit for purpose.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

WIT-50933

Over the next 12 months, we will start to design these centres in partnership with clinicians and patients. They will provide simpler and easier access to the healthcare professionals and diagnostic equipment (such as X-Rays, CT scanners) needed to assess and diagnose conditions. Importantly, if a treatment or procedure is needed this will be possible on site with the aim of getting patients safely home the same day.

This avoids multiple outpatient visits and enables earlier diagnosis and appropriate treatment, and is therefore much better for those who use our services, and makes better use of our resources. Staff will have all the facilities they need to make the right diagnosis there and then, and to provide high quality care.

Elective Care Centres will be established to provide a dedicated resource for less complex planned surgery and other procedures. Evidence from elsewhere shows that such centres can reduce waiting times for planned care, and provide a better experience for both patients and staff. The current approach of delivering both planned and unplanned care using the same facilities and the same resources, means that waiting times can be adversely affected when the demand for urgent and emergency care is very high.

By making better use of our existing resources, and organising these in a different way, we will be able to provide larger volumes of activity, to a higher quality and in a more timely manner. The centres will be a resource for the region and the way they operate will be designed around the needs of patients. The number and location of these centres will be developed in partnership with clinicians and patients, and I expect proposals to be brought forward in the next 12 months.

Acute inpatient care will change. By changing the way preventive care, primary, community and less complex elective care is provided, and by looking after people in settings that are more appropriate to their needs, the nature of acute inpatient care will change.

Acute inpatient care will therefore focus on complex planned surgery and emergency care of patients who need an acute inpatient setting, for example, patients who have had a stroke, heart attack, or trauma, and those needing obstetric, neonatal or paediatric services or those with a significant worsening of a long term health condition. Multidisciplinary working will be a key feature of good quality inpatient care.

Across many different services there is very strong evidence that concentrating specialist procedures and services in a smaller number of sites produces significantly better outcomes for patients, as well as a much better and more supportive environment for staff

The role of our hospitals will therefore fundamentally change as they will focus on delivering the highest quality of specialist and acute care. However, not every service will be available in every hospital.

In the past few years we have seen the successful development of region-wide and cross-border **networks for highly specialist services** such as cancer, neonatology or cardiology as well as the development of the first truly all-island service in children's congenital cardiology. These are delivering innovative, world class services and we will seek to maximise opportunities to expand this approach and deliver more services on an all-island basis, where clinically appropriate to do so.

This is about changing the way that services are delivered, improving safety and quality, and making the best use of the resources we have. The Expert Panel, working with clinicians, has developed criteria which will help us to assess the sustainability and future of how services are provided, and this provides us with a route-map to work in partnership with those who use and deliver our services.

Mental Health

The North has a particular challenge with mental health, having the highest rates of mental illness in these islands. There are many talented and hardworking professionals in the system and the voluntary and community sector, who do excellent work in the services they provide. It is clear that our services need to continue to evolve and improve, building on the Bamford reforms from the last decade.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

WIT-50934

Mental health is one of my priorities as Minister of Health, and it is an issue that I will champion at every opportunity. I want better specialist mental health services. This would include further support for perinatal mental health and inpatient services for mothers, with potential to address the need that exists across the island. We will expand services in the community and services to deal with the trauma of the past. Underpinning all of this, I am committed to achieving a parity of esteem between mental and physical health to ensure that we are tackling the true impact of mental health on our communities.

Carers

Families and friends take on most of the caring responsibilities for their loved ones and this makes an enormous contribution both to the HSC and to society as a whole. I fully recognise that carers are an equal partner in providing care, and they need our support to be carers. They also need support to enable them to do the things that those without caring responsibilities take for granted such as working, going out socially, having a break or going on holidays. In the case of young carers, they need help and support just to do the things that young people do. I am committed, along with other government departments and their agencies, to providing that support.

We know that the needs of carers are changing, this means the type of support we need to give them is also changing. We need to encourage greater take up of carer's assessments and expand the options for short breaks, as well as enabling the greater use of personalisation and personal budgets where appropriate. We need to ensure carers can access up to date information and crucially consider how we can support carers to live their own lives. The role of carers and how we can better support them will be central to the Review of Adult Care and Support and I encourage everyone to make their views known when we bring proposals forward for consultation in spring 2017.

DELIVERING ACUTE CARE AT HOME

This service enables this vulnerable patient group to retain their independence and dignity and prevents unnecessary and stressful hospital admissions.

It was designed and implemented by East Belfast Integrated Care Partnership (ICP) and subsequently rolled out across Belfast. Similar services are available in some other Trust areas.

In the Belfast area, the average length of stay for Acute Care at Home patients is 6 days compared to 11 days in hospital. Over 1084 referrals have been received for the extended service in the Southern area.



Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

WIT-50935

Organising ourselves to deliver

To deliver care in a different way, it is clear that the way we plan and manage health and social care will also need to change. Therefore, in line with the recommendations of the Expert Panel's Report, we need to empower local providers and communities to work in partnership, including health and social care trusts, independent practitioners such as GPs and voluntary providers.

Embracing new models of care has the potential to harness the strengths of different parts of the system, across traditional organisational boundaries, across sectors and beyond what is traditionally considered to be the health and social care sector.

Working together, they will be expected to plan integrated and continuous local care for the populations they serve. I will set the outcomes we expect them to deliver, and the frameworks within which they need to operate, and hold them to account accordingly. For the first time, they will have the autonomy to make rapid and sustainable changes to improve services and address health inequalities in their area.

Where services are highly specialised, they will be planned and delivered on a region-wide basis. Building on the programme of work currently underway with Department of Health counterparts in Dublin, we will continue to explore opportunities to plan and deliver services on an all-island basis.

The recent consultation on HSC structures supported the need to reduce bureaucracy and put in place a more effective streamlined mechanism for how we plan health and social care services.

Starting now, we will work with the wider HSC system to design the new partnership approaches to the planning and management of HSC services, which moves away from competition towards collaboration, integration and improvement.



PRIMARY PERCUTANEOUS CORONARY INTERVENTION (pPCI)

This service, based in Belfast and in Derry, means that patients having a particular type of heart attack are taken from anywhere across the North straight to a specialised centre which can undertake this life saving procedure on a 24/7 basis.

On average a total of 66 pPCI procedures are being carried out per month and from May 2016, Donegal patients have access to the Derry based service.

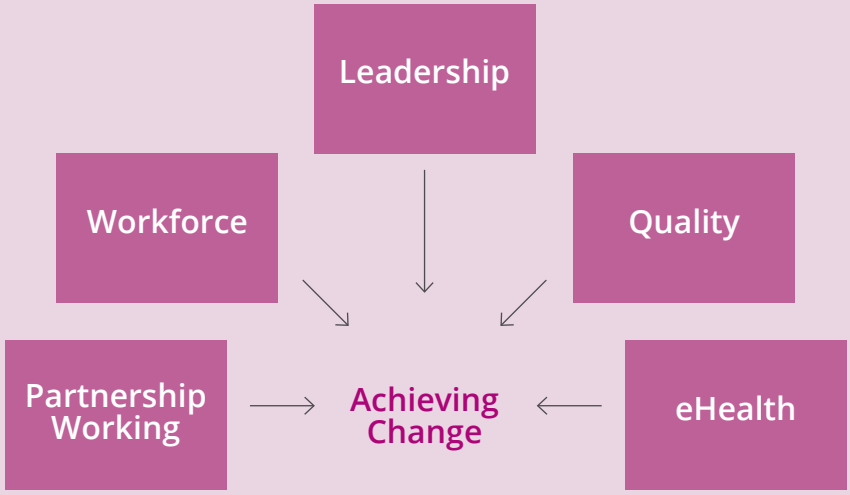
Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

WIT-50936

4 THE APPROACH

How we plan, design, support and implement service transformation is as important as the changes we wish to make.

Only by taking the right approach will these changes be the best ones for our population as a whole, and be sustainable in the long run.



Partnership Working

With people who use and deliver services

Our Health and Social Care system belongs to all of us and we all bring valuable insights to how it can improve. We must work in partnership - patients, service users, families, staff and politicians - in doing so we can co-produce lasting change which benefits us all. Everyone who uses and delivers our health and social care services must be treated with respect, listened to and supported to work as real partners within the HSC system.

Building on the good practice which already exists in the HSC, such as the Mental Health Recovery Colleges, we will work collaboratively in the spirit of openness and trust to deliver agreed outcomes.

When we embark on a change to our system or services, all relevant individuals or groups will be brought together, including those who use and those who deliver our services. A clear terms of reference will be developed collaboratively, ensuring all parties are clear about the task at hand, and how we will work together.

We will adopt creative and innovative ways to maximise involvement. All views and opinions will be received with equal merit. In the past the system has been criticised for delays in bringing forward change, we will support teams to work at pace.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

WIT-50937

Co-production will empower patients, service users and staff to:

- **design the system** as whole to ensure there is a focus on keeping our population well in the first place and ensuring that when people need support and help they receive safe and high quality care;
- work together to **develop and expand specific pathways of care and HSC services** which are designed around people and their needs, including setting outcomes to measure impact;
- be partners in **the care they receive** with a focus on increased self-management and choice, especially for those with long-term conditions.

A move to this model will not happen overnight. However, I am fully committed to this approach and will support this new way of working across the HSC. In order to start this process in November I will embark on a period of engagement about my proposals for the model of health and care for the future.

I am making a commitment that the design of new and reconfigured services will be taken forward on the basis of co-production and co-design.

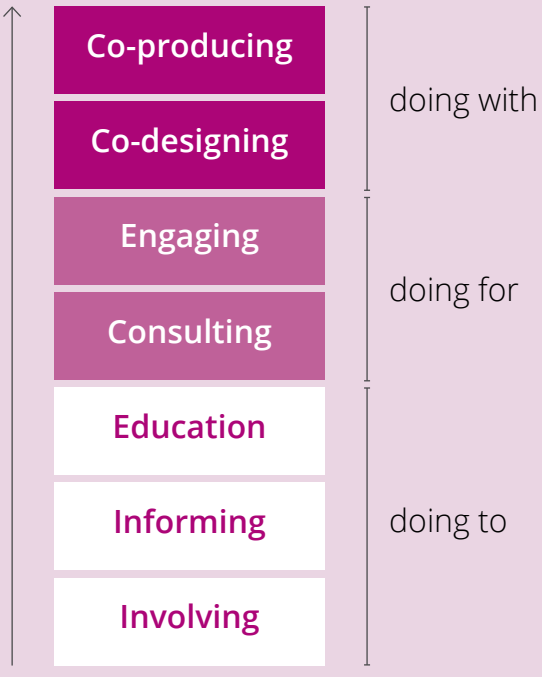
We will strengthen the capacity of both those who use our services and those who deliver them to bring about positive change for and by themselves. This includes continued investment in initiatives such as Expert-by-Experience programmes, which provides training and development for users who work with the HSC to improve our services. We will also train staff to support the continued roll-out of the Quality 2020 Attributes Framework.

In addition, I intend to maximise the patient voice across our system, and align it much more closely to the quality improvement, and inspection and regulation. I also want to hear the voice of staff particularly those on the ground closest to those who use our services. In early 2017, I will consult and design a new feedback platform open to all those who both use and deliver our services. This will enable users and staff to tell us what matters to them in terms of their health and social care and to raise issues in as timely a manner as possible, so that they can be addressed early before they escalate to a complaint.

Co-production - a new approach to the design and development of mental health services

An example of how co-production can make a big impact on our services is the design and delivery of Mental Health Recovery Colleges. This is an innovative model that assists individuals in their personal and collective journey of recovery. This recovery focussed approach creates opportunities for those with lived experience to contribute as volunteers and in paid roles. These peer educators assist those with mental health problems to discover personal talents and develop life skills which can help them enter the labour market.

A number of people with lived experience have and continue to be developed to become peer educators and are now making a contribution to care delivery. Over 236 sessions of peer education have been delivered.



Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

WIT-50938

With other providers

Partnership with other providers of care and other service providers is key to improving and safeguarding social, emotional and physical wellbeing. Health and social care has a strong tradition of working with other professions and sectors including the voluntary, community, criminal justice, education, housing and private sectors. These partnerships will be maintained and strengthened to maximise the impact we can make on improving people's health, social wellbeing and quality of life, as well as making the best use of resources.

Improving Quality and Safety

In the design and delivery of health and social care, quality and safety will always be a fundamental priority. The Expert Panel said "any system that aspires to be world class must take a strong position on quality improvement, with the patient and service user represented as part of this".

It is clear to me that, in order to achieve our ambition for health and social care, we need to establish an infrastructure capable of supporting, enabling and driving the improvements we seek, with people at its heart. There needs to be a greater alignment between quality improvement, partnership with those who use our services, and how we regulate those services.

Like many healthcare systems, there has been a gradual increase in improvement capability across our health and social care service. One example is the Regional Mortality and Morbidity Review System, which supports the review of all hospital deaths by multidisciplinary 'frontline' teams to identify learning to improve the quality and safety of care. The system is well embedded in two Trusts at present and will be fully embedded across all Trusts by April 2017. Another example is the Medicines Optimisation Quality Framework which is supporting improvement by scaling up good practices for the appropriate, safe and effective use of medicines across health and social care.

We now need to fully integrate quality improvement into the work of every HSC organisation and provide real support for local and regional improvement work. That will mean improving our capacity to foster local innovation and to implement what works at scale. It also requires us to be able to proactively detect hazards in care settings and implement solutions to reduce risk before harm occurs. Developing the science of improvement can be done at the same time as making improvements.

To deliver a sustainable and world class service into the future will require of all of us to work together very differently. We need an infrastructure that makes this possible.

For that reason, I intend to establish an Improvement Institute that will better align existing resources to enable improvement in our system of care. These include resources currently devoted to patient safety, regulation, evidence gathering, data analytics, information and, critically, those with experience of using our services. My aim is to establish a strong and integrated infrastructure to support improvement wherever it needs to happen across our system of care. This aim will only be achieved with the support and engagement of all leaders across the HSC system.

I have asked my Department to convene a group of local clinicians, professionals and service users with experience in improvement to advise on the design of that infrastructure. This will not be a new HSC organisation but will align existing resources and functions. The design work will be complete by February 2017 and I expect the Institute to begin to test how it will operate by May 2017.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

WIT-50939

Investing in our Workforce

The Expert Panel has re-affirmed that effective workforce engagement and planning are key enablers to HSC transformation. I believe the far-reaching transformation journey we are about to embark on needs the commitment and engagement of workers across the HSC at every grade if it is to succeed. I am confident that working together we can succeed.

The increasing pressure on services has contributed to difficulties in attracting and retaining experienced staff and the vacancy rate in a range of disciplines continues to grow. These factors have led to an escalation in the costs of maintaining safe service provision through the use of expensive agency and locum staff, as well as longer hospital stays than necessary.

Clearly, this is unsustainable and workforce planning cannot continue to be used simply as an exercise to ensure that existing rotas are filled. It has to be a vehicle for supporting the implementation of a new and sustainable model of care. It has to take account of increasing demand as a result of demographic trends, be informed by robust and accurate workforce information and analysis, and map to the new configuration of services in secondary care and the increased focus on primary care. It also has to address the factors that enhance the attractiveness of key jobs, such as domiciliary care.

However, effective workforce planning is only one aspect of what is needed. We want to ensure that we are harnessing the skills and experience of the 72,000 individuals working in the wider HSC family.

As stated earlier, I want the HSC to be an employer of choice, leading by example and investing in the health and wellbeing of its staff. We will explore ways to build on and consolidate the health and wellbeing services we provide for our staff.

I recognise the fears and anxieties about job security, role and job location that any change process will create. Based on their lived experience, HSC staff at all grades are all too well aware of the unintended day to day impact on their own teams of previous change initiatives. Too many of these experiences to date have not been positive.

I am determined that the unique store of knowledge, commitment and public service ethos that the HSC workforce represents will be listened to, engaged and nurtured at all levels. It is the single most important resource we have to achieve lasting change.

In collaboration with stakeholders, we are committed to ensuring a Workforce Strategy is developed by spring 2017 which will cover all aspects of the HSC workforce, including retention and recruitment; opportunities for introducing new job roles and of reskilling and upskilling initiatives. This will require investment but we are convinced that investment in every area of our workforce is critical in delivering this new model of sustainable care.

But it is clear that some action needs to be taken now to address current workforce challenges. Therefore, we will continue to invest in training by expanding GP and nurse training places. I have asked for a number of areas to be looked at in detail, including the appointment of a Nursing and Midwifery Task group which will report within 12 months with recommendations for how we can maximise the contribution nursing and midwifery can make to improved outcomes for the population.

The forthcoming Reform of Adult Social Care and Support will consider the nature, size and skills of the social care workforce needed to deliver social care in the future. I will consider carefully the findings of the Domiciliary Care Workforce Review, which is due to be completed by the end of 2016. I am committed to taking steps to improve the recruitment and retention of this critically important group of staff.

Leadership and Culture

If we are to develop a culture of quality improvement and partnership working, this must be underpinned by a new approach to collective and system leadership. We are fortunate to have some of the most capable, committed and enthusiastic people making up our health and social care workforce. Many leading edge research and reports provide evidence that having continuous learning cultures and team working in health and social care organisations is crucial to ensuring safe high quality care.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

WIT-50940

Rather than concentrating power at the top, I want all those working in health and social care to feel able to effect change and improvement in care. This means developing leadership at all levels, a truly collective leadership model. I will flatten and remove unnecessary hierarchy, eliminating those policies which inhibit innovation and improvement. If we are to move towards a model of care powered by multidisciplinary teams, we need to empower all teams to deliver care, not micro-manage them. Working in partnership with our staff, I believe this is achievable.

This will require a major programme of cultural change and it will not happen overnight. But we need to start now.

As part of this we need to enhance our clinical leadership. The Expert Panel said that change *"will be more successful if… implemented in a setting which encourages clinical and professional engagement"*. I want to see our structures have more professionals directly engaged in the management and leadership of our services, effecting the change supported by skilled and able managers.

I have recently re-established the Strategic Health Partnership Forum and see this as an important contribution to the development of a new culture of partnership, involvement and listening.

Over the next 6 months, an HSC-wide Leadership Strategy will be developed to support this aim. Resources will be directed over the next 3 years and beyond to develop the right staff and leaders, with the skills, behaviours and values that will be so crucial in developing the compassionate, collaborative and high performing culture we seek.

eHealth and Care

Making better use of technology and data is essential if we are to move to a model focussed on service users, on improving the health and wellbeing of the population and on getting beyond organisational and professional silos. I am determined to realise the potential and opportunities presented by modern information technology to improve outcomes for service users and free up time for front line staff. To do so, co-production must underpin our approach, and we must learn the lessons and build on the experience of current and past HSC IT initiatives.

We will expand the range of information and interaction available to citizens, service users and those providing services both online and through apps. This will include building a new patient portal which will allow secure online access to their own health and care information where service users want this. This new patient portal will be in place for dementia patients next year and rolled out across the North by 2021.

To ensure our staff can focus on supporting individuals, the right information must be available to the right professionals, at the time they need it. Our award-winning approach to sharing information across different IT systems (the Electronic Care Record) has significantly changed the way care is delivered and improved safety. However, we still have too many different systems across the HSC making it difficult to join up data and focus on the service user.

We are currently assessing the best way to achieve a much more consolidated and common patient and user record, with fewer separate IT systems. This will be a major undertaking. We will aim to liberate time for care by equipping our community based workforce with new technology that will increase the time that doctors, nurses, therapists and social workers have to spend with patients. If we can realise a 15-minute increase in care time by reducing bureaucracy this equates to over 1,000 additional care professionals working with service users. These initiatives will also allow more staff in the HSC to work remotely, saving travel to and from hospitals, care centres and offices.

Moving to a more consolidated health record across the North will allow us to make better use of information about our population - designing new ways to intervene early and support people in managing their conditions. A programme of work to improve our use of health analytics, focussed on dementia patients, will start in 2017.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

WIT-50941

5 THE ACTIONS

In this document I have set out my commitment to change but I recognise that much work is needed to develop, design and deliver the building blocks that will enable sustained improvement. I am committed to achieving the change required using a process of co-production.

The task is challenging and will take sustained and incremental effort over the next ten years to achieve real transformation.

But we start now. In the next section I have set out my actions for the next 12 months. These will be taken forward to make a positive and ambitious start towards stabilisation, reconfiguration and transformation.

As I have said, to deliver real and meaningful change will require an extension of the political goodwill and cooperation given to the Expert Panel. Moreover significant investment will be required. I believe this shared investment will not only improve people's health and wellbeing but have a positive impact on every aspect of their lives.

I fully believe that it is only by working together we can deliver a world class health and social care system.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

WIT-50942

Stabilisation

1	Develop a comprehensive approach for **addressing waiting lists** which takes account of the ongoing work of the Health and Social Care Board, as well as the recommendations from the Expert Panel.	*January 2017*
2	To improve access and resilience, and support the development of new models of care, make **significant investment in primary care** to ensure there is a multidisciplinary team focussed on the patient and with the right mix of skills. This will be supported by: - increased GP training places; - continued investment in Practice Based Pharmacists; - ensuring every GP practice has a named District Nurse, Health Visitor and Social Worker to work with; - supporting the development of new roles such as Physician Associates and Advanced Nurse Practitioners; and - further roll-out of the AskMyGP system. Bring forward a public consultation on the role of GP Federation and whether they should become HSC bodies.	*March 2017*
3	Bring forward proposals relating to the extension of placement options for **Looked After Children**.	*October 2017*
4	Following the completion and evaluation of a pilot project, roll-out access to the electronic care record (NIECR) to **community pharmacists** and establish a pilot to test access to the record for **independent optometrists.**	*October 2017*
5	Begin development of a new framework to fully realise the potential of **community pharmacy services** to support better health outcomes from medicines and prevent illness.	*November 2016*

Reconfiguration and service change

6	Embark on a consultation on the criteria set out in the Expert Panel Report and start a programme of **service configuration reviews**. These will be clinically led, working in partnership with those that use the services.	*November 2016*
7	As part of this process, my immediate priorities are: • following extensive review and engagement, launch a public consultation on proposals to modernise and transform **Pathology** services designed to improve service and workforce sustainability ensuring a high quality pathology service for the future;	*November 2016*
	• move forward with the implementation of the new **Diabetes** Strategic Framework, which has been, and will continue to be, developed through partnership with patients and their representative groups;	*November 2016*
	• launch and commence implementation of the **Paediatric Strategies** (2016-2026) designed to modernise and further improve the standard of treatment and care provided in hospital and community settings, and palliative and end of life care for children and their families; and	*November 2016*
	• launch a public consultation on proposals to develop sustainable **Stroke** services and further improve the standard of treatment and care provided to stroke patients.	*February 2017*
	• following a recent review, launch a public consultation on the configuration of **Imaging** services, taking account of advances in technology, demographics and demands, and looking to both national and international best practice;	*February 2017*
8	Bring forward proposals for the location and service specification for **Elective Care Centres**, and **Assessment and Treatment Centres.**	*October 2017*
9	Develop design for new structures and approaches to support the **reform of planning and administration** of the HSC	*March 2017*
10	Identify current **innovative HSC projects** at the local level and develop a rolling programme and implementation plan to scale up these projects across the region.	*April 2017*

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

WIT-50943

Transformation

11	Embark on a **period of engagement** with staff and service users to build a collective view of how our health and social care services should be configured in the future, and encourage a much wider public debate.	*November 2016*
12	Establish and seek members for a **transformation oversight structure** with membership drawn from within and outwith the HSC.	*November 2016*
13	Consult on proposals for the reform of **adult social care and support**, to consider different approaches to ensuring the long-term sustainability of the adult social care system.	*April 2017*
14	Consult on proposals for and complete design of a **new user feedback platform** open to all those who both use and deliver our services.	*October 2017*
15	Complete the initial design work for the **Improvement Institute.**	*February 2017*
16	Develop a **Workforce Strategy** covering all aspects of the HSC workforce, including retention and recruitment; opportunities for introducing new job roles; and upskilling initiatives.	*May 2017*
17	Develop a **HSC-wide Leadership Strategy** to consider a 5 year approach and plan for development of collective leadership behaviours across our system.	*May 2017*
18	Expand the range of information and interaction available to citizens online and development **patient portal** for dementia patients.	*October 2017*

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

SYSTEMS, NOT STRUCTURES:

CHANGING HEALTH & SOCIAL CARE



Expert Panel Report

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Panel Membership

PANEL MEMBERS

Professor Rafael Bengoa (Chair)

Dr Alan Stout

Bronagh Scott

Mairead McAlinden

Mr Mark A Taylor

EXPERT ADVICE ON SOCIAL CARE WAS PROVIDED BY:

Sean Holland

Fionnuala McAndrew

THE PANEL WAS SUPPORTED IN ITS WORK BY:

Alastair Campbell

Vikki Greenwood

Catherine Tumelty

The Panel would also like to record their gratitude to the many organisations and individuals from across the HSC who gave of their time and expertise to informing this work. The report would not have been possible without their involvement.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

CONTENTS

SECTION 1
THE PANEL'S REMIT 7

SECTION 2
THE BURNING PLATFORM –
AN UNASSAILABLE CASE FOR CHANGE 9

SECTION 3
THE PANEL'S VISION –
A NEW MODEL FOR HEALTH AND SOCIAL CARE 37

SECTION 4
ROADMAP FOR IMPLEMENTATION 53

SECTION 5
RATIONALISATION 69

SECTION 6
LIST OF RECOMMENDATIONS 79

ANNEX A
THE PANEL'S PRINCIPLES 83

ANNEX B
LIST OF GROUPS & INDIVIDUALS CONSULTED BY THE PANEL 87

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry



SECTION 1

THE PANEL'S REMIT AND THE POLITICAL SUMMIT

In his speech of 4 November 2015, the then Minister for Health, Simon Hamilton MLA, announced that in response to recommendation 1 of **The Right Time, The Right Place** report by Sir Liam Donaldson, he would appoint an expert, clinically led panel to consider and lead an informed debate on the best configuration of Health and Social Care services in Northern Ireland.

Sir Liam's report stated:

"A proportion of poor quality, unsafe care occurs because local hospital facilities in some parts of Northern Ireland cannot provide the level and standards of care required to meet patients' needs 24 hours a day, 7 days a week. Proposals to close local hospitals tend to be met with public outrage, but this would be turned on its head if it were properly explained that people were trading a degree of geographical inconvenience against life and death. Finding a solution should be above political self-interest".

The Panel was appointed in January 2016 and comprises local and international members. The Panel was given the remit to:

- Produce a set of principles to underpin reconfiguration of health and social care services.
- Support and lead debate including at a political summit to be held in early 2016 to agree the principles.
- Use the results of the political summit to develop a clinically informed model for the future configuration of health and social care, which will ensure world class provision for everyone in Northern Ireland.
- Clearly quantify the specific benefits in health outcomes that will be derived from the new model, both for individuals and the Northern Ireland population as a whole.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Political Summit: 17th February 2016

The panel along with MLAs and advisors from the DUP, Sinn Fein, UUP, SDLP and Alliance met for a one day health summit to discuss the need for change and agree a set of principles that would guide the panel in structuring a New Model of Health and Social Care for the people of Northern Ireland. Each party provided both verbal and written comments to a 'draft set of principles'. In turn the panel considered all comments and revised the principles to take as many of these on board as possible.

The final set of principles is attached at Annex A.

Engagement

The Panel has engaged extensively with stakeholders across health and social care, and the following key messages were heard consistently:

- The unsustainable nature of the 'status quo'. Major workforce gaps in all areas of the current model of service requiring significant investment in agency staff to maintain the current distribution of acute care.
- Underinvestment in primary and social care, the very services that can prevent hospital admission, because of over-investment in the current hospital model.
- Even with the funding used to purchase independent sector and 'in-house' waiting list initiatives, there are increasing delays for elective care.
- The contribution of unpaid carers and the voluntary sector, and the desire for the voluntary sector to be a trusted partner in care.
- Independent providers are delivering significant elements of care in domiciliary and residential care home settings and are struggling to cope with current funding levels.
- The need to invest in improving the health of our population and to take a more co-ordinated approach to supporting people with complex needs.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

SECTION 2

THE BURNING PLATFORM – AN UNASSAILABLE CASE FOR CHANGE



Context

In the course of its work, the Panel has heard repeated references to 'review fatigue'. In essence, there seems to be a sense that the Health and Social Care (HSC) system has repeatedly spent significant time and resources analysing the challenges it faces, identifying the weaknesses in the current model, making recommendations for change, but subsequently failing to enact the necessary transformation to make these happen. The timeline at fig. 1 gives a sense of the main reforms and reviews that the system has experienced since the 1970s.

Across the system, there has been a broad consensus among those the panel has spoken to that there is a need for transformational change in the way services are delivered and the way our system is organised. It is important to fully understand the nature of the challenges and demands that health and social care services face, and also the reasons why the model that is currently in place is outdated and is not the one that Northern Ireland needs. Many of these issues will not come as a surprise to those working across the system or those who use its services. Indeed, many of these issues were plainly articulated to us from a number of different sources, who made clear their concerns with regard to factors such as rising demand, changing demographics and patterns of illness, financial sustainability, workforce planning and vulnerable services. Although there are committed and talented people at all levels of the system, the system itself is not making the most effective use of the available public funds to meet service users' needs.

Northern Ireland is not alone in facing these challenges. Health and social care systems across the developed world are currently struggling with the question of how to adapt their services to deal with continuously rising and changing patterns of demand. Most countries also recognise that simply adding more money and resources to tackling these issues is not enough to make services higher quality and sustainable, radical transformation is required. This is not an easy thing to do; change and transformation are always difficult, they create uncertainty and they require us to give up what we have in exchange for something new. This is particularly difficult when it involves something that is very important to us, such as the health and social care services that we and our families will all need to call on at some point in our lives.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Fig. 1 – Reviews and Reforms of Health and Social Care in Northern Ireland

1973	The HPSS (NI) Order provided for the establishment of four Health and Social Services Boards, responsible for administering and arranging provision of services.
1989	A Government white paper introduced the concept of an internal market. In Northern Ireland, this led to the establishment of 19 Trusts.
1998	Fit for the Future proposed the abolition of the internal market with commissioning decisions taken as close as possible to patients and clients and centred on primary care.
2001	The Acute Hospitals Review suggests the establishment of a single Strategic Health and Social Services Authority to replace the four HSS Boards. It also recommends moving to a service with 9 acute hospitals
2002	Developing Better Services supports significantly reducing the number of HSC organisations, including the creation of a single regional authority. Also recommends the 15 Local Health and Social Care Groups (LHSCGs) should be brought together.
2002	GP fundholding abolished. Arrangements for LHSCGs, as committees of the four HSS boards are put in place to assess need and design services. 15 were in place by 2005.
2005	The Appleby Review focuses on the need for rigorous performance management and greater incentivisation of strong performance.
2007	The then Minister decides against a regional Health Authority. Instead, he confirms the creation of 5 new integrated Trusts, 5 Local Commissioning Groups, a smaller Health and Social Care Board focused on commissioning, financial and performance management, and a Public Health Agency.
2011	Transforming Your Care sets out a broad new model of care, moving away from hospitals and into primary, community and social care services. Recommends 5-7 hospital networks
2014	Sir Liam Donaldson endorses the policy behind TYC but recommends the appointment of an impartial panel of experts to deliver the right configuration of HSC services.
2015	Following the Donaldson report and an internal review of commissioning, the then Minister launches a consultation on a review of the HSC administrative structures. The review recommends abolition of the HSCB.
2016	The appointment of an international expert panel to develop a clinically informed model for the future configuration of health and social care.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

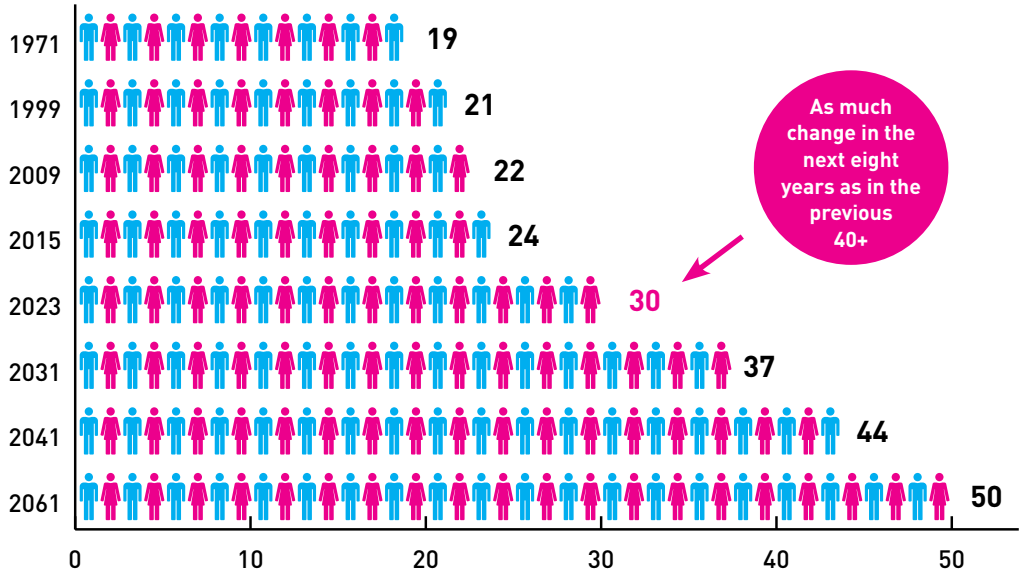
However, it is important that the case for change is clearly understood by those who use and those who deliver these services, and also the risks of not making these changes in a planned and transparent way. In this section of the report, the evidence that the existing system is already struggling to sustain services in the face of these changing circumstances is set out and the case made for new service models. Without systematic and planned change, already stretched services will undoubtedly be forced into unplanned change through fire-fighting and crisis.

The stark options facing the HSC system are either to resist change and see services deteriorate to the point of collapse over time, or to embrace transformation and work to create a modern, sustainable service that is properly equipped to help people stay as healthy as possible and to provide them with the right type of care when they need it. This report presents an opportunity that must be seized and acted upon.

Demographic Change

As a population, we are living longer than ever before and, for most of our lives, are healthier than ever before. When the NHS was created in 1948, life expectancy was 65.8 years for men and 70.1 years for women. It is now 78.1 for men and 82.4 for women. The number of older people in our community is also increasing as a proportion of the overall population. In 2013 there were estimated to be 279,000 people aged 65 and over, with 33,000 of them over 85 years. This is projected to increase considerably in the next 20 years to 456,000 and 79,000 respectively. As the graph below demonstrates, the demographic shift for the period from 2015-2023 will be equal to the demographic shift in the preceding 40 years.

Fig. 2 – Population Projections (2015-2061)



An ageing population: Number of older people (65+) per 100 aged 16-64

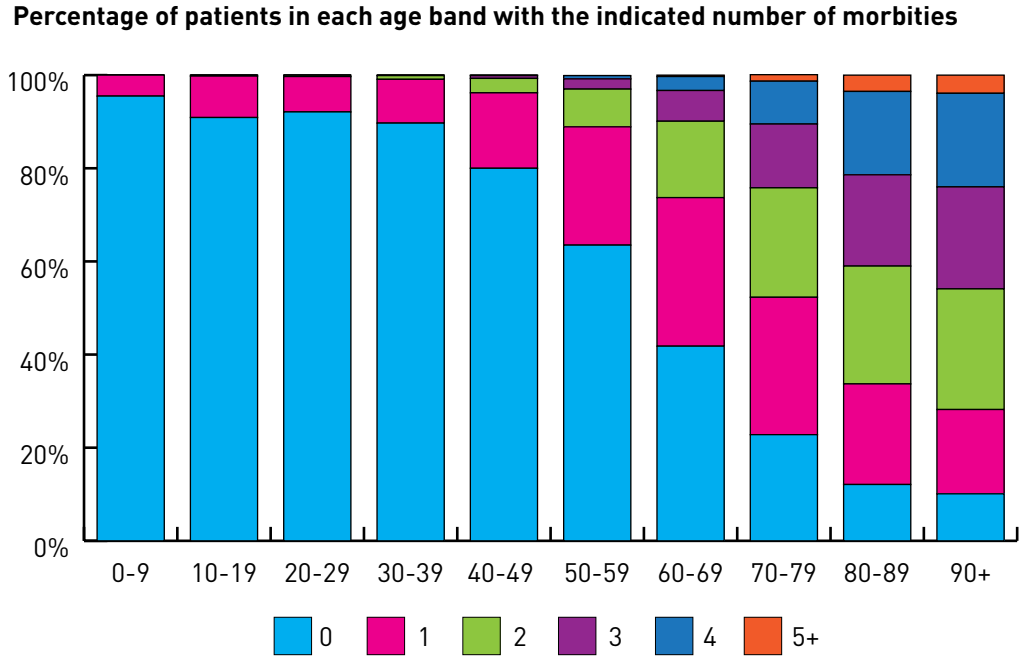
Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

It is a similar picture across the UK and Ireland. However, out of all the UK countries, at 43.1% Northern Ireland had the largest percentage growth of people aged 85+ between mid-2004 and mid-2014. This is projected to continue over the 25 year period between mid-2014 and mid-2039.[1]

This increase in life expectancy is a great achievement, but it signals a major shift in demography and in patterns of demand for health and social care services. Ageing brings an increased likelihood of some degree of disability, dependency and illness, and older people are now the main users of Northern Ireland's health and social care services. The rate of disability among those aged over 85 is 67% compared with only 5% among young adults.[2] Dementia is also a growing issue for our older population, with 60,000 people projected to be suffering from the condition by 2051.[3] In addition, the profile of older people requiring care is becoming more complex, with many people now living with multiple chronic illnesses.

As well as living longer, developments in how we are able to treat and manage conditions mean that we are all much more likely to develop and live with one or more long term conditions. The table below[4] clearly demonstrates that as we get older, the likelihood of multiple morbidities increases dramatically, meaning that the care and treatment that we require becomes much more complex.

Fig. 3 – Co-morbidities by Age Band



1. NISRA Statistical Bulletin: 2014-Based Population Projections for Northern Ireland (published 29 Oct 2015)
2. Transforming Your Care, Health and Social Care Board, December 2011
3. Dementia Strategy, DHSSPS, 2010
4. Source – Health and Social Care Board, 2016

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

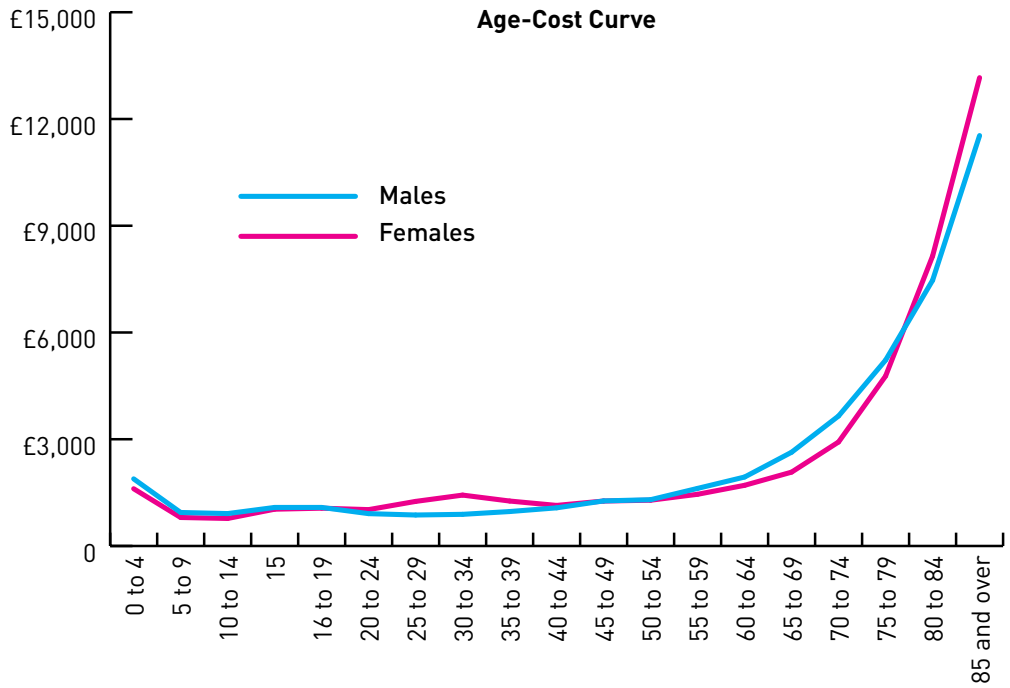
Impact on the HSC system

According to the latest figures, currently in Northern Ireland:

- Two thirds of acute hospital beds are currently occupied by people aged over 65;
- 9,670 people over 65 live in residential care or nursing homes;
- Approximately 23,400 users weekly receive domiciliary care.

In terms of costs, users aged over 65 account for more than two-fifths of HSC spending – 42%, compared to their population share of 14%. Whereas the average cost of treating a 55-59 year old stands at £1,970 per head, this rises to over £6,000 for 75-79 year olds and £14,000 for the over 85s.[5]

Fig. 4 – Age/Cost Curve



Ultimately, all of these figures and statistics illustrate a significant success story for Health and Social Care. As a population, we are seeing a marked reduction in acute life-threatening illnesses, but in their place we are now dealing much more commonly with long term conditions and disability as a result of the population's increased longevity.

The pressure that this is placing on the HSC's finite resources cannot be resolved by continuing to rely on the current acute care model. The change in the nature of the demand facing the system is not reflected in the ways services are designed

5. Source – Department of Health

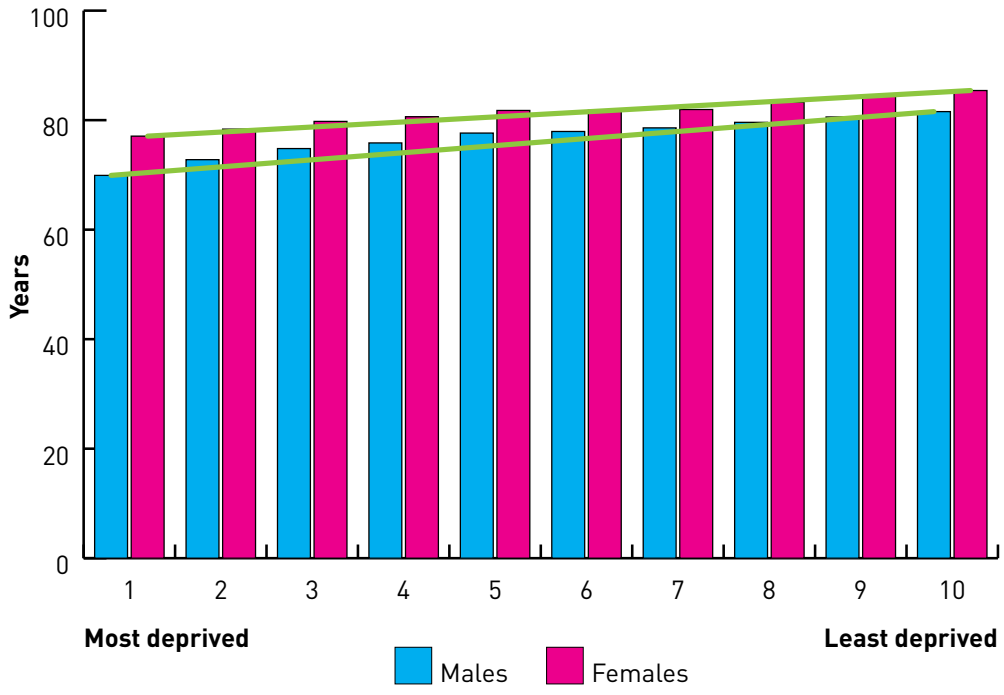
Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

and delivered. The vast majority of care is provided in the person's home or in local communities by unpaid carers, primary and community care teams, and the voluntary and independent sector. Acute hospitals are designed to deal with acute illness, not chronic conditions, and yet the beds in acute wards are filled with those whose needs may well be met more effectively and more efficiently elsewhere. The question that needs to be posed is whether the current system, which was set up to meet the needs of the mid to late 20th century, is still the right one to meet the changing patterns of illness and demand that we face in the 21st century.

Health Inequalities

While overall people are living longer and healthier lives, health inequalities continue to be a major issue. Life expectancy for males in the most deprived areas of NI is on average 7.5 years less than their counterparts in the least deprived areas. For females, the differential is 4.3 years.[6]

Fig. 5 – Deprivation & Life Expectancy



6. Source – Department of Health

The healthy life expectancy of people in the most and least disadvantaged areas differs dramatically. On average males live 58. 7 years in good health, females 62.2 years. However, female healthy life expectancy in the most deprived areas is 14.2 years lower than in the least deprived areas; and comparable figure for male healthy life expectancy is 11.8 years.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

These inequalities also have a detrimental impact on the HSC system.

- There are 9 admissions to hospital for every 20 people in the most deprived areas compared to 6 admissions for every 20 people in the least deprived areas;
- Emergency admissions to hospital are 74% higher in most deprived communities than in the least deprived;
- Elective admissions to hospital are 25% higher in most deprived communities than least deprived;
- Hospital day cases are 21% higher in most deprived communities than least deprived.

Evidence from Marmot's review of health inequalities in England indicates that addressing health inequalities requires co-ordinated action across the wider determinants of health.[7] Action is required across government, to do more to improve universal public services as well as more targeted services for those with greater need.

In fact, research shows that only about 20% of health outcomes are related to clinical care: 10% is related to physical environment (air and water quality, built environment, etc); 40% is related to socio economic factors (education, employment, social support, community safety); and 30% is related to behaviours.[8] The diagram below shows some of the key indicators highlighting the gaps between most and least deprived.[9]

Fig. 6 – Health Inequality Indicators

Indicator	Baseline Year	Unit of Difference	Simple Gap
Male Life Expectancy	2009-11	Years	7.2
Female Life Expectancy	2009-11	Years	4.4
Infant Mortality[20]	2007-11	Deaths / 1,000 live births	0.8 (16%)
Smoking during Pregnancy	2012	Percentage	22 (280%)
Breastfeeding	2012	Percentage	30 (52%)
Key Stage 2 - Communication	2011/12	Percentage	20 (24%)
Key Stage 2 - Mathematics	2011/12	Percentage	21 (24%)
GCSE	2011/12	Percentage	22 (35%)
Alcohol-related Admissions	2009/10 - 2011/12	Admissions / 100,000 population	1,246 (452%)
Teenage Births	2011	Births / 1,000 Females	3.9 (570%)
Suicide	2009-11	Deaths / 100,000 population	21 (244%)

7. Fair Society, Healthy Lives, Marmot, 2010
8. http://www.countyhealthrankings.org/our-approach, County Health rankings and roadmaps, Robert Wood Johnson Foundation
9. Source – Department of Health

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

We can see that health and health inequalities are interrelated with the economy, economic inactivity, poverty, social isolation, educational underachievement, criminal justice, regeneration, and many other parts of government.[10]

Access to health and social care services is of course an essential component for the population's health outcomes, but as mentioned above, there is evidence that it is not in itself as important as lifestyle and environment – the circumstances in which people live, work and bring up their children.

While much of this is beyond this panel's terms of reference, it is clear that the Department of Health needs to continue to work in partnership with other departments and sectors to tackle the underlying social, economic and environmental determinants of health across the population. Local health and care partnerships, if properly organised, can also do much through local initiatives and shared budgets to address these fundamental determinants of health and wellbeing. As a major employer, the HSC has much to contribute to 'pathways to employment' through apprenticeships and other schemes to improve employability, and the estate owned by the HSC can provide opportunities for affordable housing. The HSC can also be a leader in the 'green economy' and improve the environment in local areas.

Rising Demand

As mentioned above, the demand for health services is growing and will continue to grow, driven by demography, an increase in chronic conditions, emergence of new technologies and changing practice in health care.

Currently in Northern Ireland:

- 1 in 5 people have a long-standing health condition;
- 60% of people are overweight (37%) or obese (23%);
- Almost one in five adults in Northern Ireland shows signs of a mental illness;
- 10.3% of the population claim Disability Living Allowance;
- The population is getting older;
- People have higher expectations.

These factors are creating pressures across the system and putting increasing demands on an already stretched system.[11]

10. Marmot, 2010

11. Source – Department of Health

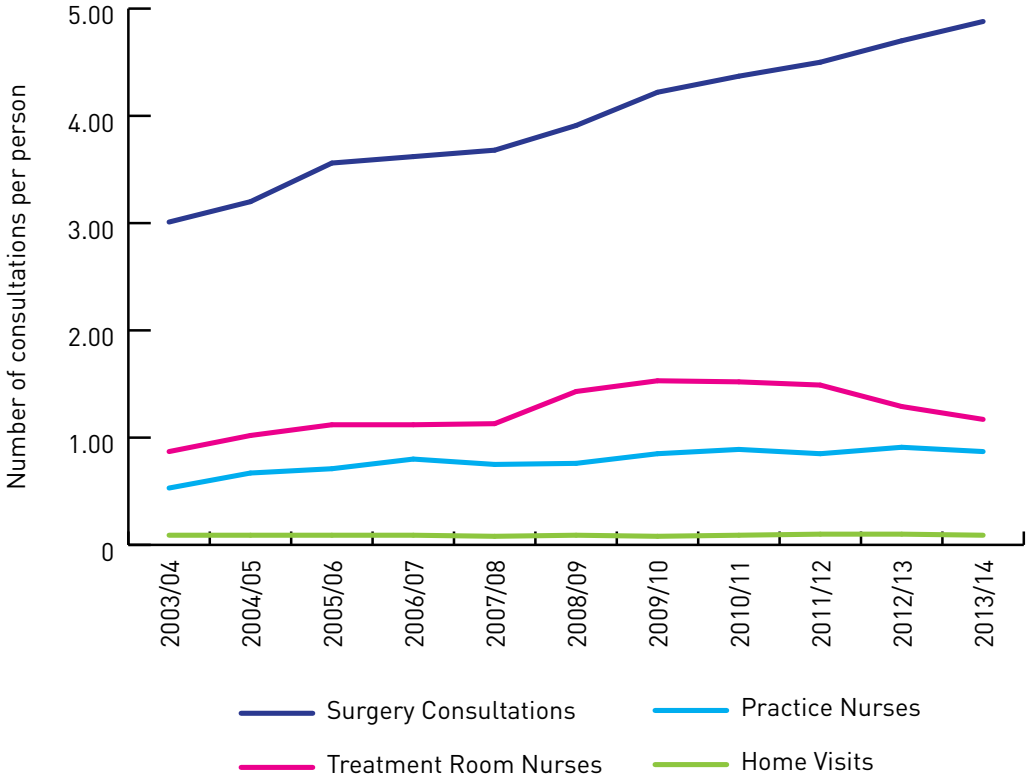
Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Primary Care Service

Primary Care, as provided by General Practitioners (GPs), is the entry point to the Health and Social Care system for the majority of clients. Over the period 2008/9 to 2013/14, the demand for access to GP surgeries has increased on average by 21.5% whilst over the same period demand for GP Out of Hours (OOH) services has increased by 18%.

As the figure below shows[12], since 2003, there has been a steady and persistent rise in consultation rates for GPs. In 2008/9, 10.2 million consultations were undertaken by GP Practices; in 2012/13, 12.4m consultations were undertaken. This equates to an average of 6.9 consultations per patient per year in NI which is at the very high end of the spectrum compared with other OECD countries. In the south of Ireland the figure is 3 consultation per patient per year.

Fig. 7 – Consultation Rates



In conjunction with the rise in the number of consultations, there is also a growing number of complex patients who are more likely to have several co-morbidities.

12. Ibid

This rising demand cannot be resolved by the existing reactive model of care.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Hospital Services

People who require more specialist care are referred by their GP to the acute hospital sector. In addition to this, Emergency Departments provide a 'front door' to people who either self refer or who are assessed by primary care as needing urgent care. In 2011, **Transforming Your Care** forecast that the demand for acute services could grow by around 4% per year by 2015 and suggested that without change this would require:

- 23,000 extra hospital admissions;
- 48,000 extra outpatient appointments;
- 40,000 extra ambulance responses.

In fact, these estimates have proved to be a significant underestimate. The Department of Health's figures show that:

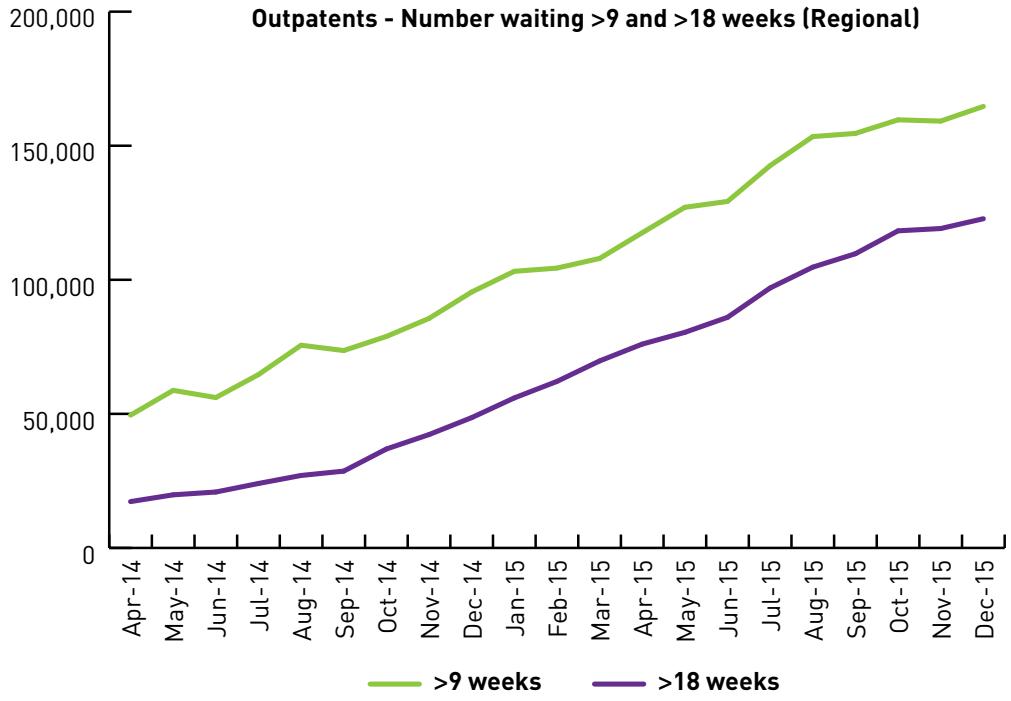
- The number of outpatient appointments, including appointments in the independent sector, increased by almost 121,000 between 2010/11 and 2013/14.
- The number of inpatient and day case hospital admissions, including those in the independent sector, increased by almost 48,000 by 2013/14.
- The number of Category A, B and C ambulance responses increased by almost 52,000 between 2010/11 and 2014/15.
- There has been a 5.7% increase in the number of inpatient admissions to hospital over the period. However, within the overall figures, there has been a 13.3% increase in non-elective admissions.
- In 2014/15, more than three-quarters (77.9%) of inpatient admissions were non-elective compared to 72.6% in 2010/11. Such an increase in emergency and urgent admissions can impact on hospitals' capacity to meet the demand for elective care, meaning more cancelled operations and appointments, and longer waiting times as priority is given to responding to the increasing demand for urgent care. This has been a major factor in the rise in waiting lists and waiting times for elective care in Northern Ireland.

13. Source - HSCB

In 2014/15 the financial constraints on the public sector led to a reduction in both in-house and independent sector waiting list initiatives. As a result, the number of outpatient appointments and hospital admissions dipped slightly (although still remaining significantly higher than 2010/11) while demand continued to increase. This resulted in sharp increases in waiting times and waiting lists (see table below[13]).

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Fig. 8 – Outpatient Waiting Times



These figures more accurately reflect activity rather than demand. The increase in elective care waiting times indicates that there is further, unquantified demand for care.

As the growing waiting lists clearly show, the existing model is not addressing these challenges effectively.

200000

>18 weeks

>9 weeks

150000

100000

50000

Apr-14 May-14 Jun-14 Jul-14 Aug-14 Sep-14 Oct-14 Nov-14 Dec-14 Jan-15 Feb-15 Mar-15 Apr-15 May-15 Jun-15 Jul-15 Aug-15 Sep-15 Oct-15 Nov-15 Dec-15

Social Care Services

Although health and social care services are integrated in terms of delivery organisations in Northern Ireland there are differences between them. Provision of social care is often determined by different legislation. Unlike healthcare it is not universally free at the point of delivery with adults receiving social care being subject to means testing.

There is a far greater diversity of providers of social care than health care with very significant amounts of social care being delivered by the private and voluntary sectors. How to deliver adult social care on a sustainable basis in ways that reflect people's preferences for how they want to lead their lives is an important challenge but this has not been the focus of this report and it is understood that the Department of Health is undertaking a separate exercise to consider these issues. They are however related. The purpose of social care is to promote social wellbeing including protection from abuse, reducing social isolation and the

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

promotion of independence. Poor social wellbeing can have a negative impact on the quality of people's lives, including their health and in turn can have an impact on other public services, including healthcare, criminal justice and the benefits system. Social care can be particularly important in helping prevent people from being admitted to hospital and in facilitating their discharge when medically fit. Pressures on social care will inevitably have an impact on healthcare.

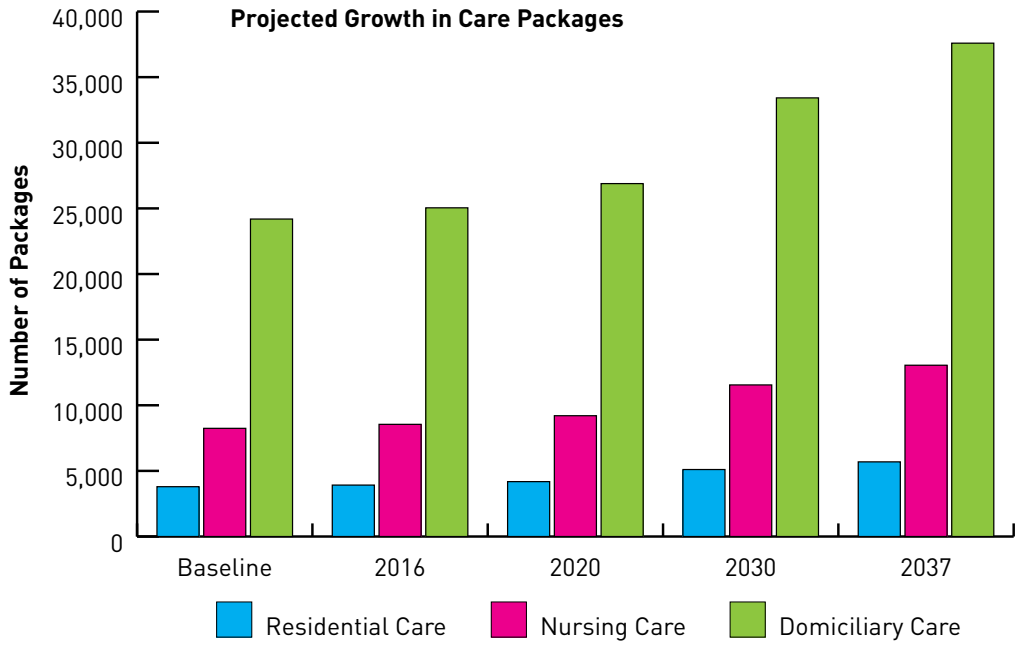
Expenditure on the Elderly Programme of Care amounts to 62% of total expenditure on adult social care services, with £543m of a total £873m being spent in this area.[14] Therefore, it is clear that an increase in the older population will require more support from the adult social care system and will require significant additional resources to adequately provide for people in need of care and support.

Using NISRA 2014 based population projections the Department of Health has carried out a crude projection of future demand for domiciliary care, residential care and nursing home care following the same growth rate as the population (18-64 and 65+).[15] The projections indicate that:

- an additional 4,050 care packages will be required in 2020 compared to current levels, an increase of 15%;
- an additional 20,101 care packages will be required in 2037 compared to 2016, an increase of 68%.

The graph below demonstrates the projected growth in the numbers of packages required:

Fig. 9 – Projected Growth in Care Packages (estimate)



14. Source – Department of Health

15. NISRA 2014-Based Population Projections, Projections by sex and single year of age (published 29 Oct 2015)

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Demand and the Patient/User Experience

Of course, none of the preceding three service areas exists in isolation and any increase in demand, or lack of capacity to deal with this demand, in one part of the system has significant implications for the others.

This can be demonstrated most clearly by the impact caused by unmet demand for social care at both the front end (i.e. admission to hospital) and back end (i.e. discharge from hospital) of the system. The level of care people receive in their own community increasingly plays an important role in supporting people to live in their own homes and reducing the need for medical interventions either in a primary or secondary care setting. It also plays a fundamental role in the way the system operates by providing a way out of hospitals and a route back to the community or to an individual's home.

The sum of all this pressure is building to create a perfect storm for the entire Health and Social Care system. Patients are admitted to hospital unnecessarily because they can't access the treatment they need in their community, and, once admitted to hospital, are forced to stay longer than they need to because of the absence of domiciliary care packages to support them at their homes. This immediately causes:

- Pressures on the number of available beds;
- Unnecessarily busy Emergency Departments;
- Reduced capacity for dealing with elective/scheduled care;
- Poorer patient experience;
- Increased pressures on health and social care staff.

Ultimately, if there is insufficient capacity in social care to meet demand, this has a serious impact across the system in terms of increased GP appointments, Emergency Department attendances, higher rates of hospital admission and delayed discharges for patients who are well and ready to leave the hospital setting.

Workforce

The HSC's workforce is its biggest resource, its biggest strength and its biggest cost. Our health and social services cannot function without the commitment and skills of the people who work in them. These are also the people who have to cope at the coalface with the impact of the enormous pressures caused by rising demand.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Health and social care systems in Northern Ireland and in other jurisdictions, are reporting severe difficulties in recruiting and retaining staff. There is a growing doomsday scenario of not having enough GPs, hospital consultants and junior doctors, nurses, Allied Health Professionals, and social care staff that will inevitably lead to people not receiving the care they need.

There is also a recognised frustration among the highly educated and experienced workforce at all levels of the system with the lack of opportunities to work to the full level of competence to which they are trained.

Current health and social care models and the workforce designed to provide and implement those models are not sustainable in the long term and focus too much on a paternalistic approach based on ill health rather than working with patients towards a model of self care that is based on maintaining the health of the population. Breaking down the professional boundaries between staff and creating new generic roles is critical to providing an integrated, sustainable model of care for the population.

The transformation required in workforce will require a significant mind shift from the traditional, hierarchical and often professional silo approach to roles and responsibilities. It will require the relaxing of some of the strong and restrictive professional regulatory barriers that often delineate one professional role from another. For a workforce that maintains patient safety, professional regulation will always remain a prerequisite to protect the public from rogue professional practice.

A key message from the preparatory phase of producing this report was that without a radical review of the workforce in Northern Ireland the ambition to deliver co-ordinated care around patient need at population health level, local community level and individual level, the required transformation will not be possible.

Some of the issues and challenges facing workforce development currently in NI, as in the rest of the UK, have been highlighted in the Nuffield Trust report - Reshaping the Workforce to Deliver the Care Patients Need, 2016. They include:

- Lack of role clarity
- Lack of regulation and competency framework
- Understanding the implications of nurse staffing ratios
- Fragmentation of care
- Professional resistance[16]

16. Imison C, Castle-Clarke S, Watson R, (2016) Reshaping the Workforce to Deliver the Care patients Need, Research Report, Nuffield Trust

Recent reviews of the service in NI (TYC, the Donaldson Review, Quality 20/20 etc.) have identified that in order to transform services fundamentally, it will require a modern health and social care workforce that can work collaboratively to meet the needs of the population.

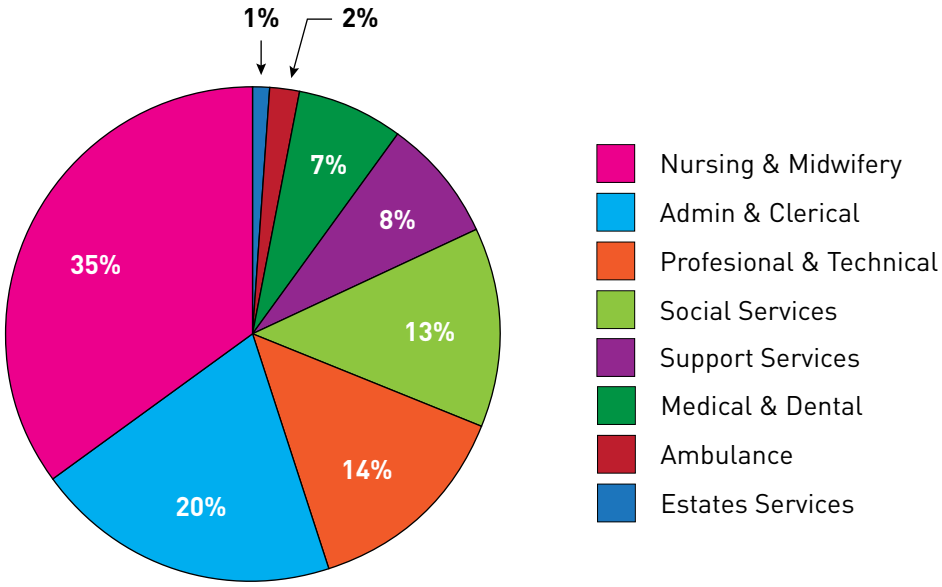
Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

An approach to a workforce that responds to a population health model requires one of a blended nature where staff, professional and unregistered/unregulated, are recognised for the combined expertise they bring to a health and social care team that is built around the needs of patients. This will require a real shift from the current, sometimes narrow professional boundaries, to one that recognises that nurses, doctors, allied health professionals, and Health Care Assistants all have a role to play and one that focuses on having the right people in the right place at the right time to provide/contribute to the best care pathway for patients.

The success of any new service model will be absolutely dependent on staff being employed and deployed in such a way that makes the best use of their skills and which allows them to continue to develop as professionals while providing the services that users and patients need. The patient experience, and their perception of the quality of care they receive, depends in a very significant way on having well-trained, experienced and motivated frontline staff.

The HSC currently employs 54,637 whole time equivalent members of staff. The mix of staff is primarily driven by the need to support the existing care model, which is institutionally based. Comparing the most recent data with the mix of staff set out in TYC, it would appear that there has been little progress in attempting to shift resources away from this model. (See chart below)

Fig. 10 – Workforce Mix



Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

The Panel has found that one of the major flaws of the current medical workforce mix is that it is focused on filling rotas and maintaining existing services, even where there are clear signs that these are not sustainable, rather than on detailed forecasting of demography and need. As one professional put it, "we are currently papering over the cracks in the current system, rather than investing in long term strategic change".[17]

As a case in point, it is proving extremely difficult to recruit and retain junior medical staff to deliver services where they would be unlikely to get the experience they need in terms of volumes and case mix in order to maintain their skills and develop new skills. This is reflected in the current, highest ever level of vacancies in training posts.[17]

Locum/Agency Costs

In recent years there have also been stark increases in costs associated with locum and agency staff to provide a safe service where it is not possible to recruit to permanent positions. The Northern Ireland HSC currently spends almost £77 million on locum and agency staff across the HSC workforce and these costs have been steadily rising. This is more than it spends on the entire GP OOH service.

Fig. 11 – Locum/Agency Spend 2010/11-14/15[18]

Agency Spend (includes locums)	2010/11	2011/12	2012/13	2013/14	2014/15
Medical & Dental	23,644,956	23,093,817	32,439,996	32,558,600	38,506,733
Nursing & Midwifery	6,916,885	8,641,658	9,852,129	11,116,340	12,094,055
Prof & Tech	1,217,178	2,388,060	4,940,249	3,978,227	3,039,152
Admin & Clerical	5,002,680	6,618,493	10,915,492	10,830,821	10,561,767
Support Services	2,033,150	2,882,374	4,725,091	5,273,308	6,312,881
Estates & Maintenance	0	0	10,084	601	19,945
Social Services	4,082,394	4,620,066	5,529,989	5,819,582	5,811,160
Ambulance	140,208	89,451	140,436	101,210	135,929
Other	0	22,429	124,726	0	26,988
Total	43,037,451	48,356,348	68,678,192	69,678,689	76,508,610

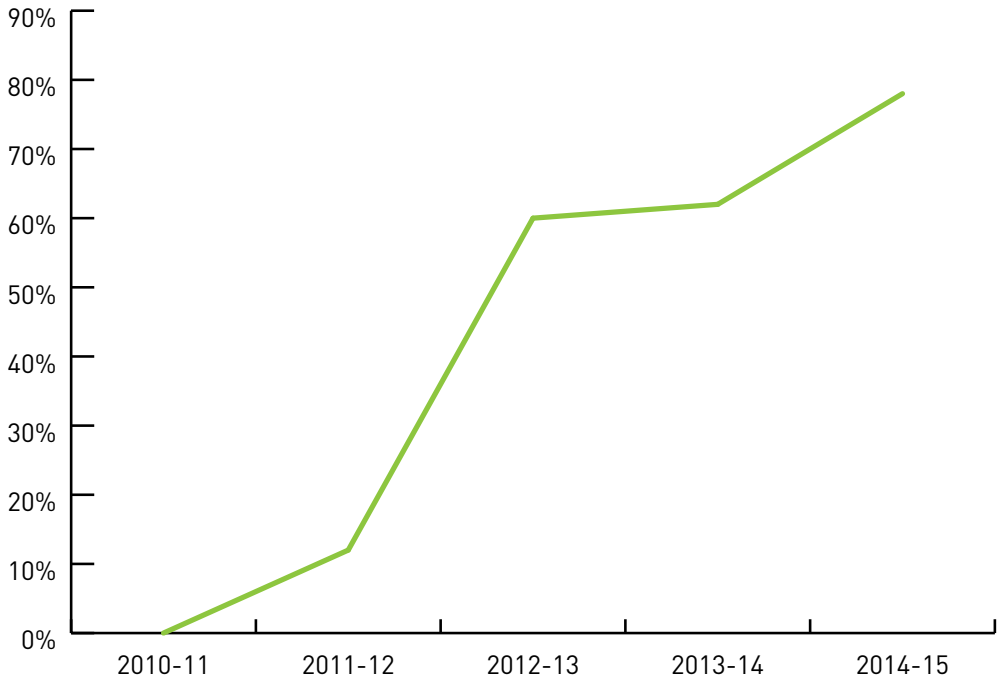
17. Source - NIMDTA

18. Source – Department of Health

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

In only five years, the amount the HSC spends on agency and locum cover has increased by 78%. The panel has even been presented with anecdotal evidence that for some junior doctors, the benefits of taking on locum work have superseded the benefits of having a permanent position.

Fig. 12 – Total Annual Locum/Agency Spend Increase from 2010 Level



Much of the marked increase shown above is due to the high cost of filling rotas and propping up services where there is little or no chance of recruiting staff into permanent positions. It is also worth highlighting that what the system spends on locums or agency staff is money that is not available for investing in other parts of the HSC. Locums are expensive to employ and this money could be much more effectively invested in developing services that are sustainable in the long term. This would also have real benefits for staff, who would have improved professional development and job satisfaction, and for patients, in terms of the quality of care they receive and the continuity of the people delivering that care.

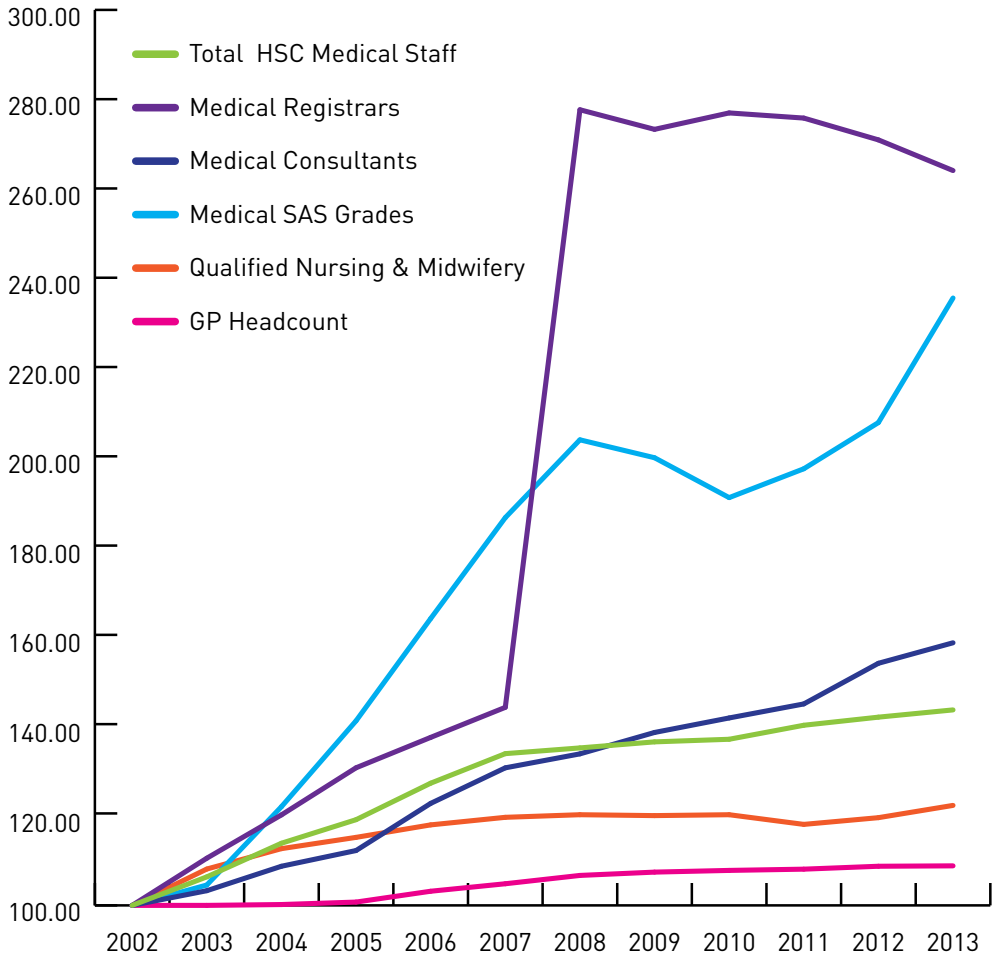
The locums themselves are of course not the problem, but their presence on this scale is a symptom of the structural problems facing the service. The answer is not providing more funding to try to fill these vacancies. This hasn't worked. The answer is changing the model of care to make sure that we create the right kinds of posts for all health professionals working in the system – posts that give our workforce the opportunity to use and develop their skills as part of wider teams, working together to best meet patients' needs. Many permanent staff have highlighted continuity and consistency issues in a service that relies on transitory locum and agency staff.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Primary Care Workforce

There are 347 General Practices in Northern Ireland, which are staffed by 1279 GPs. Data produced by the Department of Health suggests that the growth in the GP medical workforce has not kept pace with demand, or indeed with the growth in hospital medical staff. Furthermore, the average list size of 1641 patients per GP is the highest in the UK.

Fig. 13 - Index of Northern Ireland Medical and Nursing Workforce 2002 – 2013 (base 100)[19]



19. BMA Northern Ireland, General Practice in Northern Ireland: The case for change, February 2015

20. Ibid

The age profile of the general practice workforce also shows that just under a quarter of GPs here are aged 55 or older, which means that many will be planning to retire in the near future.[20]

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Fig.14 – GP workforce by age band

AGE BAND	% OF GPs
29-34	11
35-39	18
40-44	14
45-49	16
50-54	17
55-59	16
60-64	6
65 and over	2

Social Care Workforce

Social care is different from the other parts of the system insofar that it is largely commissioned by the HSC from for-profit and voluntary sector providers. The independent sector now provides 100% of nursing home care, 83% of residential care and 62% of domiciliary care. There is also still a significant proportion of care that is provided in-house by Health and Social Care Trusts and they and the independent sector are often put in the difficult position of competing for the same pool of staff.

Fig. 15 – Sectoral Distribution of Care Providers



21. Can we trust the trusts? (ICHP, UKHCA) 2013

Approximately 12,000 people are employed in the residential, nursing home and domiciliary care sectors.[21]

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

There are some significant concerns about the availability of an adequate future workforce to meet growing demographic demand. In England, for example, it is estimated that an additional one million care workers will be required by 2025.[22]

Recruitment and retention difficulties may, in part, be due to terms of employment including the use of zero hours contracts and staff being paid below the minimum wage.[23] The Commissioner for Older People has also identified the need for a well trained and registered social care workforce which is respected, valued and properly remunerated with opportunities for career progression.

In recent years, some providers have argued that the fees paid by the HSC are insufficient to attract and retain staff and that this risks creating instability, threatening the economic viability of their services. Indeed, some domiciliary care providers have already withdrawn from the market, citing affordability as the reason. Similarly, in the residential and nursing home market there have been some high profile closures, with the potential for more in the coming year.

This is a great, and growing, risk to the entire HSC. As we have stated above, if the social care sector fails to meet demand this will place enormous pressure across the rest of the system – particularly in relation to hospital admissions and discharges.

In the context of the demographic challenges outlined above, it must always be remembered that the most important, and the largest group by far, of staff delivering care services in Northern Ireland is unpaid.

Carers NI estimate that carers save the government some £2.4 billion and it is clear that the support of carers is absolutely essential in order to ensure the sustainability and viability of the system. Engaging and supporting carers is a fundamental aspect of maintaining service users within their own home and it is essential that the HSC improves its performance in this area.

22. The Future Care Workforce (ILC) 2014

23. The scale of minimum wage underpayment in social care (Resolution Foundation) 2015

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Nursing and Midwifery

There are in excess of 16000 registered nurses and midwives employed by the HSC in Northern Ireland. This constitutes almost one third of the health and social care workforce in a variety of settings.

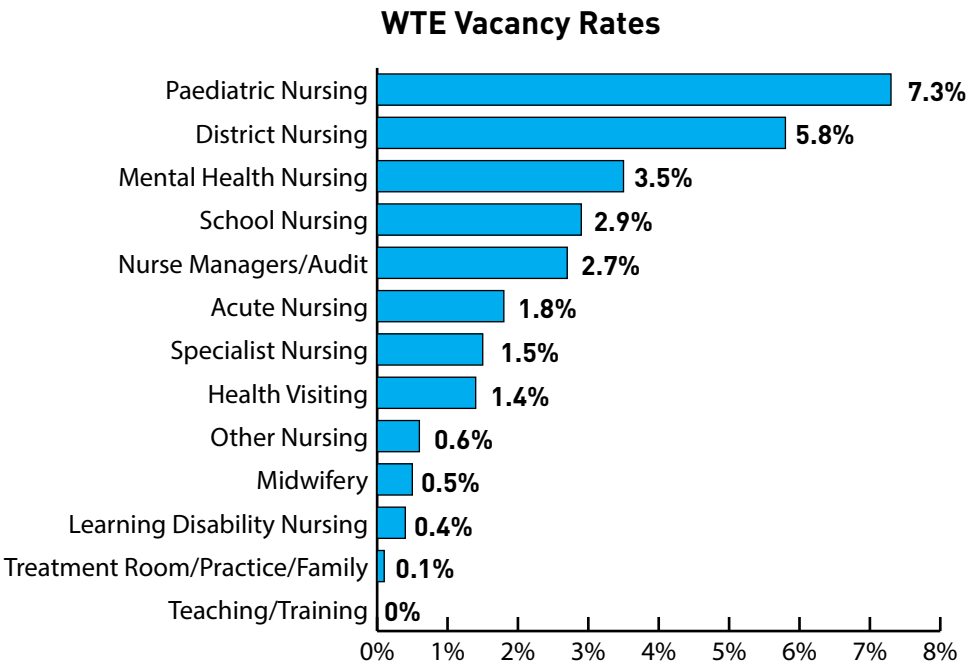
Fig. 16 – HSC Registered Nurses & Midwives as at 31st March 2014[24]

Combined Grades	Staff in Post Headcount (HC)	Whole-time Equivalent (WTE)
Registered Nurses	15,319	13,286.2
Midwives	1,327	1,042.5
Total	16,646	14,328.7

Figures from 1st October 2015 show that there were 531 (480 whole time equivalent) vacancies.

A vacant post is defined as a post '**actively being recruited to**'. The Department of Health collects data on vacancies via a survey twice a year. The figure below presents the available vacancy rates of permanent posts (based on whole-time equivalent) as at 30th September 2013.[24]

Fig. 17 – Available Vacancy Rates of Permanent Posts (based on whole-time equivalent) as at 30th September 2013



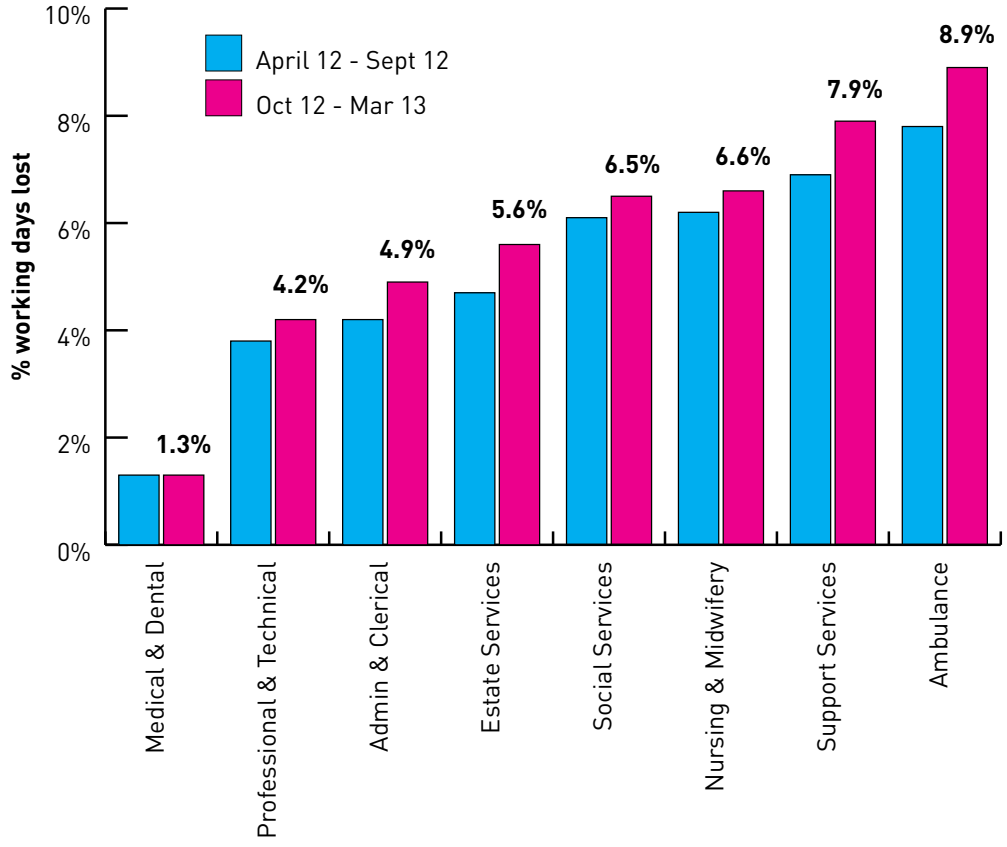
24. Source – Department of Health

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Organisations reported that they did not expect to be able fill all these vacancies. In particular, they noted difficulties at a local level in recruiting to a number of specialties, including mental health services, care of older people, non-acute hospital care, theatres, critical care, general medicine, community, learning disability and prison health. However the composition of difficult to recruit specialities varied from Trust to Trust.

In addition, the graph below shows absence rates by occupational family across the HSC. We can see that absence rates are rising across all areas.[25]

Fig. 18 – Absence Rates by Occupational Family



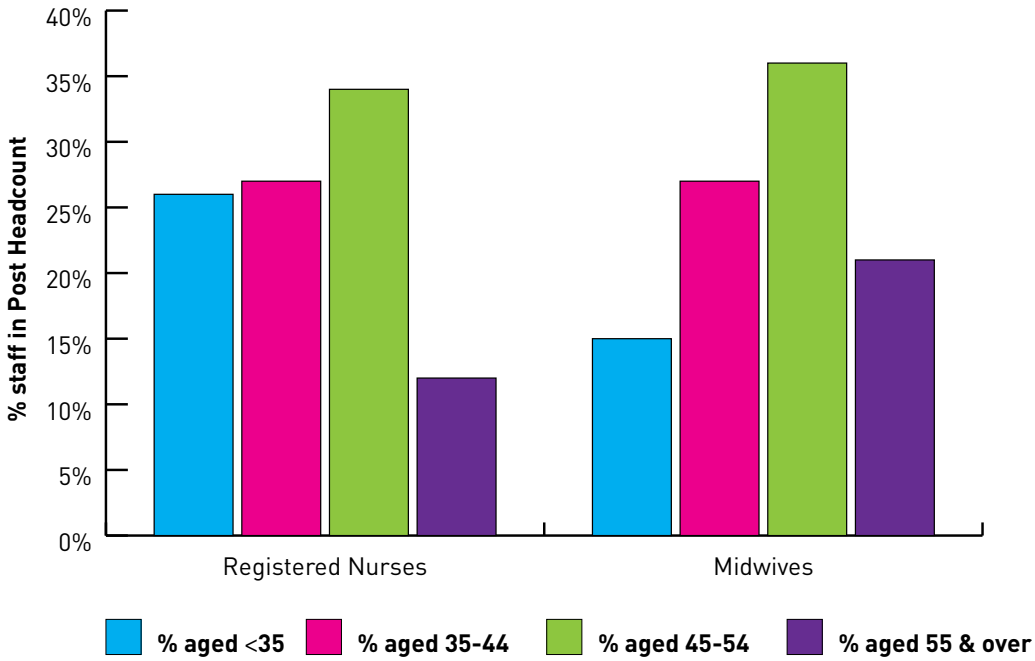
25. Source – Department of Health

26. Source – Department of Health

Furthermore the age profile of the nursing workforce shows the majority of the qualified staff to be above 45 years old, within a 10 -15 year period of average retirement age. The graph opposite shows the nursing and midwifery workforce broken down by age.[26]

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Fig. 19 – Nursing and Midwifery Workforce by Age



Working patterns have also changed significantly. Almost half of qualified nurses are now working part time and almost two thirds of midwives.

Earlier this year, the then Minister took action to address these recruitment issues by increasing the number of commissioned student nurse places in Northern Ireland universities by 100 for the 2016/17 intake. This is very positive, but it will not impact on the service until 2019/2020. Steps are currently being taken to support a region wide recruitment process for nurses from EU and Non-EU countries.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Staff Morale

These issues are also reflected in the reported experience of staff in the HSC. In the most recent HSC staff survey, only 35% of staff felt that there were enough staff in their team to carry out the work and a significant proportion (36%) reported having experienced injury or illness as a result of work related stress. HSC Occupational Health Consultants have noted an increase in the number of staff presenting with stress related illness.

The cumulative effect of staff vacancies is ever-increasing workloads, higher risk of illness and a constant focus on the short term over the strategic. This risks creating a culture that exists by 'fire fighting' only. Innovation, learning from best practice and implementation of new systems are the unfortunate casualties of such a system. In all the encounters with stakeholders, from every part of the health and social care system, the panel have received the same message in terms of the need to invest properly in the staff that provide health and social care in voluntary, community, primary and secondary care settings.

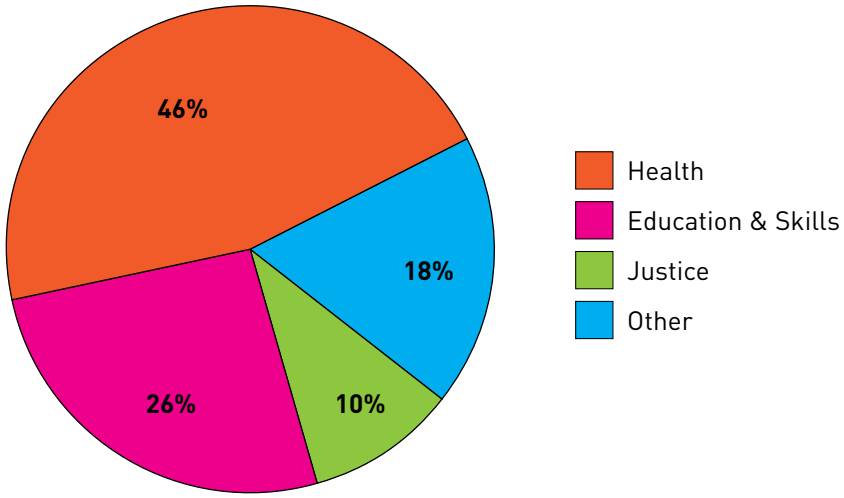
The demands facing the current service model are putting severe pressures on the workforce. This is not fair to them or to the people who rely on them for care. Resolving this is not about money, it is about creating an environment in which staff are enabled and empowered to do the jobs they have been trained to do in a way that meets patients' needs. As the evidence above demonstrates, the current model has the patients in the wrong place and at the wrong time; this brings organisational de-motivation as staff feel unable to provide the highest quality of care to those they serve.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Financial Sustainability

As can be seen in the chart below, the Department of Health's budget is the largest among the Executive departments by some distance, with a budget of almost £4.6 billion, or 46% of the entire NI Executive spend.[27] The next largest sector in terms of budget is Education & Skills, with a little more than half of the health and social care budget.

Fig. 20 – Northern Ireland Budget by Sector



If we accept a conservative estimate of inflation at 1%, new medical developments at 1% and demand rising at 4%, then the Health and Care system as currently configured would require at least a 6% budget increase each year simply to stand still.[28]

Using this rationale, if the system continues in its current form, we can expect costs to double by 2026/27 simply to maintain current levels of performance.

Other

Justice

Education & Skills

27. OECD Reviews of Health Care Quality: United Kingdom 2016, p242

28. http://www.nuffieldtrust.org.uk/node/4190)

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Fig. 21 – HSC – Projected Costs 2014/15 – 2020/21

Year	Total (£billion)	Year	Total (£billion)
2014/15	£4.6	2021/22	£6.92
2015/16	£4.87	2022/23	£7.34
2016/17	£5.17	2023/24	£7.78
2017/18	£5.48	2024/25	£8.25
2018/19	£5.81	2025/26	£8.75
2019/20	£6.16	2026/27	£9.23
2020/21	£6.53	2027/28	£9.83

Although it is now more than ten years old, Professor John Appleby's 2005 review was an exhaustive look at how resources were being used across the system, with a particular focus on elective care and waiting times. Appleby updated his own results in 2011 and found that per capita spend in Northern Ireland was roughly 11.5% higher than in England, but that there is an 11.6% higher level of need. We can therefore draw the conclusion that the system is as well funded as other UK jurisdictions, with perhaps a very slightly lower level of funding per head once local levels of need and deprivation are taken into account.

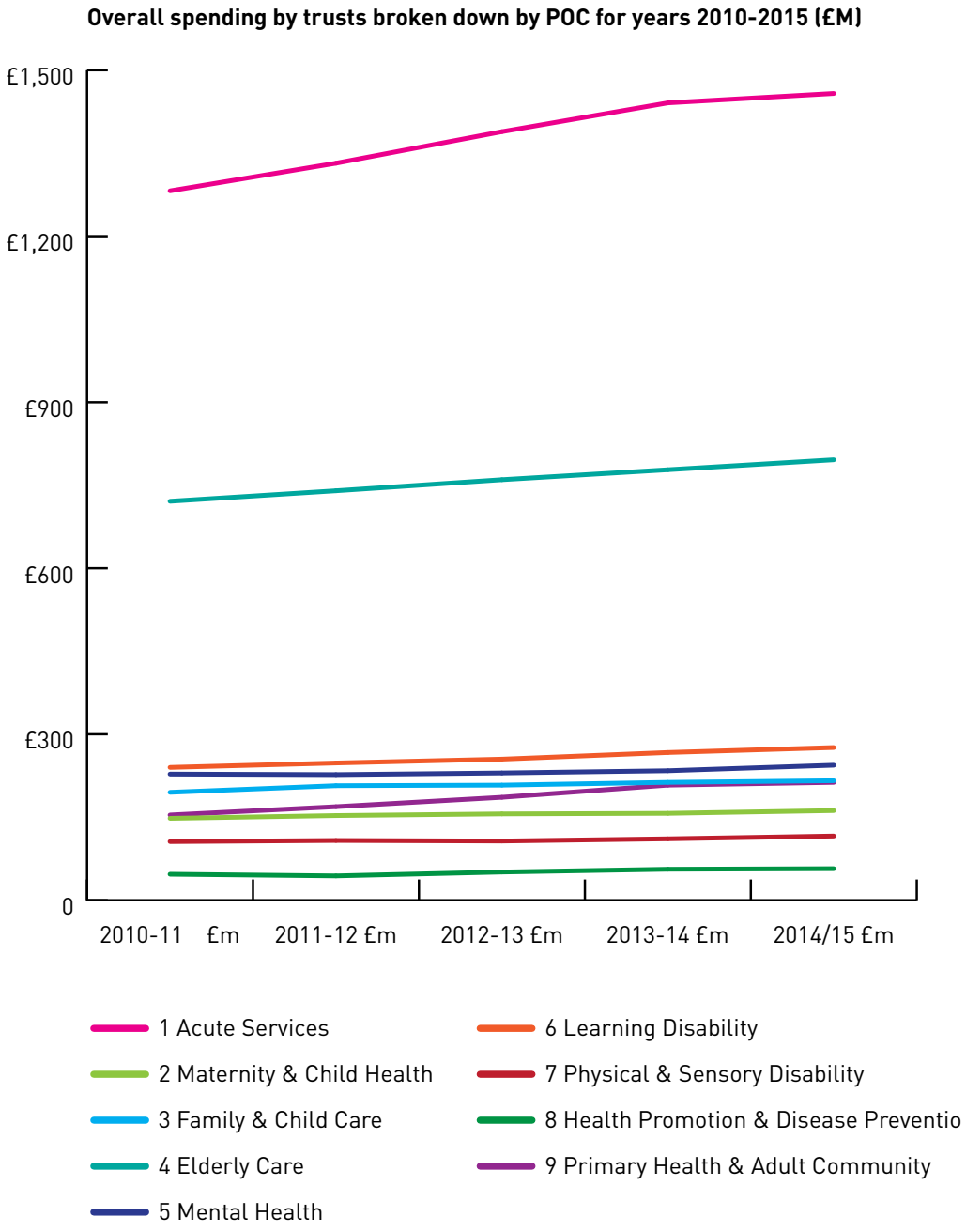
However, Appleby's review also found significant disparities in some programmes of care. For example, according to his figures, mental health needs in Northern Ireland were estimated to be nearly 44% higher than in England, while actual per capita spending on these services was in fact 10-30% lower.[29]

These findings would support the argument that it is not the level of funding that it necessarily the problem, rather than how it is used to deliver services. If we consider the division of funding within the system by programme of care, it can quickly be seen that the majority of resources are invested in the acute hospital sector, which dwarfs all of the other programmes of care in scale.

29. Appleby, J (2011) Rapid review of Northern Ireland Health and Social Care funding needs and the productivity challenge: 2011/12-2014/15, Department of Health

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

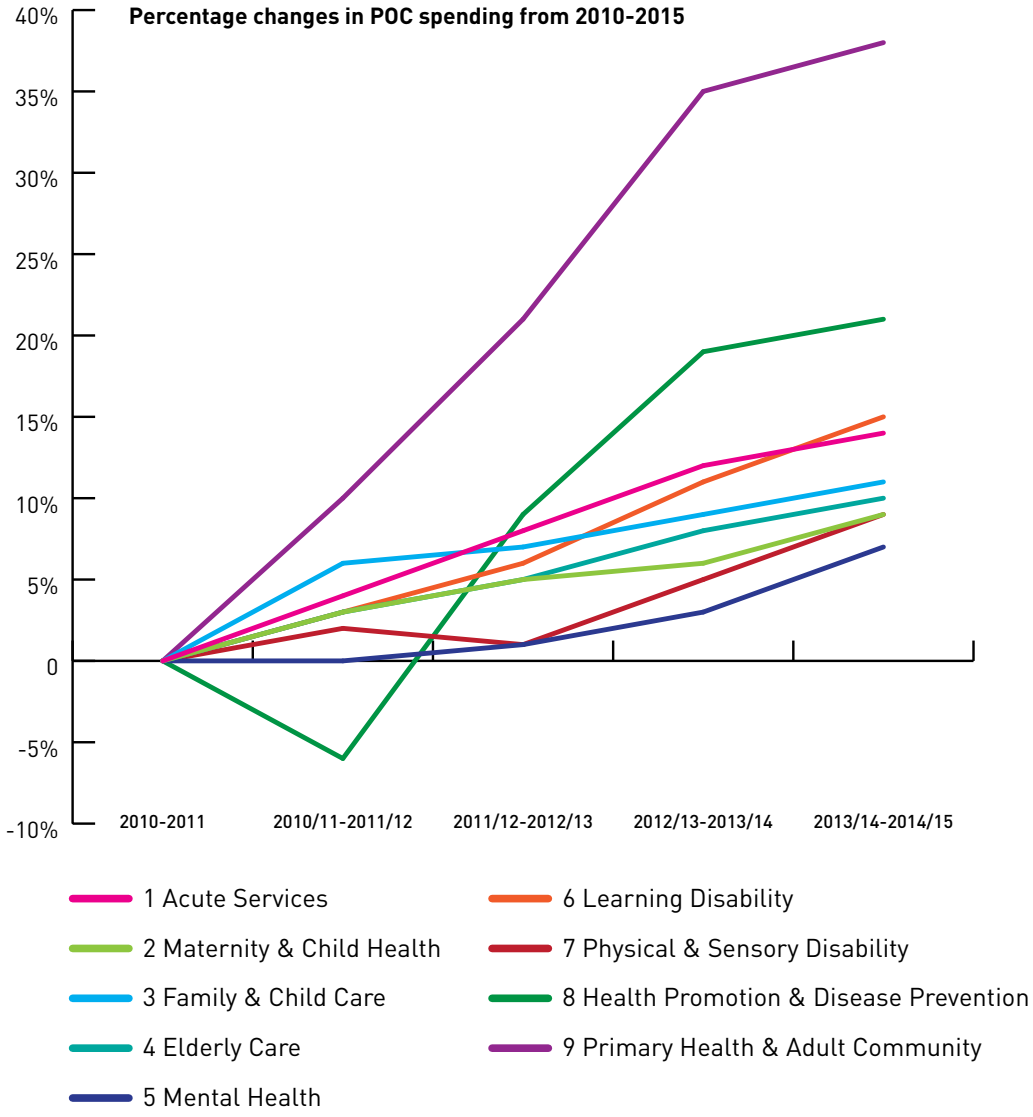
Fig. 22 – Funding by Programme of Care 2010/11-2014/15



As we can see from the graph above, spending on the acute sector continues to grow, although it is reassuring to note that the rate of increase has slowed down when compared to other programmes of care. While this may be indicative of a push by the system towards community based services, it also illustrates clearly that there is still a long way to go in making the shift from acute to community real and meaningful.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Fig 23 – Rate of Increase of Spending by Programme of Care 2010/11 – 2014/15



The OECD's report on Healthcare Quality across the United Kingdom, published in 2016, concluded that while there were examples of good practice in shifting resources from the acute sector to the community sector, there was no evidence that this was being managed systemically or strategically. Their report also concluded that funding was largely managed in silos and was often based on historical funding arrangements rather than an assessment of population need.

For a budget this size, the current one year commissioning cycle is also far too inflexible and short term to allow for any sustained investment or innovation. The Panel has heard from many sources that this prevents long term strategic planning and encourages a short term 'sticking plaster' approach to services, perpetuating the status quo rather than enabling transformation.

A real strategic approach to this will require a greater level of inter-sectoral funding, longer term commissioning cycles, and increased work across government to address the wider health determinants.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

SECTION 3

VISION FOR A NEW MODEL FOR HEALTH AND SOCIAL CARE – ORGANISING FOR SUCCESS



There is an unassailable case for change. If we do not change the way we provide health and social care, the situation will only continue to get worse – the demand will continue to increase, activity will remain static and waiting times will continue to lengthen.

Following on from the evidence above, it is clear that:

- Given the challenges of today, business as usual, even if optimally managed, will not be enough to meet future demand.
- Transformation will require key cultural and operational changes in health care systems and in the way these systems are accessed by the public.
- Something very different has to happen at the delivery of care level.
- The funding mechanisms are not currently sufficiently aligned with the need to integrate care at the provider level.
- Health and social care are not working together as effectively as they might. If they were, there would be better outcomes and reduced waste.
- Front line improvements and innovation at the provider level need to be encouraged, sustained and scaled up where they can demonstrate three outcomes of the Triple Aim.
- The workforce needs to be empowered and engaged in designing the new models of care.
- The public should be honestly informed about why change is needed. Service users should be supported and encouraged to become 'informed and expert patients' who take individual action to manage their own health and well-being.

Given the challenges of today, business as usual, even if optimally managed, will not be enough to meet future demand.

The Panel has heard a strong sense of frustration among those working in the system, particularly from those on the front line, that the current pattern of investment which is prioritised to maintaining the current configuration of hospital

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

care would be better utilised in a new model of care outside hospital which better supports improved population health and well-being. The Donaldson report also identified the need to rationalise hospital infrastructure as a key part of reform.

Put simply, this work is not about closing hospitals. It is about fundamentally changing the way the HSC provides services.

As a panel, we agree that it will absolutely be necessary to rationalise the provision of some specialist acute services as part of changing the service delivery model. As identified by Hayes, Compton and Donaldson, the current configuration of acute services is simply not sustainable in the short to medium term. As part of the transformation process, it will be necessary to reorganise services in such a way that resources are freed up from some parts of the existing model in order to allow them to be used for implementing new models that will offer higher value care. With respect to how this rationalisation is achieved, we will come back to this later in the report.

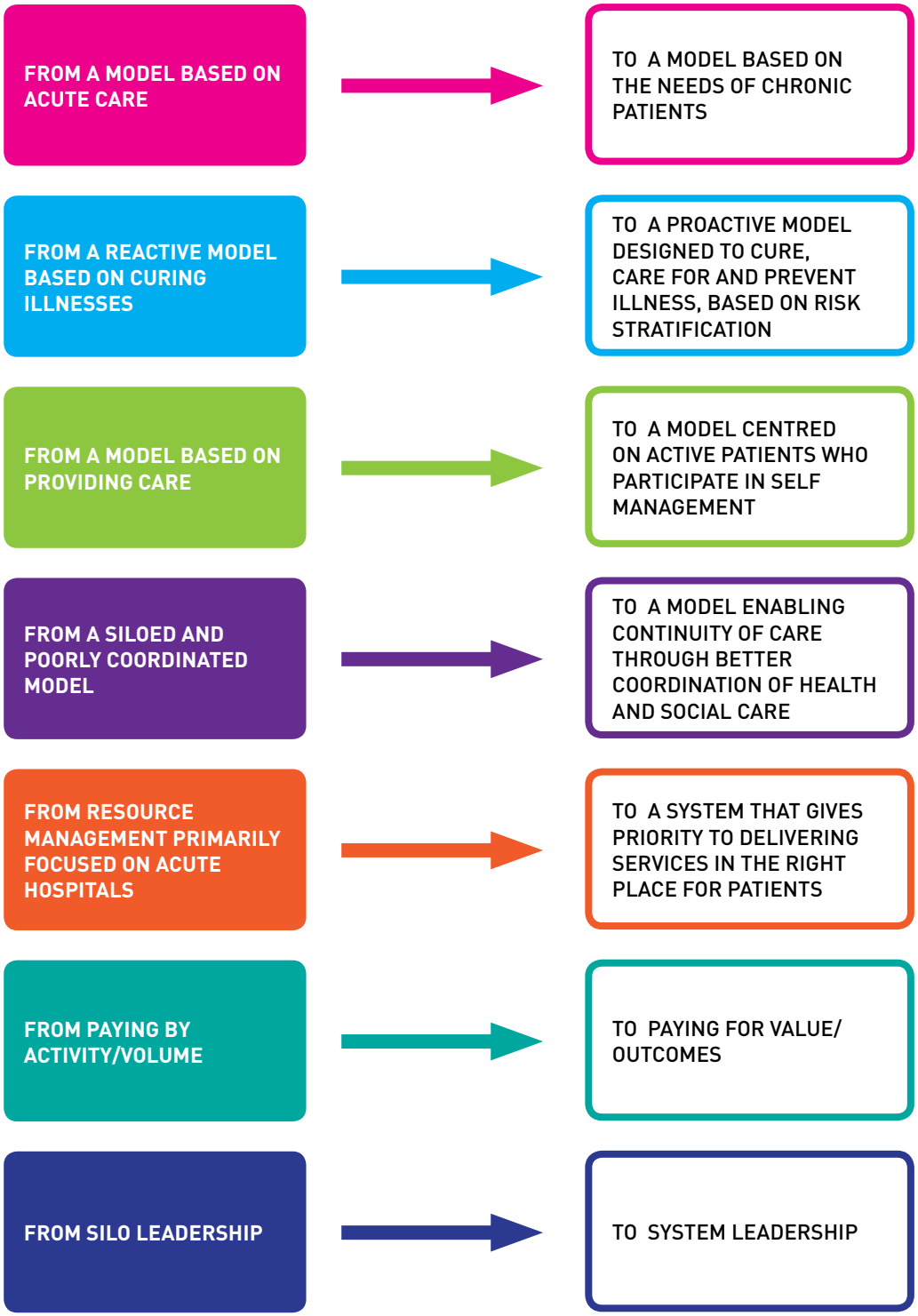
However, rationalising services is not the same as transforming the health and care system and the two should not be confused. The current overreliance on acute infrastructure is a contributory factor to the challenges facing the sector rather than their sole cause. While some rationalisation and concentration of specialist resources will be necessary to allow new delivery models to take effect, they are not ends in themselves. The meaningful transformation is in moving to a more patient centred, population health model, delivered at a sustainable cost.

Put simply, this work is not about closing hospitals. It is about fundamentally changing the way the HSC provides services. In some cases this may mean that some buildings/hospitals will close; in others it may mean that these buildings are used in different ways to provide a more effective and responsive service to meet the local population's needs.

The table opposite shows the main ways in which the system needs to change.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Fig 24 – Transformation



Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

The Triple Aim

There are numerous health care systems in the world facing similar pressures and undertaking similar reforms in health and social care. These are the most important reforms in decades and an increasing number of them build around the Triple aim as a framework.

Although health care systems internationally are different from each other in many ways, they all have the same fundamental challenges:

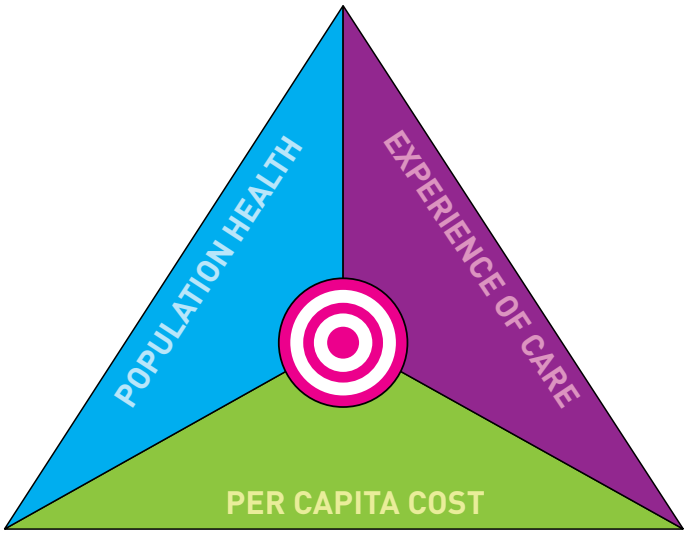
- All have sub-optimal organisation of care;
- Most are paying for volume and not for value;
- All use about 50% of expenditure on only 5% of the population;
- All have key challenges in prevention, quality and patient safety;
- Chronic patients receive fragmented and non continuous care; and,
- All could do more to reduce costly hospital admissions and readmissions.

There are numerous health care systems in the world facing similar pressures and undertaking similar reforms in health and social care. These are the most important reforms in decades and an increasing number of them build around the Triple aim as a framework.

The Triple Aim is a framework developed by the Institute for Healthcare Improvement (IHI). It is characterized by a simultaneous focus on three objectives:

1. Improving the patient experience of care (including quality and satisfaction);
2. Improving the health of populations; and,
3. Achieving better value by reducing the per capita cost of health care.

Fig. 25 – The Triple Aim



Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

The Triple Aim is perceived by many as a key framework to improve services, but it will not happen at scale unless there is a powerful policy intervention regionally as well as empowered innovation at a local level. The Panel proposes to use this framework to move forward on the broader health and social care transformation.

Of course, all of the policies and strategies in the world will not succeed if they do not pay attention to the people who deliver services on the front line. On this basis, the panel recommends including a fourth dimension (sometimes called the quadruple aim) based on improving the work life of those who deliver care.

RECOMMENDATION 1

The Panel recommends using the dimensions of the Triple Aim as a framework for reform, including an increased emphasis on the experience of those who deliver care.

The ongoing economic crisis in Europe has made the numerous vulnerabilities of all health care systems more visible. The immediate reaction in many countries has been cost containment. Senior leaders have reacted to this difficult immediate context by seeking efficiencies and, as a result, day to day crisis management has been centred on taking some major cost containment decisions, especially regarding human resource salaries, the pharmaceutical budget and co-payments.

However, there is a growing acknowledgement that these interventions do not correct the main problem of health care – its basic design around reactive episodic care and a weak focus on population health.

In other words, even if these crisis decisions are handled in an effective way, they do not create in themselves the capacity for health systems to cope with the future challenges of demography, chronicity, prevention, fragmentation, sustainability and patient centeredness.

Today in Europe, as well as elsewhere, most of the policy decisions in health care are not about having to decide whether to ration or to transform. Rather it is about finding the right balance of both and not letting rationalisation dominate the broader transformation. This document considers both agendas, and the Panel would recommend progressing and managing them both simultaneously.

The Triple Aim provides a new framework for a strategic response. While it may sound theoretical, it is practical in its application and has already been used to guide a number of prototypes in Northern Ireland which are already showing powerful results. We will cover some of these projects later in the document.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Advancing towards a Local Accountable Care System

The present model of care is not delivered on a population agenda. It is not providing continuity of care in an organised way and the organisations delivering care are still operating as silos.

The Panel has heard consistently and agrees that care should be personalised, preventative, participative and predictive. However none of those objectives can be achieved in the present reactive and fragmented system. The HSC therefore requires a new organisational form at the local delivery level, an organisational arrangement which will allow those approaches to be embedded in the culture of everyday health care.

The present model of care is not delivered on a population agenda. It is not providing continuity of care in an organised way and the organisations delivering care are still operating as silos. We need to move away from this hospital centred model of care to a more integrated model.

The Panel has heard of changes to the provider sector that are already being carried out to achieve the size and scale required to better manage, and indeed change, the current demand for services. General Practice is moving from the 'small business' approach to bring together Practices within larger geographies as 'Federations'. By working more collectively, it is hoped these Practices can share skills and services, manage workforce pressures, operate more efficiently and more effectively meet the rapidly increasing demand for primary care services. Services within Trusts are increasingly networking on a cross-Trust, cross-profession and indeed NI-wide basis where these services are specialised and there is a need to collaborate to meet demand. Trusts sub-contract with the community, voluntary and independent sectors for health and social care provision. There is a mix of provider models for GP OOH services.

So the provider sector – Primary Care, Trusts, 3rd sector and independent sector – is already becoming increasingly integrated and inter-dependent without structural reform. However, this is happening in the absence of strategic intent, and is operating under traditional contract models and output targets that do not support the system transformation which is required to address the challenges set out in section 2. This report proposes the development of Accountable Care Systems to integrate – by agreement, and without the need for structural reform – the provider sector to take collective responsibility for all health and social care for a given population and with a joint capitated budget linked to population based outcomes under agreement with the commissioning system to be decided by the Minister.

There are models where this collective provider model is starting to emerge. For example, the Sustainability & Transformation Plans (STPs) in England, where 44 planning and delivery systems have been set up based on geographical footprints, and charged with planning and delivering system-wide change. This will include a more integrated approach to health and well-being, self care, more proactive care for those with the most complex needs, and a smaller, more efficient hospital sector. This is all intended to both improve care outcomes and drive out collective financial deficits in their areas. Accountable Care Systems will also provide a structure for better patient engagement, empowering people to become active participants in their own care.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

There are lessons learned from Accountable Care Systems elsewhere that provide evidence of the key components that can be put in place to drive more integrated working without structural reform. These are:

- Size and scale – the population footprints must be of sufficient size to manage the majority of population's care needs, to take accountability for managing variations in demand and expenditure, and to take 'internal decisions' to change the delivery of care, but also importantly to support local partnership working and risk sharing;

- A defined population where the new model of care can be delivered at pace, focusing on the stratified risk of that population – already available in General Practice if this information is collated and shared;

- New working arrangements, including shared leadership, shared accountability and devolved budgets, development of new roles to push the boundaries of the skilled but not qualified workforce and the 'generic professional case manager', and a partnership approach with the 3rd sector to deliver a more standardised service offering within local communities to reduce loneliness and isolation, improve well-being and to provide high quality care;

- New support tools, including shared information, accessible patient and client records, and a capitated funding system that incentivises an integrated provider response;

- Service user engagement, at population, service and individual level;

- Cost and quality measures which are measurable, comparable and outcome based.

Some services are so specialist that they must be delivered at a Northern Ireland level. These will require a different commissioning or provider model — set at a regional level

Under an ACS, providers would collectively be held accountable – under a shared leadership model – for achieving a set of pre-agreed quality outcomes within a given budget or expenditure target, with agreed risk share arrangements and incentives. They would also need to have maximum autonomy to make rapid and sustained changes to improve care and outcomes for the population they serve.

Of course, not all services will be amenable to this model. Some services are so specialist that they must be delivered at a Northern Ireland level. These will require a different commissioning or provider model – set at a regional level – to ensure specialised resources are concentrated on a small number of high volume sites, that they are sustainable in the long term, that inefficient duplication is avoided, and that they can be supported and incentivised to innovate and to develop world-class treatment.

Transformation to deliver the Triple Aim will also require a new approach to the commissioning and delivery of care. The Department of Health carried out a review of commissioning in 2015 and found that the current system was complex, slow to take strategic decisions, unresponsive and with too much emphasis placed on

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

WIT-50989

activity/volume over value/quality. The current commissioning model has also failed to effectively shift accountability to the provider level and this has led to an overly transactional approach. It is worth highlighting that the lack of a devolved budget and insufficient autonomy have been identified in other jurisdictions as key reasons why some population based models have not achieved their potential.

RECOMMENDATION 2

The Panel recommends that the HSC should move to:

- Formally invest, empower and build capacity in networks of existing health and social care providers (such as Integrated Care Partnerships and the developing GP Federations) to move towards a model based on Accountable Care Systems for defined population based planning and service delivery; and,

- Regionalised planning for specialist services.

Northern Ireland already has many of the building blocks to move towards Accountable Care Systems – perhaps even more so than many other nations.

Building on Existing Foundations

Northern Ireland already has many of the building blocks to move towards Accountable Care Systems – perhaps even more so than many other nations. The Panel believes that many of the key elements of a more integrated organisation, such as Integrated Care Partnerships as 'learning labs' for what will make integrated delivery systems work best and the emerging GP Federations, are already in place, but these building blocks need to be taken to the next level and be fully enabled with devolved autonomy and incentivising funding mechanisms linked to measurable population outcomes in order to truly become local Accountable Care Systems.

Furthermore, Northern Ireland has already made real progress in establishing an array of management and organisational processes, all of which help to provide the tools needed to move forward quickly. However these need to be further developed and strengthened in the following ways:

Adding Depth to Structural Integration of Health and Social Care

The formal integration of health and social care should be a key strength of the existing system and will provide a strong foundation to pursue reform. However,

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

in practice, the benefits of integration have not been fully exploited and it would seem that there are still significant administrative silos that prevent this happening. Integration in name only is not enough and if the Panel's proposed model is to be successful there has to be better integration between all parts of the health and social care system. This level of integration will require a great deal more work on how the system plans, funds and purchases care across acute care, general practice and community health, and social care provided by statutory, independent and community , voluntary and charitable providers.

The development of the Accountable Care Systems suggested in this report will greatly reinforce the necessary health and social integration on the ground.

The primary function of social services is to improve and protect people's social wellbeing when it is vulnerable. Social wellbeing refers to the extent that people are socially connected, engaged in purposeful activity, in control of their own lives and are protected from abuse and exploitation. The primary reasons to promote and protect people's social wellbeing are because it is essential to people's quality of life and it safeguards people's human rights. However not surprisingly there is also a strong relationship between people's social wellbeing and their health. This is one of the main reasons integration between health and social care services is seen as a desirable feature of healthcare systems.

The health impact of better integration between health and social care services is reinforced by more and more studies. The impact of social factors such as income, educational attainment, access to nutritional food, good quality housing and employment status is well documented. There is a growing evidence base and literature about the importance of social determinants of health in improving the health of populations. The relative contributions of genetics (20%), health care (20%), and social, environmental and behavioral factors (60%) are well documented.[30]

Northern Ireland is better placed than others to continue reinforcing the combined action of health and social services. The move to local integrated systems of care will provide an even better platform for this happen. However it can also present challenges.

When difficult funding decisions need to be made it can be difficult to secure investment in social services when faced with competing demands for healthcare investment. However there is a strong economic rationale for investing in social interventions.

The increasing use of new commissioning models (payment models) will be a key lever towards improved health and social integration. New payment models that hold these local integrated care organisations accountable for people's health and the cost of treatment can be used to maximise the benefits of integration. A focus on holistic outcomes that includes the promotion of social wellbeing and penalises outcomes that undermine it, such as unnecessary hospital readmissions, will make the health and social care system more sustainable and more importantly improve people's quality of life.

30. Chiu, G. et al. (2009) Relative contributions of multiple determinants to bone mineral density in men. Osteoporos Int, 20(12), 2035-2047

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Payment schemes such as these would give these local organisations an economic logic to incorporate social interventions into their approach to care.

Targeted programmes can link individuals with chronic conditions to social support schemes. For example, community health workers can conduct home visits to low--income families with children with uncontrolled asthma. There are examples in which this type of intervention has reduced the use of emergency care by two thirds.[31] Managerially the children in such a scheme would be identified by a risk stratification approach in a community. This type of intervention is a practical example of targeting inequalities in a community as the targeted group are children of low income families.

Furthermore it makes economic sense as unmet social needs are associated with higher rates of emergency care, hospital admissions and readmissions. A recent study found that the 10 health conditions that accounted for the highest health care expenditure are linked to unmet social needs. These include heart disease, mental disorders, asthma, diabetes and hypertension.[32]

There are therefore numerous reasons for this integrated approach to become progressively the standard of care in Northern Ireland.

Expanding and investing in eHealth infrastructure

eHealth is a broad concept, defined as the use of electronic means to deliver information, resources and services related to health.

Data and enabling technologies are vital components of a modern healthcare system. We hold large amounts of information on behalf of our patients and we need to look after this, but we also need to use it as effectively as possible to deliver improved outcomes for individual patients, for the wider population, and for society as a whole.

31. Greineder, DK, Loane KC, Parks P (1999) A randomized controlled pediatric asthma outreach program. J Allergy Clin Immunol March 1999;103(pt 1):436-440

32. Agency for Health Care Research and Quality. DHHS . USA . 2011 - Medicla expenditure panel survey

The introduction of the Electronic Care Record (NIECR) has revolutionised the way health and care can be delivered by providing care staff with an up-to-date record that avoids duplication of tests and information gathering, and allows information to be used in ways that can lead to better decisions on prevention, treatment and care.

However, while a great deal of good work has already been carried out, much of the data that is held on patients is inaccessible to other systems within the HSC; it exists in data silos that do not communicate with other core datasets. More work needs to be done in terms of linking these systems and increasing interoperability. The Department of Health and the network of Chief Clinical Information Officers are in an ideal position to lead in setting the direction for eHealth, and in ensuring engagement from the wider clinical community.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Northern Ireland should continue to invest in this area, with the ultimate aim of providing patients with ready access to their own records. A conversation with patients and their representatives may also need to occur to discuss how the system uses HSC data and linked public sector datasets in medical research, population health planning and infrastructure development.

Patients should also have the right to see their own data and the system should move towards greater openness and access. This would allow patients to see this information and use it in managing their own health needs.

Advances in telecare, telemonitoring and electronic assistive technologies are also making a significant difference to the way services are delivered. Used effectively, they can make a valuable contribution to the quality of services by improving coordination of services, overcome geographical distances between patients and providers, enabling patients to live independent lives for longer, and engaging patients in their own health and well-being.

In a population health model such as that proposed by the panel, data, analytics and new technologies are key enablers in driving clinical innovation, and also in supporting patient self management and health ownership.

Northern Ireland is in an ideal position to take advantage of opportunities in eHealth, and position itself as a global leader in this field. There is a single HSC system, a collaborative network of organisations, engaged patients, two high quality universities and a thriving commercial IT sector. The Health and Social Care Board's eHealth strategy, which was published earlier this year, sets out how the HSC will work with industry, academia, the community and voluntary sector, other public sector bodies and government departments, and international partners to further develop uses of e-Health as a driver to improve health, well-being, prosperity and job creation.

Developing the Workforce

In addition, the health and social care system here has a powerful and expert workforce.

Despite the challenges, Northern Ireland already performs strongly in many aspects of health and social care delivery and, building on the strong foundation of its integrated workforce, has the existing capacity and capability to continue to lead the way in developing and implementing new and modern care pathways.

However, reconfiguring health and social care services will depend on the ability to reshape the workforce to support the new models of care.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

An effective workforce where skills and competence are aligned and support new service models needs to have as its key aims:

- The improvement of quality;
- Financial efficiency;
- The long term health and wellbeing of communities.

Having the right number of appropriately skilled staff is a critical determinant of the quality and efficiency of the health and social care system, yet there is a growing and recognised gap between patient needs and the skills and knowledge of the workforce that cares for them.

While across health and social care systems here, as in other countries, organisations are reporting severe difficulties in recruiting and retaining staff, it is also recognised that there is a frustration among the highly educated and experienced workforce, of the inability to progress to the level of competence to which they are educated.

Integration of health and social care should permit easier transferability of staff and skills across the clinical and non-clinical workforce but this will require a shift in our approach to traditional workforce boundaries, restrictions and jurisdictions.

Integration of health and social care should permit easier transferability of staff and skills across the clinical and non-clinical workforce but this will require a shift in our approach to traditional workforce boundaries, restrictions and jurisdictions.

There is also a clear need to invest not only in the immediate and short term future workforce but also on the pipeline for the longer term.

In Northern Ireland there is a real opportunity to adapt the current nonclinical workforce to meet the growing needs for patients to remain at home in local communities. There is an emerging body of evidence that shows that integrated workforce models configured around defined populations support improved population health outcomes, a better care experience, and also a reduction in the per capita cost of health care.

Immediate actions need to be taken to support the workforce to continue to deliver high-quality care to patients, clients and carers through this period of transformation. The Panel suggests that work is commenced to remove the artificial governance barriers that make role developments difficult to achieve and therefore the transferability referred to above difficult to attain.

For this to be successful, the HSC will need to:

- Put in place strong supporting systems and governance structures, including supervision of new and extended roles;
- Create a culture that supports experimentation and change; and
- Cultivate good relationships with local workforce and training bodies.[33]

33. Imison C, Castle-Clarke S, Watson R, (2016) Reshaping the Workforce to Deliver the Care patients Need, Research Report, Nuffield Trust

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Within primary care in Northern Ireland there is a need to move from the predominantly GP led model of care to a more blended approach that accommodates the rich range of professionals working in partnership to meet the needs of the practice population. This can create a robust, extended primary care team serving a local population level, including Nurses, Doctors, Allied Health Professionals, Health Care Assistants, Pharmacists, Mental Health Professionals and Social Care workers all have a role to play in improving the service offering delivered by primary care, with an increased focus on prevention and early intervention and the active management of complex patients to support them to better manage their conditions.

In order to achieve this, it will be necessary for those at the head of the HSC to create a safe environment for local innovation. This means the workforce is not only engaged for clinical purposes, but also organisational and managerial innovation.

In order to achieve this, it will be necessary for those at the head of the HSC to create a safe environment for local innovation. This means the workforce is not only engaged for clinical purposes, but also organisational and managerial innovation.

A recent Vanguard document **"New Care Models and Staff Engagement: All Aboard"** draws out an approach to ensure staff are at the heart of decisions about new models of care.

This approach includes:

- Enabling different groups of staff across organisations to "break down the barriers" – to allow them to break out of old working patterns and think differently.
- Recognising that those on the front line of care have the best ideas about how to improve it – but also that they need to feel empowered to do so.
- Recognising that if staff feel that their contribution is valued, they will want to do all they can to make new care models a success.

The panel strongly believes it will be essential to reinforce this work and to invest heavily in staff engagement.

Improving Quality – Frontline Innovation

Quality improvement has taken on increased importance internationally in recent years. Drawing on the successful practice of 'improvement science' which was first applied in manufacturing and industry, a number of countries have sought to adapt this and apply the principles to health and social care services. To date, there have been some impressive results with this approach in areas such as Qulturum, in Sweden, Ko Awatea, in New Zealand, and Healthcare Improvement Scotland.

In Northern Ireland, the Panel has seen impressive examples of innovation and improvement going on across the HSC. However, it is also clear is that there is a lack of capacity and capability to scale these projects up and to sustain them across the system. While the Quality 2020 strategy shows that there is a clear

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

While the Quality 2020 strategy shows that there is a clear commitment to quality improvement at the top of the organisation, it is not clear that this has pervaded the HSC to the extent that it can be considered to be part of everyday business.

commitment to quality improvement at the top of the organisation, it is not clear that this has pervaded the HSC to the extent that it can be considered to be part of everyday business. The Panel was told that "quality improvement is still viewed as peripheral, an activity for a small number of HSC staff". This may be a reflection of the operational pressures in the current system, which restrict opportunities for staff to become informed and experienced in improvement methodology.

A new approach may be required to support staff across the system to adopt a 'right fit' methodology dependent on their need for improvement, whether this is to:

- Do it right – standardising/removing variation to improve efficiency;
- Do it better – improving existing systems to achieve better performance;
- Do it differently – innovate and change existing systems to improve outcomes.

The previous Minister announced that the Department of Health would develop plans for an Improvement Institute to drive forward innovative improvements in how health and social care services are delivered. The intention is that this would be able both to build on the emerging improvement and innovation hubs in each Trust and to bring them together regionally, but also to support individual professional and managerial staff to develop their skills and expertise in leading and delivering innovation and quality improvements and to share these skills and expertise with others.

The Panel would endorse this approach – any system that aspires to be world class must take a strong position on quality improvement, with the patient and service user voice represented as part of this. The purpose of the Institute should be to create the conditions in which this improvement becomes the norm, from the bottom of the organisation up and the top of the organisation down.

Health and the Wider Economy

Health and social care is a significant part of Northern Ireland's Gross Domestic Product and it accounts for a sizeable proportion of jobs and public spending. A report by the Economy and jobs initiative task and finish group found that:

- Annual spend in the sector is £4.5 billion, with capital expenditure of £200 million.
- Staff employed within the Health and Social Care sector account for 9% of all employee jobs in Northern Ireland.
- The Health and Social Care sector creates approximately 10% of the total economic output of Northern Ireland.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Economic discussions about the HSC most commonly focus on the cost of running it. However, we should also recognise the enormous contribution it makes to the Northern Ireland economy.

Northern Ireland has previously been described as "small enough to be agile but big enough to matter." If the health and social care sector here can lead the way in transforming how services are delivered, then it has the potential to be a world leader in developing innovative services and products. The proposed new model, based around Triple Aim, would help to support healthcare market opportunities for Northern Ireland going forward, particularly in terms of the range of enabling technologies and processes that need to be developed to meet modern patterns of demand.

Any system that aspires to be world class must take a strong position on quality improvement, with the patient and service user voice represented as part of this.

RECOMMENDATION 3

The Panel recommends that the HSC should continue its positive work to invest in and develop the areas listed above.

There should be particular focus on the three key areas of workforce, eHealth and integration:

- As a key enabler of Accountable Care Systems, the HSC should continue to invest in eHealth to support improved self management, care at home and use of information to drive better population health outcomes.
- The HSC should immediately develop innovative primary care based models that will allow non-medical staff to work in a way that makes the most of their skills. (For example, these could be based on the community nurse-led care models being implemented in the Netherlands, or the use of pharmacists in community development here in Northern Ireland).
- Work should be carried out to identify which social interventions are most cost effective in addressing the social needs and improving health for Northern Ireland.
- Any new approach to commissioning should be aligned with the need to build integrated health and social organisations on the ground which target specific inequalities and social groups.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Emerging Practices

In addition to these areas where work is already ongoing, there are some emerging processes which the HSC may wish to explore and adopt.

Value Based Care

This Panel considers the present resources would be better used in a value based care model. This report strongly recommends Northern Ireland should start taking this route as the short term changes will in themselves be insufficient to provide a high quality and sustainable health and social care system.

A value based model in Northern Ireland would need to reinforce an integrated primary and community health and social care delivery model so that more can be done out of hospitals, encouraging work across organisational boundaries, as well as strengthened primary care sector in order to effect a shift in the balance of care. This will involve paying for value instead of simply paying for activity, accelerating home care technological support schemes, and improving coordination with the voluntary, community and independent sector as true partners in care.

This process has the potential to harness the strengths of different parts of the system, across organisational silos, across sectors and beyond what is traditionally considered to be the health and social care sector.

Co-Production

The relationship between health and social care professionals has changed significantly in recent years. There has been an increasing acceptance that people who use services and have healthcare needs will have views on how they should be treated as individuals and as groups who have interests in services. It is now recognised that people should be treated with respect and listened to and that major changes to services should be consulted upon.

Co-production describes an approach that takes this changed relationship to a new level. Co-production involves breaking down barriers between professionals and the people they serve, recognising people who use services as assets with unique skills. It involves a relationship where professionals and citizens share power to plan and deliver support together, recognising that both partners have vital contributions to make in order to improve quality of life for people and communities.

There is a difference between co-production and participation: participation means being consulted while co-production means being equal partners and co-creators. The benefits of adopting co-production include delivering change that is owned by service users rather than being resisted by them and designing services that reflect the knowledge and expertise that comes from using services.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

SECTION 4

ROADMAP FOR IMPLEMENTATION



Creating a Compelling Vision

Together, all of actions set out above will strengthen services in the community so that more can be done out of hospitals, encouraging work across organisational boundaries, as well as with strengthened primary care in order to effect a shift in the balance of care.

This is of course the strategic direction of travel that was outlined in Transforming Your Care – and it is still the direction that the system needs to move in. However, as the previous pages indicate, the Panel feels that we need to go much further. There is now a significant body of evidence internationally to show the elements that are necessary to achieve this kind of transformation, and also to demonstrate that this kind of strategic shift can produce better outcomes for local populations.

However, in order for this to happen, all these approaches need to be aligned around a common vision of transformation and not be a series of isolated initiatives. The Panel has concluded that at least part of the reason that TYC has not been the success many hoped, is that it became just one initiative among many and not the overriding strategy guiding the entire organisation's decision making.

For these reforms to be successful, they have to become the strategy for health and social care. It will not be enough for senior managerial and clinical leaders to pay lip service to the concepts outlined here, they must underpin every decision that is made and every new policy that is developed. The Minister will need to take some time to consider what this vision will be and how it will be communicated to staff and to the public. The Panel hopes that this report will help to provide the foundations for this vision.

However, in order for this to happen, all these approaches need to be aligned around a common vision of transformation and not be a series of isolated initiatives.

RECOMMENDATION 4

The Minister should create, communicate and lead a clear, powerful, long term vision for the Health and Social Care system as a first step in the implementation process.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Components of Transformation

Transforming the HSC is an enormous and complex task that will need to be progressed steadily over at least the next ten years and which will require a combination of change strategies. The Panel has identified three separate components for practical implementation:

1. **Driving the system towards Accountable Care Systems**
2. **Aggressively scaling up good practice**
3. **Rationalisation and stabilisation**

The HSC operates within a parliamentary democracy and as the political context cannot be avoided, it must therefore be managed.

While each of these stages has a different lifespan, they are all urgent, they are all connected, and they should all be launched simultaneously.

The mid-term goal is to establish new accountable care systems. The second component helps to create the conditions for the new delivery model by scaling up good practice where it is consistent with the overall vision. The third component does not change the model of care, but it is necessary to free up resources to allow the system to transform.

1. Driving the system towards Accountable Care Systems

This is a mid-term agenda, but it must start now.

The political context is of critical importance in any transformation process, as is the impact of politics on shaping the environment governing large-scale change. The Panel has frequently heard that there is a need to remove health from politics but in reality the importance of politics is a feature of all health systems and can ultimately determine whether and how far large-scale change succeeds or not. To paraphrase Tip O'Neill, the former House Speaker in the USA, all politics is local and this is nowhere more apparent than in decisions about local health services. The HSC operates within a parliamentary democracy and as the political context cannot be avoided, it must therefore be managed. Those seeking to introduce change, need to provide compelling evidence for why the change is necessary and a clear sense of the benefits the new model will offer.

The longer term demands of transformation are especially acute since electoral cycles often militate against long-term change. Results are looked for in the short term and this is especially evident in the type of change favoured which tends towards short term impact rather than long term reform.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

If a health system transformation is going to thrive, it will require supportive policies that incorporate longer time horizons[34] with regular milestones to build confidence in the direction of travel. The work on the Principles carried out with the local political parties in a political summit earlier in the year was intended precisely to help future implementation and help to get beyond those short timeframes that drive output targets (principles at annex 1) by demonstrating the need for long term and sustained reform that will deliver improvements in population outcomes.

The Principles helped to create the right environment but much more needs to be done to reinforce and strengthen that environment.

As stated above, one absolutely fundamental component in creating this environment is the development and communication of a clear vision for health and social care and a robust implementation plan to deliver it.

The task in the mid-term is to transform the model of care in Northern Ireland. This has been indicated in previous reviews. All stakeholders interviewed by the Panel agreed with the need to drive towards new models of care but they called for a stronger implementation agenda.

To this end this Panel offers an approach to implementation for these mid-term changes. These actions should start now. Northern Ireland is investing a considerable amount of resources into health care but the present payment and delivery system will not create the organisation of the future.

Northern Ireland has the scale and capacity to do this. However this transformation will not happen at scale unless there is a powerful policy intervention. It needs to be conceived and implemented as an integrated package.

We therefore propose a series of time bound actions linked to the three dimensions of the Triple Aim framework which will take the health and care system in Northern Ireland to a population based model of care. Following on from the work of Sikka, Morath and Leape, we also suggest adding a fourth component – that of the health and care professional's experience.[35]

Northern Ireland is investing a considerable amount of resources into health care but the present payment and delivery system will not create the organisation of the future.

RECOMMENDATION 5

Alongside the Minister's vision for health and social care, the Panel recommends that plans, costs and timescales for introducing each of the following actions should be prepared within the next 12 months. It is vital that the implementation of these actions is led by health and care professionals and managers.

34. Halfon N & Conway P (2013) The Opportunities and Challenges of a Lifelong Health System N Engl J Med 2013; 368:1569-1571

35. Sikka, R, Morath, J, & Leape, L (2015) The Quadruple Aim: care, health, cost and meaning in work

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Population Health

- Some work on risk stratification has already been carried out at General Practice level. This should be built on to introduce a comprehensive, system wide approach to risk stratification in of the entire NI population.

- Governance arrangements to be developed for new Accountable Care Systems (ACS), including integrated capitation budgets based on the services (excluding the most specialised services) required by the population served by the ACS to be devolved to these new autonomous and accountable provider partnerships.

- Starting immediately, progressively phase in early adopter accountable care systems, bringing together the provider sectors for a defined population into a single accountable leadership. The ACS would be responsible for utilising a capitation based budget across organisational and professional boundaries including local infrastructure to achieve agreed improvements in population outcomes.

- The Programme for Government is moving towards outcome based measures to judge the impact of political decisions and the use of public funding on the population, and the success measures for the new ACS should also be outcome focused, and should be measures of population health with priorities for improvement. The Panel recommends the development of a relatively small set of outcome based metrics which set the challenge for the new Accountable Care Systems.

Patient Experience of Care

- The use of co-production as an approach should be mandated in accountable care systems and service redesign.

- Provide the population with individual access to their health and care information.

Per Capita Cost

- Introduce new cost and quality measures which are measurable, comparable and outcome based.

- Start the process of paying for value and not only paying for activity. By the year 2020, 50% of the budget should be commissioning value.

- As new value based commissioning approaches are implemented and local integrated organisations take form, ensure that the metrics being used include combined social and health indicators.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

- Move to a rolling three year budget cycle to allow for more strategic commissioning/planning of services.

Staff Experience

- The Department to lead on the development of an 8-10 year workforce strategic framework, aimed at identifying immediate workforce challenges and planning the workforce to meet the demands of the new delivery model.

- New workforce models to be designed around defined populations and associated care functions. This should include enhanced roles for the skilled but not qualified workforce.

RECOMMENDATION 6

Many of these recommendations will require additional, transitional funding. The Panel recommends that the Minister should establish a ring fenced transformation fund to ensure this process is appropriately resourced.

The transformation process will take years, and must be sustained over the longer term. The political administration can expect some short term results from the process but must create a mid-term strategy which is sustainable over time.

RECOMMENDATION 7

For this purpose, the panel recommends the creation of a transformation board, supported by the Department, linked to the Executive's health and well-being strategy.

- This board would set the mid-term strategy, oversee the transformation process and would be tasked with creating the right conditions for the local system of care to develop successfully.

- It should help to transform organisational structures and management processes by promoting local decision making, local innovation and scaling up of best practices among the local systems of care.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

2. Aggressively Scaling up Good Practice

Not only does Northern Ireland have many of the elements that are necessary to allow it to move forward, it has numerous examples of good practice that are consistent with the overall vision described above. Many of these could simply be scaled up and implemented on a regional basis where they will drive the system change and improved population outcomes set out in this report.

Targeting Mental Health

Implementation of the Rapid Assessment Interface and Discharge Project

This project was developed in recognition of the fundamental role that mental health plays in promoting and sustaining positive physical health. There are strong relationships between presenting physical ill-health and underlying mental health problems and by addressing these needs we can support better health outcomes and recovery rates.

The Rapid Assessment, Interface and Discharge Team (based on the Birmingham RAID model) is a multidisciplinary mental health team based in an acute hospital setting. It brings together diagnosis, treatment, psychosocial and psychological based approaches to ensure the best outcomes for patients. The service is a specialised multidisciplinary liaison psychiatry and psychological medicine team that provides rapid, timely and high quality interventions to promote the recovery and well-being of patients who present at Emergency Departments and/or are admitted to general hospitals.

The service replaces the multifaceted approach to mental health referrals with a single point of contact for all mental health referrals. The team operates 7 days per week and over 24 hours, responding within 2 hours to all Emergency Department referrals and within 24 hours to routine ward based referrals or quicker if deemed necessary.

Whilst the Northern Trust RAID is a hospital based service, one of the key benefits of the service is its ability to outreach into the community and to act as a conduit to mental health services. Improved communication with community teams such as community mental health teams and Older Persons Teams have supported discharge planning within wards and support earlier discharge from Hospital. There is enhanced communication with Primary Care and GP's are provided with a report, in respect to RAID involvement.

This innovative model has required a new way of thinking and approach to service delivery. It has required staff who previously worked on their own to adopt a different way of working which included; working as part of a strong cohesive team, working across organisational boundaries, and working shifts for previous 9am-5pm workers.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

The RAID concept has been evaluated by the London School of Economics in Birmingham. This has shown reduced length of stay and enhanced discharge processes. Early indications show similar emerging patterns in Antrim Area Hospital. RAID input has also contributed to the reduction of emergency hospital readmissions within 30 days, thus reducing the overall cost of care.

Dealing with Chronic Conditions

An Integrated Respiratory Service

Within the Western Health and Social Care Trust in 2013, deaths due to respiratory diseases accounted for 16.2% of the total number i.e. 2% higher than the NI average. In addition, the majority of deaths occur in the elderly population and this is therefore expected to rise. This has implications for service provision, including an increased need for social and emotional support, especially for those patients with chronic respiratory diseases and their families and carers.

Having mapped existing services and reviewed good practice elsewhere, it was decided to create a WHSCT Integrated Respiratory Service that would enable patients with a chronic respiratory condition to be cared for in the most appropriate setting, by the most appropriate person, with access to specialist respiratory advice to enable the patients to achieve maximum health and improved health outcomes.

Previously patients with a chronic respiratory disease may have received care from a diversity of core services and this contributed to confusion for patients, duplication of services, inconsistency of approach, and inequity of access.

A new Community Respiratory Team (CRT) ensured that the patient population and their carers would receive a high standard of co-ordinated care, be better informed and educated about self-management, have improved functional ability, and have enhanced access to other services e.g. palliative care, pulmonary rehabilitation, oxygen services, support networks and voluntary agencies.

A single point of contact was put in place at each of the three sites. Referral processes were streamlined to an electronic referral system. A new operational framework was developed and communicated to all services that refer and work with the CRT. To support the CRT, a respiratory consultant rota was established as well as a monthly multi-disciplinary team meeting for complex patients managed by the CRT in the home setting. Direct referrals from GPs to the team were introduced as well as from the Northern Ireland Ambulance Service. Databases to record data were developed for all sites.

This team provides a streamlined service for GPs, hospital staff and patients. This model ensures a more coordinated and responsive service and acts as the interface between the acute hospitals, the community service, primary care and the

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

community and voluntary sector. Referrals are accepted from Hospital Discharge Service, GPs, NIAS, self-referral (patients previously with the service), Out of Hours and Respiratory Outpatients Service.

The programme has delivered great benefits in terms of patient experience, reduced waiting times, improved self management, reduced admissions to hospital, and, above all, better outcomes for patients.

Providing Alternatives to Hospitalisation

Acute Care at Home

The Southern Health and Social Care Trust (SHSCT) has the fastest growing over 65 years population in Northern Ireland and is set to grow by 35% from 2012 to 2023, with the over 85 year old population set to grow by 73% in the same period.

Emerging evidence from models in Torafen and Lanarkshire indicated that a consultant led community Acute Care at Home (AC@H) service was proving to be an effective way of caring for acutely ill older patients in their home as an alternative to an admission to an Acute hospital.

Following 18 months of planning, Phase 1 of the consultant led AC@H service commenced in September 2014 aiming to assess patients within 2 hours of referral. The primary focus of the service is to maintain older people at home in the event of an acute illness or unexpected deterioration in health through the prevention of inappropriate admission or facilitation of early discharge. The service provides medical triage, assessment, diagnosis and treatment as an alternative to in-patient care specifically to those at risk of or potentially requiring admission to hospital, i.e. in the absence of such care, they would otherwise require inpatient treatment.

The patients have the same access as patients in an acute hospital ward to laboratory results and to diagnostic appointments (for CT scans, Ultrasound scans, X-ray, MRI scan).

The Team consists of Consultant Geriatricians, Speciality Doctor, Specialist Occupational Therapist, Specialist Physiotherapist, Specialist Nurses, General Nurses, Pharmacist, as well as Healthcare Rehabilitation Assistants and Clerical support. Clinical and managerial leadership provided strategic direction and inspired confidence in other stakeholders.

In the 19 months from 22/9/2014 to 30/4/2016 the service has safely cared for over 830 acutely unwell patients in the community who otherwise would have been admitted to an acute hospital. Consultants and other professionals report that older people are recovering much quicker, the risk of acquiring a hospital acquired infection is eliminated and risk of falls is greatly reduced, with little or no incidence of delirium, than if they had been in an inpatient setting.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

The Trust worked in partnership from the outset with the Local Commissioning Group and the Integrated Care Partnerships throughout the development and implementation of the service. Working with the LCG enabled agreement on a service model with key performance indicators. The ICP were key to developing strong interfaces with primary care and community pharmacy.

The service could be replicated across the regions however it will be slow to develop fully at scale due to workforce issues.

Better Aftercare for Patients

Transforming Cancer Follow Up (TCFU)

TCFU is a strategic partnership between Macmillan, DoH, HSCB, PHA and NICaN which commenced in 2011. The TCFU project team and wider multidisciplinary cancer teams across all five Trusts have striven for transformational change to the follow-up and survivorship needs of patients on completion of cancer treatment. TCFU is a large scale, complex, service improvement programme testing new models of cancer follow up that has begun to transform how after care services are delivered. It was initiated through a patient workshop in 2009 where key messages were heard from people affected by cancer.

More people are now living with a cancer diagnosis which is an indication that things are improving and that the cancer landscape is changing for the better. Services need to adapt to those changes.

It's widely acknowledged that the current system of review and follow-up is not sustainable – it is not efficient and it does not fully meet the supportive care needs of patients.

TCFU allows patients to be provided with information tailored to their specific needs, provided in a format that signposts them to self-management support services and provides guidance on life style changes to maximise health and well-being and get their lives back on track; while at the same giving reassurance and a clear point of access back into the system if required.

The TCFU project team and wider multidisciplinary cancer teams across all 5 Trusts in NI have delivered transformational change to the follow-up and survivorship needs of patients on completion of cancer treatment.

TCFU has shown that by taking full account of the views of patients and by carefully adapting the services we provide it is possible to develop better more patient centred services whilst at the same time working more efficiently to meet increasing demand for scarce resources.

In the interests of space, each of these projects is only briefly summarised here, a full case study of each project is included at the end of this report.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

International Good Practice

Other countries and regions are heading in the same direction using best practice examples as an approach to change the model of care. They indicate both better health outcomes and higher efficiency in the use of resources.

These are a few examples.

- Pharmacist Consultations for High-Risk Patients. Pharmacists meet with high-risk patients and their caregivers at primary care clinics or in their homes to provide medication management and education. Pharmacist consultation programmes have demonstrated a 30% reduction in 30-day readmissions.

- Nurse led models of care. In the Netherlands, ongoing financial pressures within the health sector led to home care providers cutting costs by employing a low-paid and poorly skilled workforce who were unable to properly care for patients with co-morbidities, leading to a decline in patient health. Giving district nurses far greater control over patient care broke this lose-lose approach and is demonstrating significant care improvement as well as an overall reduction in cost.

- This community nurse-led care model sees management functions shared between staff and ensures at least 60% of time spent is with patients. The Buurtzorg – or "neighbourhood care" – model uses teams of district nurses to deliver care in people's homes. These teams are self-managed and co-ordinate care with other healthcare professionals, such as GPs and Allied Health Professionals. They work within guidelines including the requirement to use 3% of their turnover for training, have a diversity of nurse specialisms, and to share eight defined management and administrative responsibilities between them. The nurses have access to coaches for wider support and a central back office that processes their billing, but are responsible for their team's own finances and use of time.

- Reinforce Tele-Primary Care Visits consultations with primary care physicians (also known as Virtual Primary Care or Tele-Outpatient Visits) decrease total cost of care and help patients avoid more complex interventions. Studies comparing e-visits with face-to-face care demonstrated net savings.

RECOMMENDATION 8

The system should identify and scale up at least two innovative projects per year where there is clear evidence of improved outcomes for patients or service users.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

RECOMMENDATION 9

The Panel recommends that the Minister should adopt a continuous improvement methodology to support the reform of health care towards local systems of care.

To make this actionable, it is necessary to continue with plans to create stronger quality improvement systems. While the exact remit for this will need to be decided by the Minister, the Panel feels that it should be locally owned and tasked with providing support and intelligence to enable new projects at the provider level.

There is clear and unambiguous evidence to show that specialised procedures concentrated on a smaller number of sites and dealing with a higher volume of patients, will improve outcomes.

3. Rationalisation and Stabilisation

Rationalisation

One key aspect of this is the need to rationalise services to liberate resources that can be invested in transformation. The majority of resources in the HSC are still invested in delivering acute care, and within this some services are being delivered sub-optimally in terms of both quality and value. There is clear and unambiguous evidence to show that specialised procedures concentrated on a smaller number of sites and dealing with a higher volume of patients, will improve outcomes.[36 37 38 39]

Continuing to invest large sums of money in trying to keep unsustainable services in place will only serve to delay their collapse and represents a significant opportunity cost to reforms elsewhere in the system. More importantly, it is also contributing to variation in terms of the quality of care received by those using services in different Trust areas. In a population the size of Northern Ireland, this is unacceptable. In changing the way services are provided, it will be important that decision makers clearly demonstrate the evidence for, and benefits of, change.

Given the importance of this process as an enabler for wider reform, it is dealt with separately in the following section.

Stabilisation

The significant rises in waiting lists and waiting times in the past year have received significant media coverage. While clinicians and managers have made every effort to ensure that the clinical impact on patients has been kept to a minimum, it is clear that this mismatch between demand and capacity has had a negative impact on the public's confidence in the HSC. While the longer term transformation must

36. Bilimoria, K et al (2008) Directing surgical quality improvement initiatives: comparison of perioperative mortality and long-term survival for cancer surgery, J Clin Oncol

37. Morris, S, (2014) Impact of centralising acute stroke services in English metropolitan areas on mortality and length of hospital stay: difference-in-differences analysis, BMJ

38. Crawford, R & Greenberg, D (2012) Improvements in survival of gynaecological cancer in the Anglia region of England: are these an effect of centralisation of care and use of multidisciplinary management? BJOG: An international Journal of Obstetrics and Gynaecology

39. Meyer, J et al (2014) Assessment of Cardiology and Cardiac Surgery for Congenital Heart Disease in Northern Ireland and the Republic of Ireland

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

be progressed, it will also be important to increase public trust in the system by reducing waiting times to an acceptable level.

The Department of Health and the Health and Social Care Board are currently developing an elective care plan which will set out proposals for dealing with this issue in the short and longer term. Although the plan is still being developed, the Panel has been briefed on the direction of travel. In the Panel's view, this is consistent with the vision articulated in this document and should be implemented as a matter of urgency. It is expected that the elective care plan will be ready by the time that this report is published.

RECOMMENDATION 10

The Panel recommends that the Minister takes steps to address elective care performance. However, while this is important, it should not be allowed to overshadow the need for long term transformation.

Leadership for Implementation/Organisational Culture

This report signals the need to rationalise services as well as to implement transformational change. Both of these are extraordinarily difficult and will require a planned approach to change. Furthermore, the requirement to accelerate the development of local integrated care organisations implies a new profile of leadership both locally and centrally.

It has been estimated that the success of any transformational change initiative is likely to result largely from a mix of politics and context.[40] The Panel has tried to create a positive and constructive political context for these changes by holding a political summit at the beginning of the process, providing a safe space for discussion and debate on these important and contentious issues. We have also been engaging with the political parties both before and after the elections in NI. The continued involvement of the political representatives will be an important factor in the process from now on.

Based on previous analysis (Ovreveit 2012) the Panel believes that transformational change can be successfully implemented if senior management leans on:

- the growing evidence on community based integrated networks;
- the development of the right implementation competence;
- a favorable financial and regulatory context.[41]

40. Hunter D et al (2015) Doing transformational change in the English NHS in the context of "big bang" redisorganisation : Findings from the North East transformation system, Journal of Health Organization and Management 2015 29:1 , 10-24

41. Ovretveit J &Klazinga N (2012) Learning from large-scale quality improvement through comparisons Int J Qual Health Care, 24(5):463-9

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

The Panel sees no reason why these conditions cannot be created in Northern Ireland. One can see from the existing building blocks explained above that Northern Ireland has an at least as good, and probably better, chance than others to move forward successfully.

The Panel believes that one key element of that implementation competence is to develop a balanced top down/bottom up approach to leadership.

That balanced approach of top down and bottom up leadership will be key to implementation. It is people, not strategies, that bring about change and it is relationships, not systems, which make it work. The model of care proposed for the future in this report will require a new form of system leadership in order to achieve integration of care and true networking among delivery organisations.

This requires an environment where staff can innovate on organisational issues that improve delivery of care

A planned approach to a transformative process needs some form of 'system leadership' at a senior level and most likely a combination of approaches such as 'push' which could imply top down policies, targets and timescales, and 'pull' which is more focused on shared values, empowerment and vision. At this level, health care transformation seems to be best achieved by a 'channeling' leadership, i.e. people who facilitate and direct the organisation's energy in a way that gets the most out of people.

This implies avoiding pushing policies onto the system. Rather, it implies developing a vision and creating the conditions for local improvement as a key mechanism to facilitate implementation.

A key component of this channeling leadership will be to develop a "high involvement culture" with health care professionals. They are the key agent of change.

That is to say that the one key predictor of positive patient outcomes and satisfaction is the level of employee engagement. Evidence indicates that staff engagement is also linked to improved financial performance in an organisation.[42]

This approach to "high involvement cultures" requires an environment where staff can innovate on organisational issues that improve delivery of care (and not only on clinical issues).

Command and control from above will not accomplish this and it will fail to exploit the energy in the organisation. The changes required by the Triple Aim approach will be more successful if they are implemented in a setting which encourages clinician and health professional engagement.

In this sense change is everybody's business.

Finally, if these difficult decisions are going to be made, they must be taken and supported by leaders at all levels of the HSC. Changes such as these are not easy to pull off. They will require political, managerial and clinical leadership to

42. West M & Dawson J (2012) Employee engagement and NHS performance, Kings Fund

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Changes such as these are not easy to pull off. They will require political, managerial and clinical leadership to come together to ensure that the case for change is fully evidenced, efficiently implemented and effectively communicated.

come together to ensure that the case for change is fully evidenced, efficiently implemented and effectively communicated.

This can only work if every part of the system is moving in the same direction and working towards a common goal. Clinicians must identify the evidence for change, managers must ensure that the correct processes are followed, and the Minister, supported by the Executive, must act quickly to take the final decision. **All three groups will need to be prepared to defend the decision publicly.**

This approach will not happen spontaneously. It has to be made **actionable**.

One key approach for this will be to continue eliminating regulatory obstacles and simplifying the structures which block local innovation. The focus on health and social integration implies local networking and local leaders building partnerships. Local innovation is key to achieve integration of delivery organizations.

RECOMMENDATION 11

The Panel recommends that at the strategic leadership level, the HSC should:

- Foster new system leaders by protecting and empowering clinical leaders who take on leadership roles.
- Analyse and eliminate regulatory obstacles which may get in the way of implementing the new networked local health and social care organisations.
- Take the formal decision to empower leadership close to the front line.

Starting the Conversation

If we are to fully support transformation, as well as reconfiguration of services, there is a potential to more fully engage the power of our staff, partners and the public. The new "social movement" approach, currently being adopted in the NHS, provides helpful context.

These new approaches, often underpinned by social media, can act as catalysts for discussion and a way of mobilising communities and individuals to become more involved in the way health and social care is delivered. They offer greater connectivity with voices that might otherwise be hard to reach, opportunities for collaboration, thought diversity, and a culture of openness.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Some existing projects in the HSC are leading the way on this type of work. The Safety, Quality and Experience programme (SQE) in the South Eastern Trust, the HSC Knowledge Exchange, NICON and HSC Change Day are all good examples of initiatives that try to engage with staff or service users beyond the traditional, more formal processes.

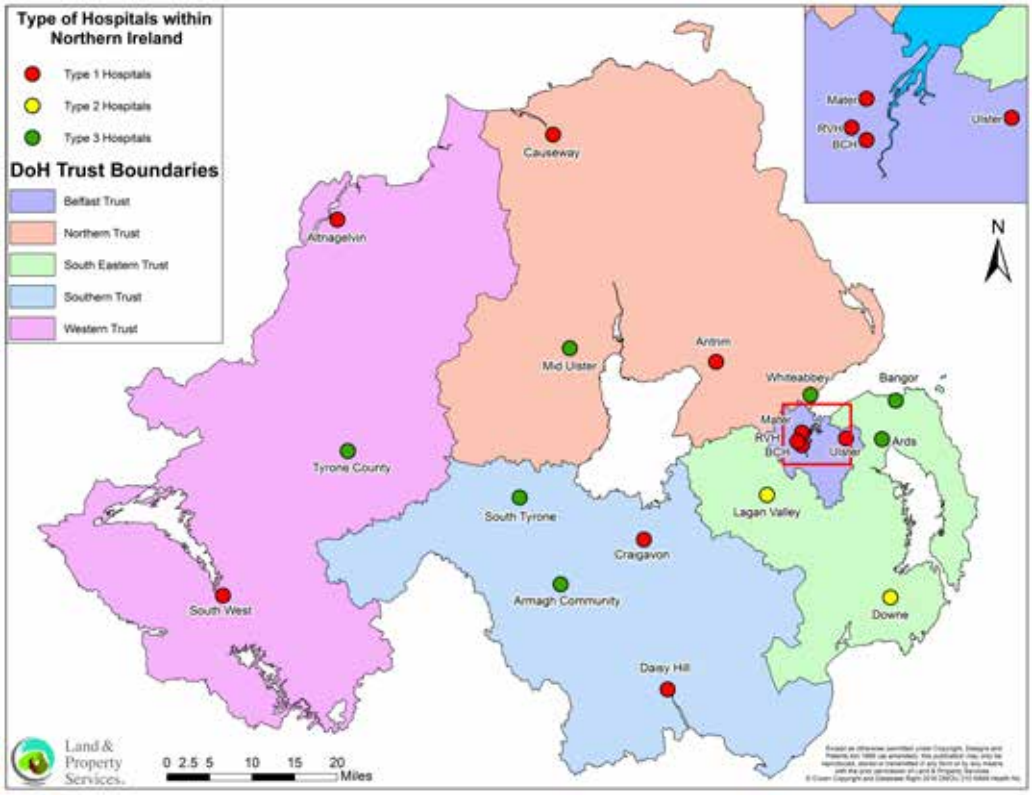
At the 2016 NICON conference, more than 450 delegates expressed their support for the panel's final principle – that Northern Ireland could be a world leader in health care transformation – and these people were joined by over 2 Million people on social media, who were in some way able to be part of the conversation. There is significant opportunity to build on this approach and use new forms of media to communicate far more widely than has been possible in the past.

RECOMMENDATION 12

The Panel recommends that the HSC should consider whether there needs to be a platform for a more open and immediate conversation with staff and service users.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Fig. 26 – HSC Hospitals by type and HSC Trust



Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

SECTION 5

RATIONALISATION



Through the extensive engagement held by the Expert Panel, we heard many common messages. These included:

- That previous reports over many years had signalled the need to rationalise acute services in Northern Ireland, but that implementation was slow due to resistance to change and the absence of a strong strategic approach to transformation.
- That some hospital services were increasingly vulnerable because of workforce shortages and junior doctor training requirements.
- That much needed investment in community services development was hindered because of the high costs of maintaining the current configuration of hospitals, particularly for these vulnerable specialties where often expensive locum and agency staffing was the only option for safe staffing, thus preventing development of those services that would provide an effective alternative to hospital-based care – a vicious circle resulting in ever increasing pressure on all parts of our health and social care system and increasing concerns about the quality and safety of some services.
- That the system is inconsistent from site to site.

Put bluntly, there is no meaningful choice to make. The alternatives are either planned change or change prompted by crisis.

Earlier in this report we referred to the sense of frustration among clinicians and senior leaders at the slow pace of change up to this point. Indeed, we have heard the view expressed that unless this report contains a detailed list of hospitals and services that should close, then it will be judged to have failed.

If the model proposed in this report is to be successfully implemented, then it is inevitable that the way services are currently provided will need to change. The evidence contained in the burning platform shows the clear impact of inaction. Furthermore, changing these services is not optional; it is inevitable. The choice is not whether to keep services as they are or change to a new model. Put bluntly, there is no meaningful choice to make. The alternatives are either planned change or change prompted by crisis.

Implementing these changes is not about making savings, it is about how we use the money we have to deliver the highest possible quality and value of care to patients and service users. The money that is currently being used to prop up

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

The difficulty does not lie in deciding what needs to be done. The difficulty lies in doing it.

unsustainable services does not deliver good value or the best quality of care for patients and could be reinvested in other parts of the system, particularly in areas such as general practice and primary care, mental health, learning disability and community care.

Focusing resources on specialist sites means that:

- Patients are seen in the right place and by the right person as soon as possible. Evidence shows that having all the services available on the same site improves the care delivered to the patient and the clinical outcomes;
- Staff have the necessary support and equipment to allow them to deliver the highest quality care to patients;
- It is possible to attract and recruit sufficient staff to deliver a safe, high quality, 24/7 service;
- The services are more stable and there is a better environment for patients and staff;
- There are the right conditions for professional development, quality improvement, leadership, teaching and other activities that are essential to a vibrant workforce expert in delivering care to acutely unwell patients;
- There is capacity for research and a greater ability to engage with academia and industry in generating new solutions and accelerating testing, adoption and introduction of existing solutions; and,
- This achieves the Triple Aim of better population health, better quality care and better use of resources.

However, as a panel we do not agree either that a prescriptive list should form part of this report. Changing the delivery of services is not like flicking a switch; they cannot simply be turned on and off at will. Hospital and community based services do not exist in isolation from each other and decisions in one area will inevitably have implications for the others. Decisions such as this must be taken carefully; they must be evolutionary; and, they must be carried out service by service, understanding the connectivity between clinical services that form the infrastructure of a hospital.

Furthermore, in the course of the many meetings, seminars, events and visits that the Panel has held and attended, it has become clear that clinicians and managers here already have a strong vision of what needs to be done to make services sustainable. The difficulty does not lie in deciding what needs to be done. The difficulty lies in doing it.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Process

While it is not appropriate for this report to dictate to people in different parts of Northern Ireland what services they should and should not expect to be located in their area or local hospital, it can provide a basis for a process within which these difficult but necessary decisions can be made.

1. Rationale for Reviewing Services

If we are serious about improving services and instituting large scale transformation, then these kinds of decisions:

- Must only be made in order to improve services – to create a more stable, sustainable service, to reduce waste and increase value;
- Must contribute to the overall vision – they should help to achieve the Triple Aim of better population health, better quality care, and better use of resources;
- Must be evidence based and clinically led – to ensure that the service meets patient and user needs more effectively, and that it can attract and retain high quality staff;
- Must be transparent – to include open communication and discussion with affected communities; and,
- Must contribute to the overall vision – they should help to achieve the broader model of integrated, community based care networks.

2. Criteria for Assessing Sustainability

This panel has developed a set of criteria for assessing the sustainability of services. We believe that those taking the decisions on the sustainability of a service should apply the following criteria:

- There is clear evidence that the outcomes for patients using these services are below acceptable levels either in the services as a whole or in particular hospitals, or where there are safety concerns.
- There is a clear clinical pathway for the patient population. Co-produced with patient groups.
- The service cannot meet professional standards or minimum volumes of activity needed to maintain expertise.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

- The permanent workforce required to safely and sustainably deliver the service is not available/cannot be recruited or retained, or can only be secured with high levels of expensive agency/locum staff.
- The training of Junior Doctors cannot be provided to acceptable levels.
- There is an effective alternative 'out of hospital' care model or an alternative 'shared care' delivery model.
- The delivery of the service is costing significantly more than that of peers or of alternative 'out of hospital' alternatives due to a combination of the above factors.

3. Centralising Services – Case Studies

The use of the above criteria implies the centralisation of certain services. This section provides some examples of its benefits when carried out by clinicians and managers working in partnership. The examples show how services can be changed in ways that benefit patients, improve quality and make more efficient use of resources whether they are at local, regional or international level.

A. London Stroke Services

The English Department of Health's National Stroke Strategy identified that care in a stroke unit was the single most important factor in improving patients' outcomes after stroke. Based on these findings, in 2010 acute stroke services were centralised across in London. Prior to this, acute stroke services were provided in 30 hospitals. After reconfiguration, specialist care was provided in eight designated hyperacute stroke units 24/7.

Following the reforms, there was a significant reduction in mortality at 3, 30 and 90 days after admission. There was also a significant reduction in length of hospital stay.[43]

43. Morris, S, (2014), Impact of centralising acute stroke services in English metropolitan areas on mortality and length of hospital stay: difference-in-differences analysis, BMJ

B. Trust Level – Stroke Services in the Southern Trust

In 2012, the RQIA carried out a review of stroke services. Overall the key findings were that stroke services in NI were too fragmented between hospital sites, many patients were not being cared for in optimal environments, community services were underdeveloped and new time-critical interventions, such as thrombectomy, were not always available on a 24/7 basis. The review also highlighted the need for progression of clinical competencies and training relating to stroke and the establishment of clearly defined stroke units and dedicated stroke wards. This has proved difficult to achieve and sustain in smaller hospitals where recruitment and retention of specialist staff is a recognised problem.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

In 2014, following public consultation, a decision was taken to create a single specialist stroke inpatient unit within the Southern Health and Social Care Trust, at Craigavon Area Hospital. The Trust is proposing to provide a consistent and specialist service 24/7 in one centre rather than spreading the specialist team of staff across four sites. Daisy Hill Hospital will continue to provide ongoing rehabilitation and support through community stroke teams working to a regionally agreed care model.

The proposals are consistent with clinical evidence which shows that patients are 25% more likely to survive or recover from stroke if treated in a specialised centre. Other benefits will include:

- High quality medical care
- Improved levels of Stroke Care in line with National Audit (SSNAP) recommendations – appropriate staffing levels to allow early assessment, observation and early rehabilitation input.
- The highest quality medical care in hospital (more concentrated levels of specialist medical, nursing and AHP care).
- Patients being admitted to a Stroke Unit as a ward of first admission. Latest medical evidence demonstrates that where patients are treated in specialist stroke units they achieve best outcomes.
- Better rehabilitation outcomes - a specialised service which will bring community and hospital based staff together as an integrated team providing care to Stroke patients. This will provide more focused care and continuity of service provision throughout the patient's pathway.

Reduced length of stay in hospital - more focused community based rehabilitation to allow Stroke patients to be discharged from hospital earlier and recover at home.

C. Regional level – Primary Percutaneous Coronary Intervention

Heart attack is a leading cause of mortality and morbidity in Northern Ireland. Approximately 40% of hospitalised heart attack patients have the more serious ST Elevation Myocardial Infarction (STEMI) heart attack. Traditionally a STEMI heart attack was treated by giving patients a clot-busting drug (thrombolysis). Patients then went a few days later to a catheterisation laboratory (cath lab), while still in hospital to have a metal stent inserted.

Primary Percutaneous Coronary Intervention (pPCI) involves the patient being taken immediately to a cath lab to widen the artery, clear the blockage and have a stent inserted, instead of using clot-busting drugs. Primary PCI reduces the mortality, complication rates and length of stay in hospital. A pPCI service needs direct admission to a designated centre with dedicated cath lab facilities capable

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

of undertaking the procedure 24/7. Running this requires many highly skilled staff, including interventional cardiologists, clinical physiologists, nurses and radiographers. Each centre needs to do a minimum number of cases each year to maintain standards.

The best fit which gave maximum geographical coverage for the NI population within an agreed travel time, while having enough caseload to maintain team skills, was to have 2 pPCI centres, one in Belfast (RVH) and one at Altnagelvin.

Making this work required commitment, coordination and agreement from senior clinical staff and managers in all six Trusts. A regional group was set up, chaired by a Consultant in public health from PHA, supported by the regional cardiac network coordinator, senior commissioner and finance officers from HSCB.

Obtaining agreement on clinical pathways and protocols was relatively straightforward. What was more difficult was trying to recruit the right number of trained interventional cardiologists to provide a sustainable out of hours rota for the Altnagelvin service, while ensuring sufficient workload to maintain their skills.

The group explored options to provide the night-time rota cover by consultants who would have daytime commitments in other hospitals, crossing Trust boundaries. The same approach was used for the Belfast pPCI service, seeking to offer opportunities to interventionalists working in other hospitals who wished to join the pPCI rota. In tandem, where there were other known gaps in cardiology services, such as in outpatient clinics, or cardiac MRI, if options were available to sort those within the overall configuration of new consultant posts then that was considered.

New IT systems were also agreed to share important patient information, both for patients waiting a daytime cath lab procedure and those waiting for cardiac surgery.

This regionally coordinated process ignored organisational boundaries when seeking the best solution for the population. Rather than focussing solely on pPCI, it used the opportunity to improve other aspects of cardiology services, with the end result that local services were strengthened as well as providing a new regional service. Primary PCI was centralised into 2 locations, because that was the best way to achieve a sustainable high quality service for patients, but others such as cardiac MRI and non-complex pacemaker implantation were able to be decentralised. This required close cooperation between clinical and management teams in all six Trusts. All had to make compromises to deliver a better, stronger cardiology service for the people of Northern Ireland.

D. Cross-Jurisdictional Level – Children's Congenital Heart Surgery

In recent years the regional Paediatric Congenital Cardiac Surgical (PCCS) Service, provided by the Belfast Trust, developed vulnerability in its surgical service due to new international safety and quality standards which could not be met because

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

of our relatively small population size. As evidenced by clinical reviews neither surgical centre (Belfast or Dublin) had been delivering a service which meets current international standards of both institutional case volume and consultant staffing: the service in Belfast did not meet the surgical case volume threshold, and the Dublin service has a medical staffing level in both intensive care and cardiology that is significantly lower than in comparably sized UK and European centres.

By December 2014 Belfast could not continue to provide an emergency and elective surgical service, and by April all interventional cardiology procedures ceased in Belfast (as these require the presence of a surgeon).

An International Working Group (IWG), led by Dr John Mayer from Boston Children's Hospital recommended the establishment of an all-island congenital heart disease (CHD) service, with a single surgical centre in Dublin capable of meeting international standards for surgical practice volumes, supported by specialist cardiology hubs in Belfast and other locations. The 'hub and spoke' network would involve all stakeholder groups including patient representative organisations in its governance structure, and be supported by enhanced telemedicine links, improved transportation, and a clinical research programme.

The all-island CHD Network was established in April 2015, following a public consultation on the recommendations of the expert group. In endorsing the IWG's recommendations, commitment was also given to the development of a specialist Children's Heart Centre in Belfast, enhancing existing facilities at the Clark Clinic within the current footprint of the Royal Belfast Hospital for Sick Children and making it fit for purpose until the new Children's hospital opens in 2021/22. This will secure the role of RBHSC as an integral part of the in the all-island 'hub and spoke' network, functioning as a 'Level 2' cardiology centre, i.e. providing the full range of non-surgical care required by CHD patients until they are ready to transition into the adult service.

The all-island CHD Network involves the two Health Departments, commissioners, service providers (management and clinicians) and patient representatives in a collaborative non-statutory structure to deliver an all-island CHD Service in line with the relevant legal and accountability arrangements that apply in each jurisdiction.

4. Maintaining Momentum

While criteria were previously developed as part of TYC, there is little evidence of these being applied in a systematic way to services or conditions. The panel believes that the Department should consider formal endorsement of these criteria and that a timetable for applying these should be developed, prioritised by specialty.

Based on the evidence the panel has received, the specialties that are currently in most need of reform would seem to be:

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Priority 1

- EMERGENCY & URGENT CARE
- STROKE SERVICES
- PRIMARY CARE INCLUDING GP OUT OF HOURS
- GENERAL SURGERY
- PATHOLOGY
- VASCULAR

Priority 2

- PAEDIATRICS
- PALLIATIVE CARE
- OBSTETRICS
- RADIOLOGY
- NEONATAL SERVICES[44]
- TRAUMA
- UROLOGY
- REHABILITATION
- COMMUNITY BASED ELDERLY CARE
- BREAST SERVICES

RECOMMENDATION 13

The Panel recommends that the Department should formally endorse the criteria and apply them to five services each year to set out the future configuration of services to be commissioned (or not) from the Accountable Care Systems.

If applying the criteria leads to the conclusion that the service is vulnerable, plans for reconfiguration should be developed and actioned within this twelve month period.

44. Paediatrics, obstetrics and neonatal services are clinically linked and should be considered together.

5. Seeing the Big Picture

Having heard from many different leaders in different parts of the system, the Panel is in no doubt that local clinical leaders know exactly what they would like to do to optimise delivery of services for their patients and service users. However, it is also clear that in the interests of patients across the whole of Northern Ireland, decisions that will have a significant impact regionally or across Trust boundaries, must be taken in a regional context and must be consistent with the long term vision.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

We therefore recommend the establishment of an appropriately resourced transformation business unit, based in the centre of the system. This unit should be tasked with providing a strategic view on projects with a regional impact – joining local and regional considerations while firmly focused on delivering better outcomes for patients. We are not advocating an expansion of bureaucracy and the past tendency to create unwieldy process management in taking forward change must be avoided.

The projects themselves would still be clinically/locally led and the role of the unit would be to bring a regional perspective to such decisions ensuring that patients' requirements are fully met. Given the inter-connections between medical conditions, this would also ensure that all the related regional impacts arising from proposed change are not being taken in isolation of the wider vision.

RECOMMENDATION 14

The Panel recommends the identification of a senior leader to lead this process at a regional level.

This process should be collaborative and inclusive and based on the criteria above.

6. Change is Everybody's Business

In taking these decisions, it is of course vitally important that there is clear engagement with communities both at a local level and regionally. People will need to be able to understand why a service is changing and what will take its place. The Panel considers this to be a fundamental component of any changes. Health professionals must support local representatives in explaining the rationale for change and the alternatives which will provide better care. Where the centre is leading and co-ordinating changes to hospital services, this should be led by professional leaders with support from clinical leaders in those services.

Finally, if these difficult decisions are going to be made, they must be taken and supported by leaders at all levels of the HSC. Changes such as these are not easy to pull off. They will require political, managerial and clinical leadership to come together to ensure that the case for change is fully evidenced, efficiently implemented and effectively communicated.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

When developing the criteria above, the Panel met with clinical leaders from across the Health and Social Care system and was struck by the support for and commitment to driving these difficult changes and wider transformation forward.

This can only work if every part of the system is moving in the same direction and working towards a common goal. Clinicians must identify the evidence for change, managers must ensure that the correct processes are followed, and the Minister, supported by the Executive, must act quickly to take the final decision. All three groups will need to be prepared to defend the decision publicly and openly, and to honestly communicate the need for change with local politicians, the public and individual service users.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

SECTION 6

LIST OF RECOMMENDATIONS



Recommendation 1

The Panel recommends using the dimensions of the Triple Aim as a framework for reform, including an increased emphasis on the experience of those who deliver care.

Recommendation 2

The Panel recommends that the HSC should move to:

- Formally invest, empower and build capacity in networks of existing health and social care providers (such as Integrated Care Partnerships and the developing GP Federations) to move towards a model based on Accountable Care Systems for defined population based planning and service delivery; and,

- Regionalised planning for specialist services.

Recommendation 3

The Panel recommends that the HSC should continue its positive work to invest in and develop the areas listed above.

There should be particular focus on the three key areas of workforce, eHealth and integration:

- As a key enabler of Accountable Care Systems, the HSC should continue to invest in e-health to support improved self management, care at home and use of information to drive better population health outcomes.

- The HSC should immediately develop innovative primary care based models that will allow non-medical staff to work in a way that makes the most of their skills. (For example, these could be based on the community nurse-led care models being implemented in the Netherlands, or the use of pharmacists in community development here in Northern Ireland).

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

- Work should be carried out to identify which social interventions are most cost effective in addressing the social needs and improving health for Northern Ireland.

- Any new approach to commissioning should be aligned with the need to build integrated health and social organisations on the ground which target specific inequalities and social groups.

Recommendation 4

The Minister should create, communicate and lead a clear, powerful, long term vision for the Health and Social Care system as a first step in the implementation process.

Recommendation 5

Alongside the Minister's vision for health and social care, the Panel recommends that plans, costs and timescales for introducing the actions detailed in the main body of the report should be prepared within the next 12 months. It is vital that the implementation of these actions is led by health and care professionals and managers.

Recommendation 6

Many of these recommendations will require additional, transitional funding. The Panel recommends that the Minister should establish a ring fenced transformation fund to ensure this process is appropriately resourced.

Recommendation 7

For this purpose, the panel recommends the creation of a transformation board supported by the Department, linked to the Executive's health and well-being strategy.

- This board would set the mid-term strategy, oversee the transformation process and would be tasked with creating the right conditions for the local system of care to develop successfully.

- It should help to transform organisational structures and management processes by promoting local decision making, local innovation and scaling up of best practices among the local systems of care.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Recommendation 8

The system should identify and scale up at least two innovative projects per year where there is clear evidence of improved outcomes for patients or service users.

Recommendation 9

The Panel recommends that the Minister should adopt a continuous improvement methodology to support the reform of health care towards local systems of care.

To make this actionable, it is necessary to continue with plans to create stronger quality improvement systems. While the exact remit for this will need to be decided by the Minister, the Panel feels that it should be locally owned and tasked with providing support and intelligence to enable new projects at the provider level.

Recommendation 10

The Panel recommends that the Minister takes steps to address elective care performance. However, while this is important, it should not be allowed to overshadow the need for long term transformation.

Recommendation 11

The Panel recommends that at the strategic leadership level, the HSC should

- Foster new system leaders by protecting and empowering clinical leaders who take on leadership roles.
- Analyse and eliminate regulatory obstacles which may get in the way of implementing the new networked local health and social care organisations.
- Take the formal decision to empower leadership close to the front line.

Recommendation 12

The Panel recommends that the HSC should consider whether there needs to be a platform for a more open and immediate conversation with staff and service users.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Recommendation 13

The Panel recommends that the Department should formally endorse the criteria and apply them to five services each year to set out the future configuration of services to be commissioned (or not) from the Accountable Care Systems.

If applying the criteria leads to the conclusion that the service is vulnerable, plans for reconfiguration should be developed and actioned within this twelve month period.

Recommendation 14

The Panel recommends the identification of a senior leader to lead this process at a regional level.

This process should be collaborative and inclusive and based on the criteria above.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

APPENDIX A

THE EXPERT PANEL'S PRINCIPLES FOR HSC REMODELLING



Vision Statement

"To create a fair and sustainable, including financially sustainable, Health and Social Care system that delivers universal, high quality, safe services that meet the Northern Ireland population's needs and which deliver world class outcomes for patients and service users."

Ethos

1. **The system should be collaborative, not competitive.**
   There are several components to this principle. Firstly, even in the short term it will not be safe or effective to deliver all services locally. Organisations must work together to provide high quality care to patients. Secondly, unwarranted variance across the system should be minimised. Patients should be able to receive the same standard of care anywhere in the region. Thirdly, the HSC should continue to work in partnership across government, with industry, academia, the community and voluntary sector, staff and patients to deliver new models of care. Finally, remodelling of the system should be a transparent and collaborative process.

2. **The system should adopt a population health and well-being model with a focus on prediction and prevention rather than reaction.**
   Like many health services worldwide, HSC resources and service developments are often locked into reactive 'disease care', which focuses on increasingly expensive diagnostics and treatment. It must be acknowledged that there should be an increased emphasis on investment in prevention and health promotion, particularly for vulnerable communities who are at highest risk of experiencing inequalities. It must also be acknowledged that addressing wider health determinants requires a cross-sectoral approach, although there is much that the HSC can do in terms of designing new models of care.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

3. **Patients should be active participants in their own care, not passive recipients.**
Patients should be treated with respect and empowered to stay healthy and care for themselves where possible. Patients should also be supported and encouraged to take greater ownership of their own health outcomes. The public rightly expects access to safe, sustainable and high quality health and social care services; however, as part of the relationship between the HSC and citizens, the public should also be enabled to take greater responsibility for their own health and well-being, and to use services appropriately.

Delivery Model

4. **Health and Social Care is already integrated in Northern Ireland. Remodelling must build on this strength and take a whole system perspective.**
The HSC in Northern Ireland is an integrated system, to the envy of many countries. Remodelling must ensure that different parts of the system are connected, interdependent, that they talk to each other and that they form an integrated whole. Patients should be able to transition smoothly between social care, community care and hospital care.

5. **Only people who are acutely unwell need to be in a hospital.**
Hospital is often not the right answer. There is evidence that for patients who do not need acute care, being in an acute hospital can be harmful. Research also indicates that hospital use is affected by deprivation, with people in poorer areas more reliant on emergency services, and making insufficient use of planned elective services. Studies have shown extremely positive feedback and satisfaction levels from patients who were treated in community settings and the HSC must continue to develop strong community care models.

6. **Very specialist services can be based anywhere in Northern Ireland.**
In the face of increased specialisation and ever rising demand, it is not practical or desirable to try to deliver specialist services everywhere. However, it is true that specialist services could be delivered anywhere. Any acute hospital in Northern Ireland has the potential to become a regional centre. Furthermore, the HSC should continue to explore and realise the mutual benefits of collaboration with other jurisdictions in ensuring patients have access to high quality, sustainable services.

7. **The location and composition of resources should be based on meeting patients' needs and achieving the best outcomes.**
Co-ordinated workforce and service planning should be carried out on the basis of the population's need rather than with the aim of maintaining services which are not sustainable in the long term.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

8. **The real value of Health and Social Care is in its people, not its buildings.** HSC staff should be given the freedom to innovate and deliver services in a way that best meets people's needs, safely, quickly, and with respect and compassion. This implies more local autonomy and innovation within a defined policy framework. Northern Ireland has a wealth of knowledge and expertise that should be harnessed and developed to allow us to provide the highest quality services to patients. Local initiatives should be encouraged and best practice should be shared across the region.

Implementation

9. **Whole system remodelling is a medium to long term process.** Funds will continue to flow into the health and social sector but simultaneously there must be significant gains in productivity. New care models allow for increased productivity. Reform and remodelling on this scale will take time and must be supported by an evidenced, costed and resourced implementation plan. This will need policy and political commitment in the long term.

10. **The system must be supported to implement change with pace and scale.** Change is inevitable and must be embraced. There is an appetite and a will to implement planned change among staff. Service developments and investment from this point should be geared towards supporting and complementing a long term strategy for sustainable and quality care.

11. **Technology should be developed and adopted where it can support and enable transformation.** Northern Ireland has one of the most advanced electronic care record systems in Europe. New technologies offer enormous potential for improved self-management, telemedicine, information sharing and communication across sub-systems. Innovation and new technologies should be embraced in collaboration with industry where they offer the potential to deliver better or more efficient services. This will bring benefits to patients, the HSC and the economy.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Leadership and Culture

12. **The panel will engage constructively with elected representatives when designing and communicating a remodelled HSC. The Panel will also engage openly with HSC staff and the public.**
Implementation will require strong political and technical leadership. Without change, the Northern Ireland Health and Social Care system is not sustainable in the medium to long term. Elected officials will play a key role in analysing proposals and enabling the public to understand the need for change.

13. **Northern Ireland can be a world leader in transforming health and social care**
Many countries are facing the same challenges and difficult choices as Northern Ireland. This process is an opportunity for Northern Ireland to be a pioneer in designing and delivering health and social care services fit for the 21st Century.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

APPENDIX B

LIST OF ENGAGEMENT MEETINGS



CO3

DOH

NIASW

RCN

BMA

Patient & Client Council

PPI Seminar event

Sinn Fein

DUP

UUP

SDLP

Alliance

BHSCT

NHSCT

Meeting with representatives from all HSC Trusts

HSCB

PHA

Dr George O'Neill, GP

QUB

Clinical leaders seminar event

NIPSA

RQIA

Pathology Network NI

NICON

Royal College of Surgeons

Royal College of Paediatricians

Age NI

NHS England

Greater Manchester Health & Devolution

ICP & LCG Delegation

AHP Delegation

Senior Nurse Delegation

ABPI

Contact NI

Commissioner for Older People for NI

Chief Clinical Information Officers

Unison

BMA – NI GPC

Safety Forum

Institute for Healthcare Improvement

Community Pharmacy NI

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

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

REBUILDING HEALTH AND SOCIAL CARE SERVICES

STRATEGIC FRAMEWORK

DEPARTMENT OF HEALTH

JUNE 2020

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

CONTENTS

		Page
	MINISTERIAL FOREWORD	3
1.	INTRODUCTION	5
2.	COVID-19 IMPACT ASSESSMENT	7
3.	MISSION	18
4.	SERVICE INNOVATION	19
5.	INCREMENTAL SERVICE CAPACITY PLANS	27
6.	IMMEDIATE PRIORITIES	32
7.	EXAMPLE PATHWAYS	42
8.	ANNEX A: ACTION LIST	55

APPENDIX A: COVID-19 IMPACTS ON HSC SERVICES, EXCLUDING SECONDARY CARE (TO BE PUBLISHED SEPARATELY)

APPENDIX B – IMPACT OF COVID-19 ON SECONDARY CARE SERVICES (TO BE PUBLISHED SEPARATELY)

APPENDIX C: COVID-19 IMPACT ON PROGRAMMES AND PROJECTS (TO BE PUBLISHED SEPARATELY)

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

MINISTERIAL FOREWORD

Before the introduction of social distancing almost three other people were infected by each COVID-19 patient in the community. As a result of social distancing and other restrictions, each COVID-19 patient now infects less than one other individual in the community. The result of this is that we are now seeing a slow decline in the number of community acquired COVID-19 cases, hospital admissions, ICU occupancy and deaths.

This Strategic Framework for Rebuilding Health and Social Care (HSC) Services will only be successfully implemented by ensuring that the number of Covid-19 infections remains at the current level or less in the future. If this increases above one there will be the risk of a second wave of the pandemic. Consequently, our ability to rebuild HSC services will be derailed by having to divert HSC resources to manage the impact of a second wave of the pandemic.

My position as Minister of Health has given me a particularly privileged vantage point to witness the impact of this terrible virus on our community. This has both humbled me and sharpened my determination to ensure that we use every available measure we can to keep the rate of infection below one.

The number of our fellow citizens who have been infected or sadly lost their lives has already been too great. As of 2 June 2020, over 76,000 people had been tested. Sadly, 705 COVID-19 related deaths had been registered up to 22 May. I send my sincere condolences to the families and loved ones who have suffered the loss of their family member. I pray that those who are recovering from COVID-19 will make a full recovery and return to a happy and healthy life. The impact of COVID-19 on our older citizens living in care homes has been particularly devastating and my thoughts are with their families and friends at this difficult time for them.

I am immensely proud of the response to COVID-19 of everyone involved in our health and social care sector. Our nurses, midwifes, allied health professions, doctors, pharmacists, care workers and other front line health and social care workers and those individuals who volunteered to return to work have bravely and tirelessly put themselves at risk to save the lives of others. In addition, staff in our arms-length bodies and in my Department have put in many long hours planning for and managing the emergency response. I know that I can rely upon their continuing commitment to deliver the highest quality health and social care services across the community as we begin the task of rebuilding the HSC.

COVID-19 has presented our HSC system with its biggest challenge since inception. We faced huge strategic challenges prior to COVID-19, which included an ageing population, increasing demand, long and growing waiting lists, workforce pressures, the emergence of new and more expensive treatments and ongoing budget constraints. These challenges have been compounded by COVID-19.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

I am deeply concerned about the impact of this activity downturn on long term health outcomes across the population. In total, 643 excess deaths have occurred up to 22 May 2020. Throughout the pandemic the HSC has continued to provide high priority and urgent services such as emergency care and many cancer treatments. Despite the action I took to protect our highest priority services, a terrible consequence of the pandemic is that for some people conditions will have gone undetected or untreated longer than they otherwise would have. I am also deeply concerned about the impact of the pandemic and the lockdown on mental health, especially for our most vulnerable citizens.

We are now emerging from the peak of the first COVID-19 wave and we must now seek to rebuild services as quickly as possible in that context. My immediate focus will be on supporting services where further delay would seriously risk the condition of patients worsening. As we do so, patient and staff safety will remain an absolute priority. We will therefore create an environment where it is safe for patients to attend appointments in both primary and secondary care settings.

I conclude by again thanking all health and social care staff for the incredible efforts to date. We will not be able to return to business as usual as quickly as we would want to and some services will take a considerable period of time to return to activity levels similar to those prior to COVID-19. At the same time we need to mainstream the important innovations that have emerged, we must retain flexible capacity to continue to manage COVID-19 patients and we must plan for the future, all at the same time.

This Strategic Framework that I have published is an honest attempt to plot the way forward to rebuilding HSC services. Because of the uncertainty about our ability to control further outbreaks of the virus our planning horizon will look no further than three months ahead as we seek to rebuild service capacity over the next 2 to 3 years. The road to achieving full recovery of services will be long and testing for all involved.

I am convinced that as a system we will rise to this complex challenge.

Robin Swann
Minister for Health, Northern Ireland

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

1.0 INTRODUCTION

1.1 COVID-19 has posed unprecedented challenges for the Health and Social Care (HSC) system, which already prior to COVID-19 was facing huge strategic challenges in the form of an ageing population, increasing demand, long and growing waiting lists, workforce pressures and the emergence of new and more expensive treatments as outlined within *'Health and Wellbeing 2026: Delivering Together'*. This is against a backdrop of financial constraints and single year budgets. Elective and diagnostic services have had to be curtailed with adverse impacts on existing waiting lists. At the end of March 2020 there were some 307,000 patients on the outpatient waiting list, almost 94,000 waiting for inpatient and day case admissions and more than 131,000 patients waiting for diagnostic tests. The existing challenges confronting the social care sector, as described in the 'Power to People' report, have also been compounded by the pandemic.

1.2 The impact of COVID-19 on HSC will be profound and long lasting. Services will not be able to resume as normal for some time due to the continued need to adhere to social distancing and for Personal Protective Equipment (PPE) at volumes not required prior to the pandemic. In addition, the resilience of the HSC workforce is likely to have been eroded and will continue to be impacted with pressures from parts of the social care sector, with care homes still managing a significant number of COVID-19 outbreaks, for instance. This could require the continued deployment of additional staff into the independent sector, which, if delivered, will further constrain staffing capacity to fully resume other HSC services. Ongoing pressures and the need to operate in new ways will likely impact the pace of stabilisation across primary, secondary, community and social care services.

1.3 Whilst the restrictions imposed by The Health Protection (Coronavirus, Restrictions) (NI) Regulations 2020 ('the Regulations') were necessary, they have impacted on the wider economic and social environment, with both long and short term effects on population health. Emerging research indicates that population health is, on balance, likely to be negatively affected by the wider impacts of COVID-19. Furthermore, the greatest effects are likely to be felt by our most disadvantaged citizens.

1.4 In addition, given the very significant downturn in HSC services, many people have not had access to the screening, testing or treatments that they otherwise would have had. In that context, the Department took action to preserve the highest priority essential services to mitigate this impact. Inevitably, however, the downturn in normal business will have resulted in some diseases going undetected or untreated longer than is desirable, with potential impact on long term health outcomes. The uncertainty and concern about the pandemic combined with the impact of the lockdown will also likely have had an adverse

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

impact on mental health, especially for the most vulnerable in society. Additional support for mental health and resilience have been provided, however it is likely that there will be significant need coming forward as we emerge from the lockdown. Delivering on the mental health action plan launched on 19 May 2020 will be essential if we are to meet this particular challenge.

1.5 COVID-19 has disrupted the clinical education and progression of a number of health professions resulting in a disruption in progression and future workforce supply. This disruption has been particularly acute in elective services which have been stood down, multidisciplinary community teams and district nursing teams where student training would have generated additional footfall. The third sector has also been negatively impacted by COVID-19 and HSC are reliant on the sector to provide support.

1.6 Careful consideration will also need to be given to the delivery of long term support for people in the community, including that provided through HSC domiciliary, residential and nursing home care and through the vital support provided by informal carers. There will need to be a careful balance struck between continuing to protect people and ensuring that other aspects of people's health and wellbeing – and their rights – are respected and looked after.

1.7 A further issue that will increasingly come into focus during 2020 is the need for readiness for EU Exit, ahead of the end of the transition period on 31 December 2020. This includes understanding the implications for the HSC sector of the implementation of the Northern Ireland Protocol and ensuring that the sector is prepared and risks are managed in areas such as workforce, health security and healthcare supplies.

1.8 The Department's budgetary position continues to be hugely challenging, with the Department facing a funding shortfall in respect of forecast inescapable pressures necessary to maintain existing services. Rebuilding HSC services whilst simultaneously dealing with the ongoing COVID-19 pandemic will require additional sustained funding and investment.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

2. COVID-19 IMPACT ASSESSMENT

2.1 The Department has collated a comprehensive assessment of the impact of COVID-19 across primary care and community services; secondary care; and a wide range of programmes and projects. This detailed assessment has been published in three separate Appendices[1], alongside this Strategic Framework. This section summarises the key impacts across these areas and also highlights some of the emerging wider population health impacts.

2.2 It is important to stress that the information included in this section and in the separate appendices was collated quickly with the intention of providing a high level illustration of impact. Please note that waiting time figures only include data that was available on the Patient Administration System at the time of reporting, with some data excluded[2]. Given the urgency in developing this Strategic Framework and associated service rebuilding plans, the data in this section and in the appendices has not been subject to any detailed data verification processes. The data is therefore provisional only and is subject to change. It has nevertheless been published in the spirit of openness and transparency.

Primary and Community Care

GP / Dental / Ophthalmic Services

2.3 COVID-19 has had an adverse impact across primary care and community services. GP appointments have reduced by 19.4% compared to last year. In addition to normal business, GP practices are receiving large numbers of COVID-19 related queries.

2.4 There has also been a marked reduction in the availability of dental and ophthalmic services with a minimum service focused on emergency care. In respect of emergency dental care this is provided through the Urgent Dental Care Centres that have been established in each HSC Trust. The net impact of the restrictions is that whilst 50,000 patients would have visited a dental practice each week in normal circumstances, this has reduced to around 2,000 (a 96% reduction) currently whilst there has been a 72% reduction in sight tests.

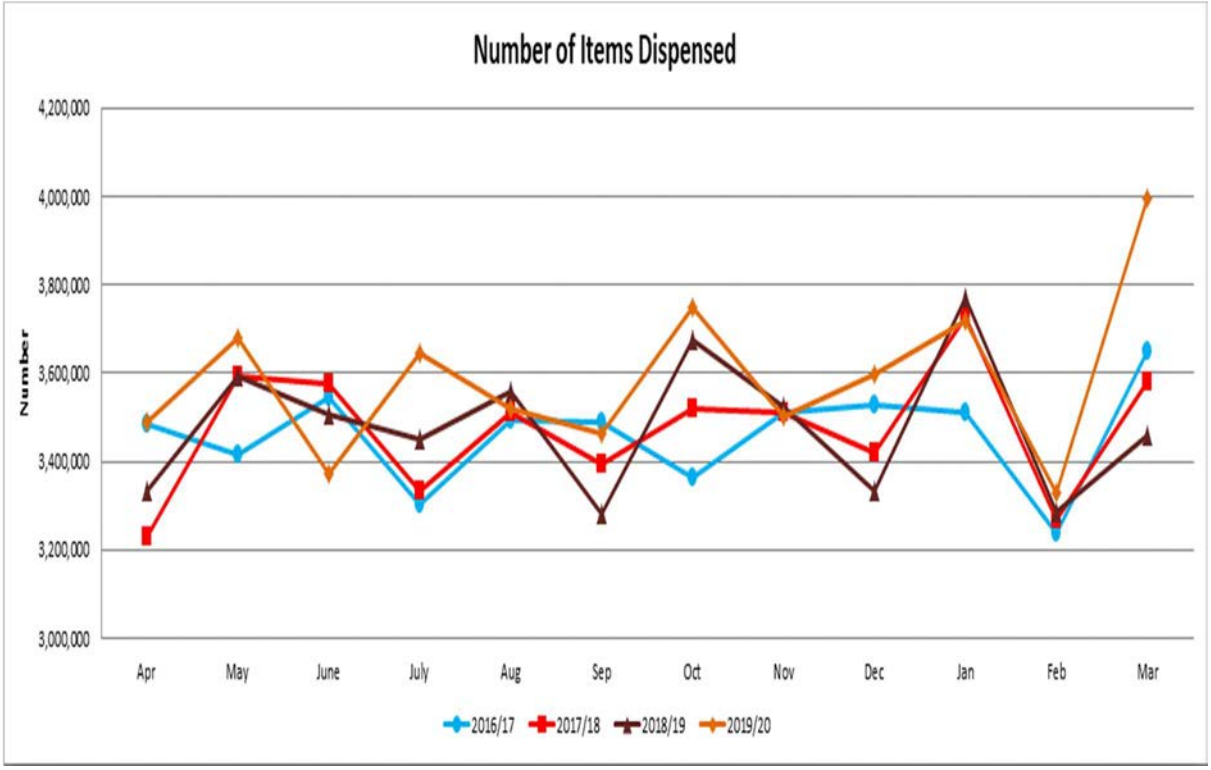
[1] Appendix A: Impact on HSC Services, excluding secondary care.
Appendix B: Impact on secondary care.
Appendix C: Impact on programmes and projects.
[2] The following Trust data is not included: Belfast - Community Paediatrics, Rehabilitation, Learning Disability, Old Age Psychiatry, Genito-urinary Medicine; Northern – Community Paediatrics; Southern – Genito-urinary Medicine; and Western – Learning Disability, Genito-urinary Medicine.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Community Pharmacy Services

2.5 Information is only now emerging on the impact of COVID-19 on community pharmacies. This is exemplified in prescription volumes which show an increase of 15.2% in total prescription items dispensed, which exceeded 4 million items in March. In reality, community pharmacies across the country experienced a huge surge in demand for prescription and over the counter medicines from mid-March (figure 1 below), placing acute strain on pharmacy staff and business owners.

Figure 1: Prescription Volumes by Month



2.6 A number of rapid interventions were needed to sustain the service through the initial emergency phase. These interventions saw the standing down of non-essential services and commissioning of new services to meet emerging population health needs.

2.7 Additional pressures also emerged. The high numbers of people shielding, self-isolating and the government message to "Stay at Home" resulted in an increase in requests for prescription deliveries. General practices encouraged the public to use prescription collection services to reduce footfall through GP practices. This resulted in a greater expectation from the public for collection and delivery services for prescription medicines, none of which was

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

commissioned. Against rising demand, community pharmacy experienced significant pressure in relation to workforce resilience. In the earlier stages of the pandemic response, staff capacity fell to below 70%. In recent weeks, it has improved to 80%.

Community teams

2.8 Community Allied Health Professional (AHP) services and community nursing services have been severely disrupted, negatively impacting patient access to community rehabilitation and recovery; assistance to support and maintenance of independent living; and the management and control of long term conditions. The demands on community teams has increased with district nursing and acute in-reach teams supporting vulnerable clients in care homes.

2.9 Health visitors have been relocated to provide care and services where needed resulting in a reduction of the number of health assessments and home visits which means issues in relation to health and development of children may not have been identified early. Closure of the schools has meant the school vaccination programme and health appraisals have been unable to be completed. This will need to be addressed when schools reopen.

Screening Programmes

2.10 Many adult screening programmes were paused from the second week of March 2020 in response to the COVID-19 pandemic. The purpose in pausing these programmes was to reduce the risk of COVID-19 infection in people eligible for screening programmes and to ensure that adequate healthcare and laboratory resources could be redirected to the pandemic response. As a result, the number of screening tests carried out in the adult programmes which were paused has fallen very significantly since the middle of March 2020.

2.11 Screening has continued to be offered for people who require higher risk breast screening, diabetic eye screening for pregnant women, newborn blood spot screening, newborn hearing screening, antenatal infections screening in pregnancy and ‘smear’ tests for non-routine cervical screening such as repeat tests requested by colposcopy or the laboratory.

2.12 Breast assessment clinics for women who have previously been recalled for assessment following mammography continue to be held within our screening centres.

2.13 Colposcopy clinics offering further assessment following a cervical screening test are also still being held where possible and tests for people who have recently been screened will continue to be processed and results sent to GPs for onward communication to patients.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Mental Heath

2.14 The impact of COVID-19 on mental health is expected to be severe. International evidence indicate short and long term direct effects on mental health and psychological wellbeing, and in some cases increased suicide and posttraumatic stress disorder (Lancet 2020; 395: 912–20). The causes of the direct effect on psychological wellbeing are identified as social distancing and isolation, bereavement, unemployment, financial hardship, inability to access health and social care services and increased stress due to work pressures. Further it is expected that the prevalence of mental disorder and mental illness will increase. Evidence from World Health Organisation (WHO) and academic research indicate that the pressures are expected in already vulnerable groups, with an increase of depression in women, increased rates of depression and anxiety in the older population, and those with severe mental disorders felt to be especially vulnerable during emergency situations.

2.15 Early indications in Northern Ireland support this research. Whilst most early intervention, prevention, mental health and suicide services reported an initial decrease in demand, this has now turned into an increase in pressures. Mental health in-patient bed occupancy (for those with the most severe mental illness) showed a 15% drop in demand between middle of February and end of March. However, since the second half of April demand has increased significantly and the daily bed occupancy levels are now around 95%.

2.16 Anecdotal evidence from clinicians also indicates an increase in acuity of those presenting with severe mental health problems, and a larger number of new presentations, previously unknown to mental health services. Early indications links this with the effects of reduction in face to face contacts, in the health services and wider society, and stress related to the pandemic.

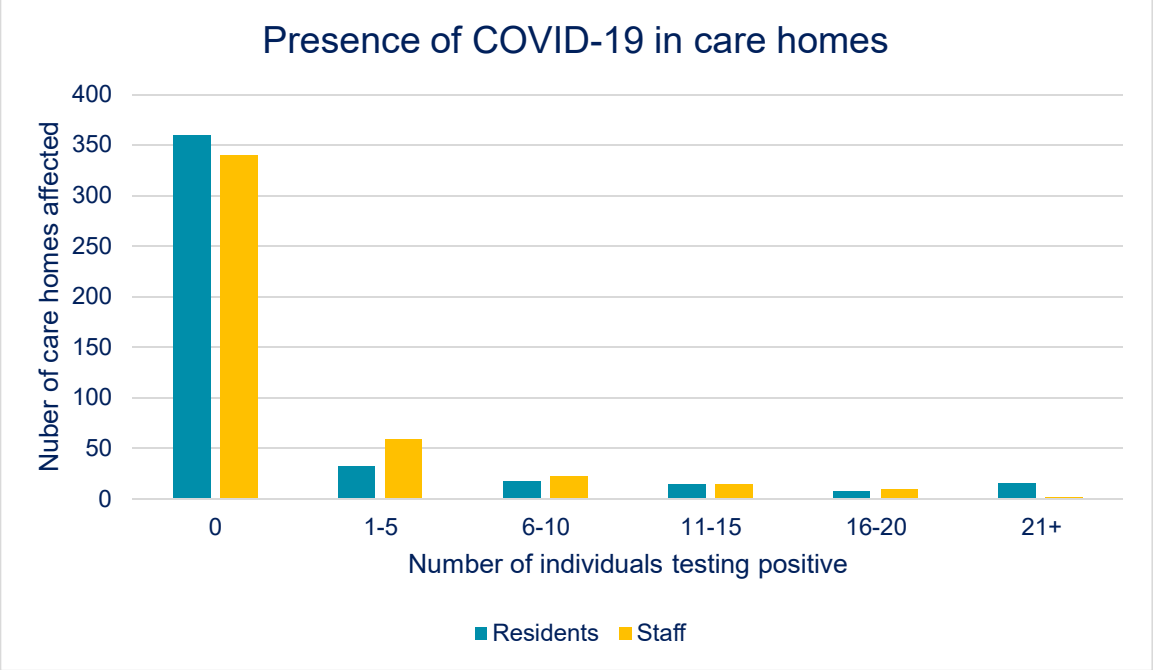
Social Care

2.17 COVID-19 has highlighted the fragility of the adult social care sector and a wider and fundamental reform of adult social care will be required. In contrast to other areas of the health system, the ongoing nature of the service limits the potential to create capacity by reducing or restricting access to the service. In particular, care homes remain in the surge period of the pandemic with pressures evident in the presence of COVID-19 among care home residents and staff.

2.18 A recent survey of care home providers indicated that 19% of providers who responded were caring for a resident who had tested positive, while 23% of providers who responded had employees who had tested positive. The chart below shows both the number of care homes affected by COVID-19, and the extent of COVID-19 presence within those homes through analysis of the number of positive tests within each home:

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Figure 2: Number of homes affected by COVID-19 - May 2020



2.19 The provision of domiciliary care has also been affected, with many recipients choosing to rely on informal care due to concerns about the transmission of COVID-19 by domiciliary care workers entering their home. Anecdotally these concerns have also impacted on the way some direct payments are used. The long term impact of this is difficult to forecast but, anecdotally, demand for formal care packages is returning. There may be a requirement for increased levels of care – whether in care homes or in people's own homes – where individuals have suffered from COVID-19 and their longer term care needs are more acute as a result.

2.20 A number of other important support services have been affected by COVID-19. For instance, Trust day centres and respite services have generally stopped. The staff and resources associated with those services have been redirected to provide more intensive support to families in their own homes. Trusts are currently discussing how services can be restarted in a way that provides much needed support and respite but also minimises infection control risks.

Vulnerable Children

2.21 The lockdown regulations and public health restrictions have created new, or exacerbated existing challenges and risks for many vulnerable children, young people and their families. Children and young people are potentially at a greater risk of harm in the home, as evidenced by increased domestic abuse rates. They are also exposed to risk from outside the home, including the risk of online grooming and exploitation. Lockdown restrictions have created a

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

range of pressures, including financial pressures. Many families, including those with a child with a disability or complex health problem, are not able to access the same level of support from services as pre-lockdown. Access to health services has been more limited and school closures have created particular challenges for families as they try to balance home life and online learning. Families are more isolated, prevented from accessing the support of wider family networks. Children generally have been less visible than before and this was reflected in a reduction in the number of referrals in the early stages of the pandemic. However, the number has steadily increased over time and now exceeds the number received during the same period last year; this is likely to be as a result of building pressure and challenges within the family home.

2.22 Since the introduction of stay at home policy, leading to school closures, there has been a shift in the source of referrals. Referral sources (from three HSC Trusts for which we have information), show half (47%) are from police, compared with 31% in year ending 31 March 2019. Referrals from schools are down from 9% to 1%.

2.23 Throughout the period Social Services Gateway Teams have continued to operate in line with normal operating arrangements and statutory duties, maintaining contact with families, using technology where face-to-face visits were not possible. Social Work Managers have closely overseen all cases to ensure appropriate risk assessments were carried out, taking full account of public health advice and guidance relating to COVID-19.

2.24 It is anticipated and evidence is beginning to emerge that that the prolonged period of lockdown will result in increased demand for children's social services.

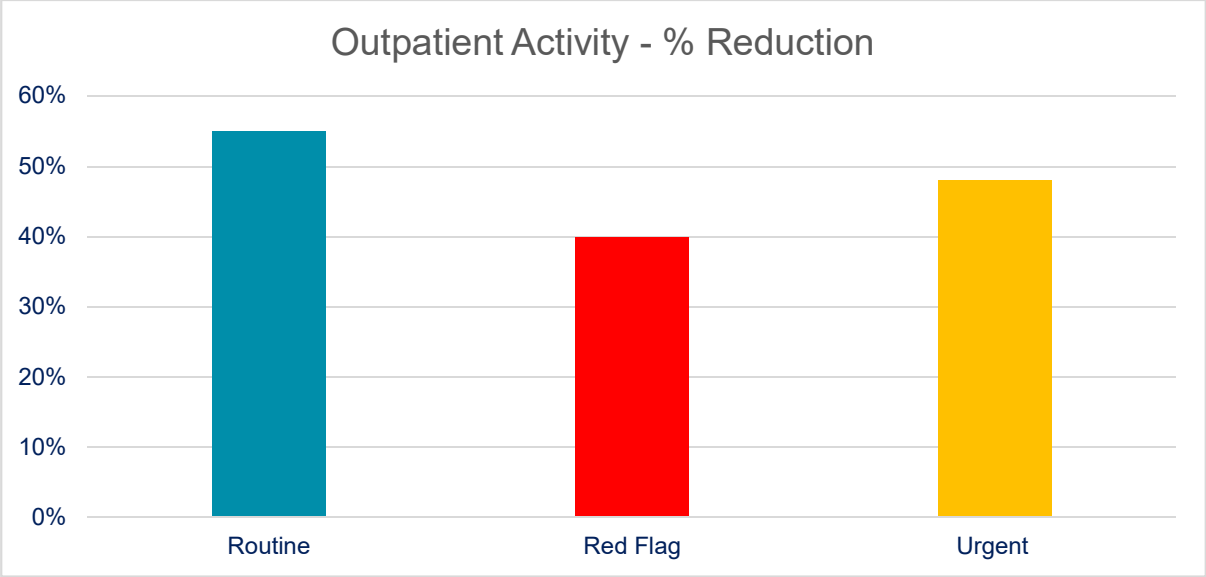
2.25 The Department is leading on the development of a cross-departmental plan that reflects the activities that will be or have been undertaken across government to meet the needs of vulnerable children, young people and their families during this time and to prepare for service recovery.

Secondary Care

2.26 The pandemic has had a devastating short term impact on secondary care activity, particularly elective care. Figure 3 below shows the reduction in outpatient activity, compared to same 6 week period last year:

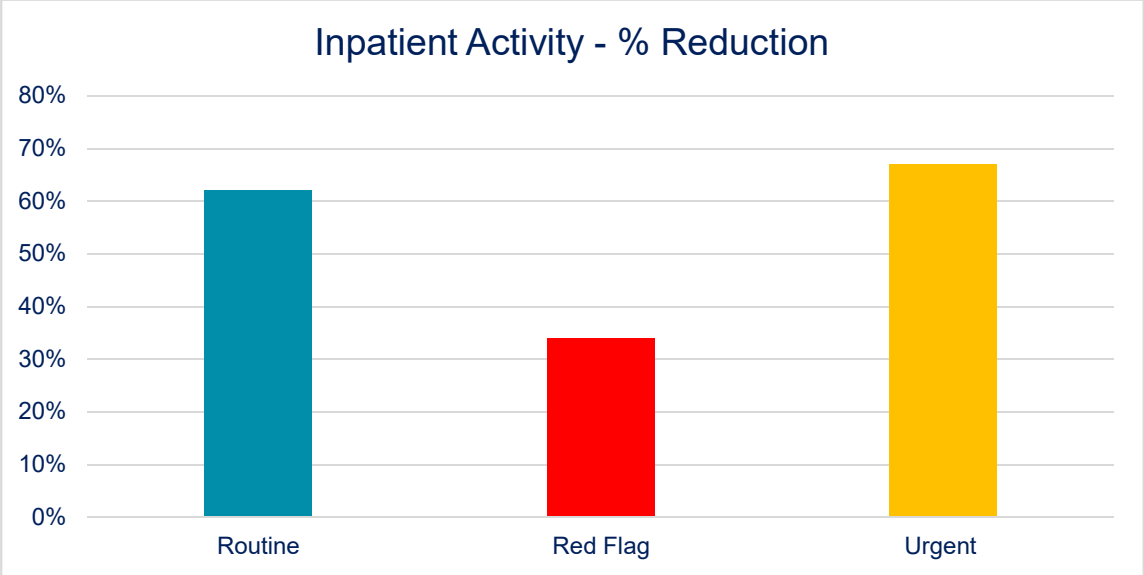
Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Figure 3: Reduction in Outpatient Activity 9 March – 13 April 2020



2.27 The situation is similar for inpatient activity, with severe reductions in activity compared to the same 6 week period last year:

Figure 4: Reduction in Inpatient Activity 9 March – 13 April 2020



2.28 The very significant downturn in secondary care activity has also, as expected, impacted on waiting lists (except for the urgent inpatient waiting list, which has reduced marginally compared to 1 April 2019). As of 1 April 2020, compared to 1 April 2019, waiting lists were impacted as follows:

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

- Routine inpatient waiting list grew by 5%.
- Urgent inpatient waiting list grew by 31%.
- Routine outpatient waiting list grew by 4%.
- Urgent inpatient waiting list reduced by 1%.

2.29 Projections by the Trusts suggests that the 6 weeks to June resulted in similar reductions in activity. This will further impact adversely on the waiting lists. Also, since the latest available comparable waiting list data is as of 1 April, waiting lists will already have increased in the intervening period.

2.30 Urgent and Emergency care has also been impacted with a 47% reduction in Emergency Department activity across Northern Ireland, compared to the same period in 2019 (9 March – 13 April).

Cancer Services

2.31 The down turn in red flag demand through April and into May means that all Trusts outside of Belfast currently report that all patients who are suitable to be listed for surgery have a scheduled date, either locally, or within the Independent Sector facilities secured by HSC. However, red flag demand is starting to increase again and this will result in an increase in the demand for surgery.

2.32 The development of the Nightingale Hospital on surgical and ICU capacity across the Belfast Trust has inevitably impacted on specialist surgical provision. The Belfast Trust has introduced measures to mitigate against this. The Belfast Trust recommenced specialist surgery w/c 25 May 2020 in Belfast City Hospital now that the Nightingale Hospital has been stood down.

Programmes and Projects

2.33 COVID-19 has curtailed a large range of projects and programmes across the Department, as staff have been redeployed to manage the pandemic. Of particular note is the impact on delivery of the priorities set out in the New Decade New Approach document. These are summarised below:

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Table 1: NDNA Priorities

NDNA Priorities	Risk Rating Anticipated delay in Delivery
Extend publicly funded IVF Cycles from 1 to 3	Amber
Develop Cancer Strategy by December 2020	Red
Improvements will be made in day case elective care by the end of 2020	Red
Improvements will be made in Urgent and Emergency care by the end of 2020	Red
Improvements will be made in stroke by the end of 2020	Red
Improvements will be made in breast assessment by the end of 2020	Red
Deliver reforms of health and social care as set out in Bengoa, Delivering Together and Power to People Reports	Amber
Mental Health Action Plan within 2 months.	Green[3]
Mental Health Strategy by December 2020.	Red
Successor strategy and action plan to the Strategic Direction for Alcohol and Drugs Phase 2?	Amber
An extra 900 Nursing and Midwifery undergraduate places over three years	Green
Introduce a new Action Plan on Waiting Times	Red
No one waiting over a year at 30 September 2019 for outpatient or inpatient assessment/treatment will still be on a waiting list by March 2021	Red
Build capacity in general practice through the ongoing rollout of Multi Disciplinary teams to cover a further 100,000 patients by March 2021.	Amber
The Executive will provide increased investment to fully implement service improvements for palliative and end of life care including enhancing the contribution of hospices; and to increase support for palliative perinatal care.	Red
The Executive will expand university provision at Magee in line with commitments made by the previous Executive, including through the establishment of a Graduate Entry Medical School.	Amber (from DoH perspective cross cutting issue)

Key: Red: High Risk of Delay; Amber: Medium risk of delay; Green: On target for delivery.

[3] Mental Health action Plan published on 19 May 2020.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

2.34 As well as recognising the impact of COVID-19 on these projects and programmes, it is also important to record that the Department's Budget 2020/21 outcome did not provide any additional funding to support the delivery of these priorities. Public expectations were raised considerably by the New Decade New Approach document, but the accompanying financial settlement did not provide the funding necessary to deliver these priorities.

2.35 The ability of the Department to re-engage and deliver on these projects will continue to be constrained against the backdrop of COVID-19 and in the absence of additional funding.

Population Health Impacts

2.36 The introduction of the lockdown regulations was essential in controlling the spread of COVID-19. However, they have impacted on the wider economic and social environment, with both long and short term impacts on population health. Emerging research indicates that population health is highly likely to be negatively affected by the wider impacts of COVID-19, with the greatest effects felt by the most disadvantaged. There is emerging evidence that many key health behavioural risk factors, such as consumption of alcohol, are likely to be worsening. In addition, public health surveillance has been disrupted and emerging evidence also suggests that the disease burden from conditions such as mental health is already rising. The development and management of long term mental health conditions is also likely to be negatively affected.

2.37 The Department commissioned an initial analysis of the wider impacts of COVID-19 and the associated regulations on population health outcomes. This has been supplemented with analysis at the UK level. This analysis considered economic factors; reduced access to public sector services; interrupted access to social/family networks, and reduced access to other goods and services. While there are both positive and negative impacts of the regulations on wider public health, overall the analysis suggests that the net effect of the measures (excluding direct COVID-19 related mortality and morbidity) is negative. There is comparatively little research into the longer-term health impacts of economic crises. However, it is widely observed that structural changes and/or deep economic downturns tend to have very strong impacts, mainly through deprivation, which can be very long lasting. The literature also points to long term impacts on chronic disease prevalence due to recessions.

2.38 It is therefore likely that any growth in life expectancy will stall and perhaps even flatten in the wake of COVID-19. In terms of the social determinants of health, there are likely to be negative impacts on poverty, employment, economic security, and potentially educational attainment. The impact on housing and

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

social capital is unclear at this stage. There are likely to be positive impacts on air quality and water quality, which will counterbalance some of these impacts.

2.39 There have also been changes emerging in terms of health related behaviours, such as smoking, alcohol consumption, physical activity and road safety. While these impacts differ for each behaviour, again the net effect is likely becoming increasingly negative the longer the restrictions remain in place. The biggest negative impacts on disease outcomes are likely to be in respect of mental wellbeing and the development and management of long-term mental health conditions.

2.40 The analysis also highlights that the wider impacts of COVID-19 are likely to increase health inequalities, with those who live in the most deprived communities most at risk.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

3. MISSION

3.1 The impact of the pandemic across HSC services, programmes and projects has been devastating, as resources have rightly been focused on the required emergency response. COVID-19 will be with us for some time and will continue to constrain service delivery across the HSC sector. In that context, the following mission statement will apply as an overarching principle:

To incrementally increase HSC service capacity as quickly as possible across all programmes of care, within the prevailing COVID-19 conditions. The aim will be to maximise service activity within the context of managing the ongoing COVID-19 situation; embedding innovation and transformation; incorporating the Encompass programme; prioritising services; developing contingencies; and planning for the future all at the same time. Specific service activity targets will be developed for each programme of care.

3.2 The remainder of this document sets out a road map on how this mission will be achieved. Service innovations that have emerged in recent months are set out in Section 4. In addition to those innovations, the intention is to, where possible, incorporate 'quick wins' from the transformation programme that had been gathering pace until the pandemic emerged, with the purpose of increasing service capacity. It will also be important that the ongoing Encompass programme is at the heart of rebuilding services.

3.3 Section 5 sets out the overarching approach to developing service stabilisation plans, with the aim to maximise activity in the context of the constraints and issues that COVID-19 presents. This will lead to incremental service activity plans and targets being developed for each programme of care / specialty to be updated in three monthly cycles for the period June 2020 to March 2022. If possible, the planning cycles will be extended if the prevalence of COVID-19 in the community improves. Section 5 also includes information on the regional approaches taken to treating COVID-19 patients; guidance on prioritisation of surgery; and the Testing Strategy, amongst other things.

3.4 Section 7 presents some early example demonstrators indicating what service delivery might look like in the next three months. These demonstrate that services will only be able to be switched on slowly and incrementally. Given the huge amount of uncertainty around the continued spread of the pandemic, it is only considered feasible to take a 3 month planning horizon at this stage.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

4. SERVICE INNOVATION

4.1 The emergency response across primary, community and secondary care services has resulted in innovative new practices that could potentially be mainstreamed as normal services are resumed. Innovation has emerged across all services and some examples of these innovations are described in this section.

4.2 Embedding recent innovations, along with transformation activities already underway, into service delivery will be an important strand in achieving the mission set out in Section 3 above.

Primary Care

COVID-19 Centres

4.3 Eleven Primary Care COVID-19 Centres have been established across Northern Ireland. Between 9 April and 6 May 2020, GP practices dealt with 23,441 COVID-19 related queries. A total of 3,702 patients who contacted their GP, or out of hours service, were triaged and referred to one of the COVID-19 Centres. 75% of these patients were provided with advice on self-management; 15% were referred to secondary care; and 10% were referred to other services.

4.4 The COVID-19 Centre model has been successful in separating Covid and non-Covid services, reducing the risk of infection and allowing GPs to protect and continue a range of ordinary primary care services such as vaccinations. The COVID-19 Centres have also proved highly effective in dealing with a high level of demand and in effectively triaging and advising patients. This has undoubtedly reduced pressures on our Emergency Departments.

4.5 In view of the potentially lengthy timescales before a vaccine is available, it is likely that COVID-19 Centres will continue to be needed in the short to medium term. However, some changes in configuration may be required in response to the emergent contours of the pandemic. Given the clear benefits of the approach, consideration will need to be given to what can be learned from the model and what elements ought to be retained to support longer term transformation of the HSC. In particular, the effectiveness of the primary care partnership with HSC Trusts and the benefits of greater joint working and resource sharing between primary and secondary care.

4.6 The model has also demonstrated the value of an independent, federated primary care sector. With strong leadership from the Health and Social Care Board (HSCB), the British Medical Association (BMA) and the Royal College of General Practitioners Northern Ireland (RCGPNI), GPs were able to move quickly to establish and operate the COVID-19 Centres. The first centre

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

opened within 12 calendar days of the first discussion of the potential for the model. This swiftness was made possible by active and committed leadership in the sector capable of bringing GPs with them.

4.7 The Department and HSCB will now consider the future use of COVID-19 Centres in discussion with BMA and RCGPNI.

Telemedicine / Video Consultations

4.8 The use of telephone triage and video consultations is now widely embedded within the primary care sector. All patients are now subject to telephone triage for around 5 minutes. Whilst exact figures are not available, it is clear that this triage addresses issues for a significant number of patients, thereby reducing numbers needing a more detailed consultation. This consequently reduced pressures on GP surgeries. The outcome has delivered a transformational impact and there are therefore clear benefits to continuing this operating model.

4.9 Video consultations, which were previously only carried out in very low numbers, are now also widely embedded within the service. Where a face-to-face appointment is not necessary, video consultations provide a more efficient model of GP to patient contact and the widespread use of technology should be incorporated into the service going forward. It is recognised that for some patients, face-to-face consultations remain the most appropriate model and will be retained in those cases. Looking ahead, there is also the potential to use this technology to work more closely with secondary care, for instance with video consultations between patients, GPs and hospital specialists.

4.10 The primary care sector will now consider the continued and expanded use of telephone and video technology in delivery of GP services. The sector will also consider ways to integrate more effectively with other sectors.

4.11 Face-to-face interpreting involving deaf service users also virtually stopped except in very exceptional cases. By way of mitigation, a new temporary free remote interpreting service for British Sign Language (BSL) and Irish Sign Language (ISL) users to access NHS111 and HSC services was procured. This was funded by the Department with support from the Department for Communities and ensures that deaf people can access vital information and support during the COVID-19 pandemic.

Multidisciplinary Teams (MDTs)

4.12 During the pandemic, MDTs including nursing, physiotherapy, mental health practitioners and social workers have emerged as an essential part of the primary care response, delivering essential support to vulnerable people at a

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

time of extreme need in the community. Anecdotally, GPs report that access to these workers has demonstrated significant benefits for the wellbeing of patients and for the effective delivery of primary care services in relevant practices.

4.13 In view of the substantial mental health challenges that are evident, there is a strong argument that MDTs could form part of the recovery effort in this regard, bringing mental health support to the community level, accessible directly through GPs. As COVID-19 Centres have demonstrated, when properly resourced, primary care can successfully reduce demand on secondary care services. Indeed, more broadly, there is clear potential in the MDT framework to improve access to patients for a range of services and to further reduce demand on secondary care. On this basis there is clear merit in exploring the role that MDTs and primary care could play in reshaping the system during the rebuilding phase.

4.14 The primary care sector will be asked to produce proposals for the role of MDTs in the future delivery of health services.

Allied Health Professional (AHP) Workforce

4.15 During the pandemic the value of skill mix and staff working at the top of their professional licence in advanced and extended roles has enabled primary and secondary care services to be responsive to the emerging complexity and volume of demand. There is clear potential to extend the role and scope of advanced nurse practitioners, specialist AHP's and consultant nurse and AHP roles to maximise the capability and flexibility of the workforce to aide rebuilding of services.

Pharmacy

Community Pharmacy Services

4.16 Community pharmacies adapted their working practices and many introduced technology to streamline prescription ordering and collection services and reduce waiting times for patients. A new emergency supply service was introduced which provided access to prescription medicines in the event that a patient had run out of their repeat medicine and they could not access their GP. Pre COVID-19, this would have been a key component of the GP Out of Hours Services workload. An enhanced on-call palliative care medicines service was also provided to support end of life care for patients at home and in care homes. To manage some of the demand on pharmacies for medicines deliveries, the HSCB worked with the Community Development Health Network to incorporate the use of volunteers to support deliveries of medicines from pharmacies. By

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

the end of May a total of 252 pharmacies and 120 community groups had registered for the scheme and over 33,000 prescriptions have been delivered by volunteers registered on the scheme.

Pharmacy Services in Trusts

4.17 Pharmacists and pharmacy teams in Trusts adapted their working practices and introduced new and innovative solutions to ensure that their patients received the right medicines, safely and effectively. This included a wide range of initiatives across all sectors, developed in collaboration with a wide range of stakeholders.

4.18 In Intensive Care, clinical pharmacists and clinical technicians joined their colleagues in critical care teams. Aseptic services in hospitals produced batch IV medicines to meet rising demand. Processes for the standardisation of critical medicines and a dedicated COVID-19 Kardex were introduced. Trusts skilled up their clinical pharmacy teams to provide seven day services. Pharmacists used technology to hold virtual clinics to maintain contact and support for patients taking specialist treatments including anticoagulants, ESA, chemotherapy and rheumatology. Renal transplant education for carers was provided for 42 transplant patients via Zoom. Specialist medicines home delivery systems, using Trust transport, were implemented to ensure that patients in high risk shielding groups received their treatment without interruption. Rapid sequence induction packs were introduced in ED and changes introduced to addiction services and to introduce in-possession medicines in prisons.

4.19 New regional systems were established to model and monitor critical healthcare supplies essential for the COVID-19 response including critical care medicines, oxygen and clinical consumables. Victoria Pharmaceuticals worked with the HSCB to supply medicines to COVID-19 and Out of Hours Centres. New systems were developed to monitor stock remotely and conduct stock checks in COVID-19 Centres and action cards and standard operating procedures for medicine management were established.

Pharmacy support for care homes

4.20 Pharmacy teams from the HSCB implemented a system to provide anticipatory care boxes to care homes for palliative care and to provide increased access to oxygen. Consultant pharmacist team members in Trusts joined with practice based pharmacists to participate in virtual ward rounds for care homes. Training sessions were provided by pharmacists to care homes staff on swallowing, pandemic packs and palliative care. Trust pharmacy teams supported the

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

establishment of the community hospitals at the Ramada and Everglades hotels.

Ophthalmology

4.21 Ophthalmology is a high volume specialty and one which is particularly susceptible to demographic pressures. As a specialty it currently accounts for 10% of all outpatient appointments, and, in elective care, cataract surgery is the highest volume surgical procedure in the developed world, and one which scores highly in terms of quality of life benefits. COVID-19 has given an opportunity for ophthalmology teams to take forward significant innovations such as:

- reviewing care pathways;
- reviewing referrals and patient notes;
- carrying out risk assessments and prioritisation in preparation for re-engagement of services;
- validating waiting lists, discharging where appropriate; and
- a move to virtual video and telephony consultations where possible.

4.22 Throughout this process ophthalmology has focused on its communications with patients, with many being contacted by telephone to discuss concerns and arrange appointments as required. Approximately 75% of urgent appointments were converted to telephone or video reviews. A video was produced to inform patients of safe practices in the Macular Unit to encourage attendance, as most patients are at increased risk due to age and diabetes. The short video clip, which has been shared on social media, reassures patients attending appointments about the measures put in place to best protect patients attending the unit.

4.23 The Belfast Trust Cataracts Team has maintained approximately 15% of cataract surgical activity through Lockdown, focused on patients most in need. This allowed the service the opportunity to test the cataract surgery pathway in the COVID-19 climate. The diabetic eye service has continued to provide treatment (laser and injection) appointments for the most urgent of patients at high risk of irreversible sight loss.

4.24 The Belfast Trust identified hundreds of review patients on glaucoma waiting lists who required only a check of their intraocular pressure. The Trust wanted to offer patients a way of getting their pressure checked without needing to attend the clinic. They developed the concept of a ‘drive thru’ where the patient gets a pressure check with the new ICare device whilst they remain in their car.

4.25 During the COVID surge, the Paediatric Eye Team ran all day clinics and accepted all paediatric eye emergencies from A&E. Across ophthalmology the

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

focus is now on incrementally rebuilding services taking account of the constraints arising from COVID-19 and ensuring that the new and innovative practices are permanently embedded.

Secondary Care

Use of Technology

4.26 The secondary care sector has, like primary care, now adopted use of technology such as telephone and virtual clinics to a much greater extent. This is the case across all of the Trusts and across a range of specialities. Within Belfast Trust, for example, Outpatients appointments have, where possible, moved to telephone appointments, consultations and essential communications. Before COVID-19 phone appointments accounted for 3% of new, and 2% of review, outpatient appointments. The comparable figures now stand at 36% and 46% respectively. Also within Belfast Trust the number of specialties using telephone clinics has increased from 25 to 55. In addition, a growing number of specialties are adopting virtual clinics using video conferencing. This approach to use of technology is replicated across the HSC Trusts.

4.27 Broadly the benefits of these technology models include reduced travel time and easier access to services for patients; less time spent in hospital for patients; and more flexible working and timetabling for staff. Technology should continue to play a significant role in the delivery of secondary care, where possible and appropriate. It will be important that clear criteria are adopted identifying which patients are suitable and the circumstances in which virtual or telephone clinics are appropriate.

4.28 Some of the early experiences of using technology suggests some issues such as withheld numbers or patients not answering. It will be important to collect data on these issues to ascertain if missed appointments are more prevalent using technology than face-to-face.

4.29 Trusts must now consider the continued use of technology in delivery of secondary care services, where appropriate.

Social Care

4.30 Many adult social care services have adopted new and innovative ways of working. For instance, care homes have made use of technology to connect residents with their families, through video-calls, and to enable 'virtual ward rounds' by GPs or other professionals with care homes residents. This has helped limit the physical footfall in and out of homes. The use of technology to monitor vital signs and residents' activities of daily living via a digital remote monitoring platform is being implemented by all Trusts. The identification of

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

residents requiring timely clinical assessment by a Registered Nurse or Doctor at an early stage is a key step in minimising the numbers of residents who clinically deteriorate in residential settings with presentations of COVID-19.

4.31 Many care homes have adopted innovative new ways of working, such as staff living in homes or creating separate changing areas as ways of trying to minimise the spread of infection. Homes have also been innovative in running activities for residents, while complying with social distancing rules.

Mental health

4.32 Mental health services have, like many other services areas, adapted to remote working, with extensive use of phone services and video communication. There are some indications that the use of remote working has improved efficiency of services, which may help reduce waiting lists post COVID-19. Further work is ongoing to evaluate this.

4.33 Other alternative methods have also been used. The HSC has partnered with ORCHA (The Organisation for the Review of Care and Health Apps) to create a library of health and wellbeing apps that have been reviewed and rated as helpful, safe and secure. As the library develops it will allow clinicians and wider professionals to "prescribe" and allocate apps to clients as appropriate.

4.34 Stress management support has also been provided using alternative channels, through Stress Control. This is a clinician-led service, available free of charge online through a collaboration across the UK nations and Ireland. It comprises of a six-session, cognitive-behavioural therapy class and is available free of charge. It runs over three weeks with two sessions a week. Work has also been escalated to develop and make psychological first aid available across Northern Ireland. The HSC has, in collaboration with the Red Cross and NHS Education Scotland, made available interim guidelines and a short E-Learning module on Psychological First Aid.

4.35 Subject to funding, Multidisciplinary Teams (MDTs) could enhance their focus on delivering mental health services to help meet the need emerging in the post lockdown period. MDTs provide direct, swift access to community services and could, if properly resourced, provide early access through general practice to mental health support and other related services. This could take the form of increased recruitment of mental health workers and social workers; better connections with community services; social prescribing; and developing shared services with secondary care; for example, Talking Therapies Hubs. Such an approach would both provide direct access to mental health services to meet the anticipated surge and would divert demand away from more specialist secondary services for those with more acute mental health issues.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

4.36 As part of the COVID-19 Mental Health Response Plan published on 19 May 2020, review mechanisms will ensure that learning from alternative ways of working will be incorporated in service developments moving forward.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

5. INCREMENTAL SERVICE CAPACITY PLANS

Overarching Approach

5.1 All HSC service providers will adopt a systematic and consistent approach to developing service specific incremental plans to increase capacity, under the auspices of this Strategic Framework. This will involve mandating the wide range of existing managerial clinical networks, project boards, task and finish groups or other service improvement vehicles to produce service specific incremental plans for their respective areas on an integrated and coordinated regional basis.

5.2 This will be achieved by reviewing the existing patient pathways, applying a range of COVID-19 factors (as summarised in the Checklist below) and producing revised patient pathways to implement rebuilding of services within the context of prevailing COVID-19 conditions.

5.3 The revised pathways will address the checklist considerations set out below and will produce revised activity levels for service providers to aim to deliver. The initial set of activity levels will cover the 3 months from July to September 2020. It is not considered feasible, at this stage, to produce plans beyond a three month planning period.

Checklist

5.4 A range of factors are likely to apply in the consideration of revising pathways and activity levels in the context of COVID-19. These are likely to include all, or some, of the issues set out below. Service providers must take account of all items that are applicable:

Communication with Patients

- Provide clear and consistent information to patients, clients and their carers, in an appropriate format, to reassure them that services are of the highest possible quality and they can re-engage with health and social care with confidence.

Staff Involvement

- Ensure you have a consistent approach to meaningful involvement of staff in developing solutions and in decisions which affect their working lives.

Working Environment Risk Assessment

- Ensure that you have an up-to-date risk assessment of the holistic working environment (reflecting the interdependencies between different services) in

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

which you will be seeing patients, clients and individuals who accompany them. You must ensure that the risk assessment addresses the risk of COVID-19 to reduce risk to the lowest practicable level by taking preventative measures, in order of priority, recognising that you cannot completely eliminate the risk of COVID-19.

- If feasible and appropriate, share the risk assessment with your workforce and the public by placing this on your website.

Infection Prevention and Control Measures

- Assess the need and provide appropriate Personal Protective Equipment (PPE) for HSC staff, by following PHA guidance, required for screening, diagnostics, treatment and social care in all HSC settings.

- Assess the need and provide appropriate Personal Protective Equipment (PPE) for specific patient groups or individuals on a risk-assessed basis within the context of regional and national guidance on PPE and taking into account the regional electronic PPE Modelling system.

Social Distancing

- Adhere to the extant social distancing requirements within all screening, diagnostic and treatment/care settings across primary, community secondary and social care sectors.

- Assess the impact of constraints on physical space for service delivery, for both patients and staff, arising from social distancing requirements.

- Assess the requirement for patients to be accompanied, taking account of the procedure or service being accessed and the individual needs of the patient and put in place protocols for safe practice.

Workforce

- In line with the Workforce Strategy, protect and support the HSC workforce by taking action to ensure the care and resilience of staff working in all HSC disciplines.

- Induction and training should be provided for staff members whose working environment has changed or who are redeployed to areas outside their normal practice.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Planning Service Delivery

- Where possible an appraisal of patient waiting lists should be undertaken to re-evaluate clinical urgency, with those with the highest clinical need appointed as a priority. This should be taken forward on a regional basis as appropriate. Patients should be updated on the rationale for any delays to their appointment in an appropriate format and signposted to support/information in the interim.

- In the planning of screening, diagnostic and treatment/care service delivery in all settings across primary, community secondary and social care sectors, assess the risk of reduction in activity throughput arising from requirements for social distancing and PPE.

- In the planning of appointments in all settings take account of the requirements for social distancing in HSC premises and public transport.

- Assess the available capacity and timescales for the reintroduction of aerosol generating procedures (such as with minimally invasive surgical techniques) and the impact on theatre schedules, length of stay and waiting times; and, align these factors with PPE requirements.

- Planning for rebuilding HSC services should take account of the potential for a further significant COVID-19 surge during autumn/winter which, if it materialises, would impact adversely on rebuilding HSC services.

Diagnostic Services

- Take account of the impact of the additional demand for COVID-19 testing in Labs and its potential impact on the capacity for diagnostic testing for non-COVID-19 service delivery when planning scheduled elective treatment, primary and community care service delivery.

- Recognise that COVID-19 testing capacity is managed as a regional resource.

Medicines and Critical Healthcare Supplies

- Take account of constraints on the supply of critical care medicines in the UK that have the potential to impact on plans for recovery in elective surgery and other treatment interventions.

- Take account of how the public will maintain access to prescription medicines, treatments for common conditions and the advice of pharmacists through community pharmacies.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

- Consider how the public will maintain access to specialist pharmacy services, medicines and treatments e.g. palliative care.

Pre-admission to Hospital

- In planning elective treatment for patients who are being admitted to hospital, take account of advice to require patients to self-isolate beforehand and that they may need to be tested for COVID-19 prior to surgery.

- The timescales will be informed by national guidance (which is not a strict requirement but guidance for clinicians). Recognising that this is an evolving environment, service providers should take account of the latest guidance, advice and protocols on testing and isolation. Please note decisions should be taken on the prevailing balance of risk for the patient.

New Ways of Working

- Identify opportunities to embed, build upon and sustain innovations in service delivery achieved during the initial COVID-19 surge, including digital innovation and skills mix in order to increase resilience.

- Ensure the principles of co-production are embedded in the rebuilding of HSC services going forward, along with the monitoring of activity and outcomes for our service user and patients.

Expert Advice

- Take account of advice from subject cells or expert groups which provide ethical, modelling, testing, PPE and social distancing policies, assessments and guidance.

Ethical Advice and Support Framework

- Guidance will be available to assist clinicians and managers in their decision making.

Discharge to Nursing or Residential Setting

- Take account of COVID-19: Guidance for Nursing and Residential Care Homes in Northern Ireland (April 2020) with reference to discharge, testing and isolation.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Testing Strategy

5.5 On 27 May 2020 the Department published its contact Tracing Strategy[4]. This Strategy aims to minimize COVID-19 transmission in the community, thereby saving lives.

5.6 The Department is also developing a Testing Strategy, which aims to reduce harm to individuals from COVID-19 and to support measures needed to protect the general population. Delivery of the Strategy is underpinned by an Interim Protocol on Testing, this is an operational tool which sets out the priority groups for testing. The protocol is subject to regular review by the Department's Expert Advisory Group on Testing and each update is cascaded to HSCB, PHA and Trusts. Service providers should deliver services taking account of testing priorities established in the Interim Protocol. The Protocol will continue to be reviewed on an ongoing basis and will be adjusted over time as additional testing capacity becomes available and as priorities for testing change as the pandemic evolves.

Co-production

5.7 It will be important that the incremental service rebuilding plans are developed through the application of co-production principles as far as that is possible. The speed at which these plans will need to be developed and adapted will undoubtedly act as a constraint on applying full co-production principles. However, where at all possible, service providers should engage in a timely manner as widely as possible in the development of their incremental service plans.

[4] https://www.health-ni.gov.uk/sites/default/files/publications/health/Test-Trace-Protect-Support-Strategy.pdf

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

6. IMMEDIATE PRIORITIES

6.1 It is recognised that developing the incremental service plans will take some months. However, there is a need for immediate action in terms of increasing normal HSC service delivery. HSC Trusts have already commenced, where possible and safe in the COVID-19 context, the scaling up of services. HSC Trusts have produced and published plans for scaling up services in the period to 30 June to ensure action is taken in parallel with development of the incremental service plans. In developing the short terms plans, Trusts had regard to the above Checklist.

6.2 Further service rebuilding plans will then be produced covering successive three month periods from July 2020 to March 2022. These three month planning cycles will be kept under review and may be extended if the prevalence of COVID-19 in the community improves.

HSC Trusts Rebuilding Plans

6.3 The initial phases of COVID-19 significantly changed the level of service that Health and Social Care Trusts ("Trusts") were able to provide, both in order to prepare for the predicted demands of the pandemic, and in order to adapt to the new ways of working necessary to sustain services. As a first stage in developing the new Strategic Framework for Rebuilding HSC Services, Trusts have produced plans setting out how they intend to increase the level of service provision for the period to 30th June while also maintaining key elements of the COVID-19 response.

6.4 In developing their plans, HSC Trusts have adopted the following three principles:

- Ensure equity of access for the treatment of patients across Northern Ireland.
- Minimise the transmission of COVID-19.
- Protect access to the most urgent services for our population.

6.5 While there is some unavoidable variation of approach depending on local circumstances, Trusts have worked together to ensure that they take a consistent approach to rebuilding services. For all Trusts, the overriding priority is to keep patients, service users, and staff safe at all times while incrementally increasing activity.

6.6 During the first surge period, Trusts took steps to prioritise urgent or time critical activity in terms of both surgery and other cancer treatments, and other urgent conditions. As we move into the rebuilding phase, Trusts will continue to see and treat patients according to clinical need and services will be prioritised on this basis.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

6.7 Similarly, in relation to daycase and diagnostics, including endoscopy, Trusts have prioritised inpatient, urgent and red flag investigations across all sites. Patients falling into these categories will continue to be the priority, but all Trusts are also increasing scheduled routine activity for daycase and diagnostics, albeit with reduced capacity due to infection control constraints.

6.8 All Trusts have maintained full access to urgent and emergency care services throughout the pandemic. Some of the short term service models introduced to allow Trust to do so will need to remain in place to allow Trusts to deal effectively with COVID and non-COVID activity. Further details can be found in individual Trust plans.

6.9 Across Trusts, some of the services that have been hardest hit have been those dealing with mental health, learning disability, and long term condition management for children and adults. Each organisation is therefore taking steps to increase provision or introduce new ways of working to allow these services to recommence. Trusts are also prioritising services relating to Looked After Children and Child Protection visits. In all cases, it is likely that continuing to deal with COVID-19 will continue to impact negatively on overall capacity.

6.10 In all Trust areas, staff have adopted and embraced new ways of working that have allowed them to maintain more of their professional and service roles with their patients and service users. In many cases, these changes have been technology enabled and have reduced the need for face to face contact while delivering safe and effective outcomes. The learning and sharing of best practice from these initiatives will help the service to maintain and increase activity in the coming months and years.

6.11 Further detail on the Trusts priorities to resume services in the immediate term is set out in their respective plans, published concurrently with this Strategic Framework.

Planning for a further potential COVID-19 Surge

6.12 Early in the preparations for the initial surge period, it was necessary to make assumptions about the percentage of hospitalised patients in different age bands who would be admitted to critical care. At this stage the best available modelling showed a significant increase in demand for hospital capacity and, potentially, a catastrophic impact on critical care. Acute service planning therefore focused on the rapid expansion of critical care and hospital capacity to ensure that every patient requiring treatment would receive it.

6.13 During the course of the epidemic clinical practice in relation to COVID patients has evolved and additional data have accumulated. It has become apparent that a smaller percentage of hospital patients are admitted to critical care, particularly in older age groups, than was originally assumed. Based on the

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

experience of Wave 1 it will be possible to refine the modelling to account for this in the event of any further waves.

6.14 Outside the hospitals, while there was a focus on planning for the impact of COVID-19 in care homes from the early stages of the pandemic, protecting care homes has been a significant challenge for the system as a whole. While significant support has been provided to care homes, this is clearly an area that will continue to be a priority for further waves and where we will need to redouble our efforts.

6.15 It is expected that there will be a second wave of Covid-19 later in the year. At this stage, the timing and scale of a 2nd wave is unpredictable as it will depend on a range of factors, including the future approach to social distancing and population adherence to these measures.

6.16 However, given that a 2nd wave could potentially coincide with colder weather and winter pressures, it will be important that there are detailed surge plans in place for critical care, hospital beds and care homes. The Department is currently carrying out detailed work to model the possible capacity requirements in these areas in range of scenarios.

6.17 In planning for a second wave, there will also be significant focus on the system maintaining higher levels of non-COVID services while ensuring that there is sufficient capacity to treat every COVID patient appropriately.

Managing planned Non-Covid-19 services in hospital settings during COVID-19

6.18 The HSC has made enormous efforts to create additional surge capacity for the first wave of COVID-19 patients. As a result of these efforts, every patient requiring treatment for confirmed COVID-19 has been able to receive it.

6.19 However, the challenge that our health and care services now face, as we move into this phase of response to the pandemic, is how to maintain the capacity to provide care for patients with COVID-19, while simultaneously increasing other urgent clinical services, important routine diagnostics and planned surgery.

6.20 As we increase the amount of planned activity in hospitals over time, we will adopt the following principles:

- The HSC will immediately start to step up services on a prioritised basis while maintaining the necessary level of care for COVID-19 patients;
- Patients across Northern Ireland should have equitable access to specialist services according to their clinical need;

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

- In order to minimise the risk of infection, COVID-19 patients and staff providing care to them should be separated from non-COVID patients and staff where possible;
- The volume of planned activity to be delivered will align with other dependencies such as testing capacity, medicines supply, and PPE.
- The HSC will need to retain the capacity to quickly repurpose and 'surge' capacity if required.

6.21 As we increase the amount of planned activity, one of the key objectives must be to minimise the transmission of COVID-19 infection within hospitals, also referred to as hospital-onset infection or nosocomial transmission.

6.22 All Trusts have taken steps to put in place effective safe zoning plans in order to maintain safety of patients and staff on sites where elective care is delivered alongside urgent and emergency care. Where possible, we will also consider the possibility of physical separation of staff and patients delivering planned care from those dealing with unscheduled care.

6.23 Prior to the pandemic, the Department had been progressing the development of a regional network of elective care centres. The essence of these centres was to organise specialised procedures on a smaller number of hospital sites, completely separated from urgent and emergency care. The main benefits of this approach were considered to be: staffing resilience; productivity; standardisation of care; reliability and efficiency; and, better patient experience and equity of access.

6.24 Many of these factors are equally, or even more, important in the context of the ongoing pandemic. Furthermore, if there is a second wave of COVID-19 cases, the creation of dedicated elective care centres would facilitate the continuation of some planned activity even in the face of increasing demand for COVID-19 treatment. Through the first wave of COVID-19, the HSC has also used independent sector facilities to increase capacity to maintain the most urgent planned care. The Department is now considering how best to utilise the independent sector facilities in rebuilding health service capacity.

Prioritisation / Delivery of Health Services

6.25 It will continue to be important that hospital services are prioritised to ensure that treatments that have the highest impact on reducing mortality and morbidity are prioritised. The overriding principles that will continue to apply are that patient safety is paramount and that equity of service across Northern Ireland must be ensured as far as possible. The development of service plans on a regional basis will encourage equity of provision across Northern Ireland.

6.26 Clinical teams are skilled at making complex decisions about patient prioritisation on a daily basis, in the context that they find themselves in.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

COVID-19 will continue to impose significant constraints and clinical decision making will therefore need to adapt to circumstances as they change. In taking decisions, clinical teams should have due regard to the NHS England / Royal College of Surgeons specialty guide[5]. In addition, the Royal College of Surgeons has recently published two COVID-19 toolkits: *'Safety considerations and risk assessment for patients and surgical teams'*[6] and *'Checklist for restarting elective surgical services'*[7]. Clinical teams should also consider these toolkits in their decision making.

6.27 Likewise the Royal College of Paediatrics and Child Health (RCPCH) has published guidance in respect of the reconfiguration and delivery of children's health services in the context of COVID-19: '*Reset, Restore, Recover - RCPCH principles for recovery'*[8]. Paediatric clinical teams should consider the principles set out in the RCPCH guidance.

6.28 Clinical teams should consider further guidance from professional bodies as it becomes available.

Cancer Services

6.29 COVID-19 has had a severe impact on a range of key cancer services. While emergency and urgent cancer services have continued throughout the surge, unfortunately, and out of necessity to reduce the risk of infection to both patients and staff, many procedures and diagnostic appointments have had to be postponed or delayed. These decisions are not taken lightly and will undoubtedly have an impact on waiting times for cancer treatment which are likely to persist for many months.

6.30 As part of the response to COVID-19 many patients' treatments plans have been modified to reduce the need for hospital visits and as a consequence the risk of infection; examples include measures such as the provision of hormone therapy or radiotherapy as an alternative to surgery, and the use of alternative drug regimens. When a decision is taken to delay diagnostics or modify treatment it is done so according to strictly observed and regionally agreed NICaN guidelines and on the basis of an individual assessment of risk / benefit. Trusts have put in place safety netting processes to ensure that any patients who has had a treatment paused or delayed resumes treatment on the appropriate pathway as soon as it is safe and possible to do so. Cancer waiting

[5] https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/C0221-specialty-guide-surgical-prioritisation-v1.pdf
[6] file:///C:/Users/1375921/Downloads/Recovery%20Toolkit%20Tool%201%20%20Checklist%20for%20restarting%20elective%20surgery.pdf
[7] https://www.rcseng.ac.uk/coronavirus/recovery-of-surgical-services/tool-2/
[8] https://www.rcpch.ac.uk/resources/reset-restore-recover-rcpch-principles-recovery

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

times guidance has been updated to reflect any changes to treatment pathways.

6.31 Work has now started to implement the reset of the full range of cancer services whilst taking into account the need for the HSC to respond to further Covid-19 surge(s) in 2020 and the existing capacity constraints in HSC. This work will be taken forward by the COVID-19 Regional Cancer Reset Cell. As part of our rebuilding programme, all patients across Northern Ireland will be prioritised in the same way and Trusts will be expected to work together in order to offer the earliest available appointment to a patient requiring diagnostics or surgery.

6.32 The Department recognises that the need to increase access to cancer services whilst minimising the transmission of COVID-19 infection within hospitals will require careful planning and organisation of services. Critical to this will be communication with the public and NICaN will continue to work with Trusts and third sector partners to ensure the provision of timely patient information.

General Dentistry / Ophthalmic / Other Allied Profession Services

6.33 The Department and the HSCB will work with the British Dental Association and Optometry NI to rebuild the services provided by General Dental Practitioners and General Ophthalmic Practices guided by the available medical and scientific guidance.

6.34 Likewise the Department and the HSCB will work with relevant professional bodies in respect of other Allied Health Professions such as physiotherapists, chiropodists etc. to rebuild services guided by the available medical and scientific guidance.

Adult social care

6.35 Across adult social care services there will be an important balance to be struck between protecting those who may be particularly vulnerable from COVID-19 and recognising the impacts this could have on their general health and wellbeing. The large majority of care homes have not had a COVID-19 outbreak and a key priority will be ensuring that this remains the case while considering how steps can be taken to facilitate engagement with families. Services such as respite and day care will need to operate differently than usual to manage infection control risks. Across adult social care there will need to be a separation of into groups of service users to try to minimise infection control risks, ongoing use of PPE and other mechanisms to minimise risks. This will include Trusts continuing to support unpaid carers, providing PPE when needed, and ensuring they have the support they need to continue providing

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

care. Sector specific guidance will be issued providing more details on the approaches to be adopted.

Children's Services

6.36 Regulations which provided flexibility in relation to the provision of services to looked after children during the pandemic came into operation on 7 May and, subject to flexibility continuing to be required, will expire on 7 November 2020. In addition, procedural changes have been implemented in children's services to take account of public health measures put in place to prevent the spread of infection. In some cases, this has promoted innovative service responses. A COVID-19 Childcare Support Scheme has been established to meet the childcare needs of key workers and to sustain large parts of the childcare sector forced to close as a result of reduced demand for childcare. Rebuilding planning is underway, which will align with the Executive's 5-stage plan and will be guided by up-to-date medical and scientific evidence.

Mental Health

6.37 Work is ongoing to consider both the safest and most effective ways to deliver services, building on emerging innovative approaches. In particular, consideration is being given to how to meet the challenge of the likely increase in demand for mental health services, linked to COVID-19 and recognising that very significant capacity challenges were faced by mental health services before the onset of COVID-19.

Workforce

6.38 The HSC workforce has been under significant strain during the pandemic and it will be necessary to consider the implications for staff with mental health issues, ensuring appropriate support.

6.39 It will also be important that proper induction and training is provided for staff members who are redeployed to areas outside their normal practice or working environment. Equally employers must ensure that proper risk assessments are carried out for all staff. This will include application of social distancing, to help avoid contact with COVID-19 wherever possible, and to manage that contact safely when there is no alternative. This should include particular risk factors for staff who are shielding; Black, Asian or Minority Ethnic; pregnant etc., and proper training for managers.

6.40 Early consideration must also be given to utilising learning from the COVID-19 response in relation to recruitment, resourcing and job banding. This will include a critical look at, and changes to be recommended in respect of, speeding up recruitment as well as proposals to develop a "reserve" of appropriately-qualified staff who can be called on in an emergency scenario.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Childcare and 7-day working patterns will also be considered. It will also be important to consider incorporating existing work on safe staffing, and agency and locum reduction within the rebuilding services agenda. It will also be important to provide clarity on means and timing of re-establishing pre-registration training and education.

6.41 Employers should engage with trade union representatives in a timely manner on all workforce issues.

Encompass Programme

6.42 The Encompass programme is the flagship digital investment that replaces ICT systems that are urgently end-of-life; supports regional reform initiatives; enables patient safety, quality and efficiency requirements; and supports the service in addressing rising demand within constrained resources.

6.43 Encompass working with Epic alongside frontline staff, operational management, and patients and carers, will implement a single Digital Care Record for every citizen, including a fully integrated patient portal. This will enable services to consolidate standardised digital workflows and revised patient pathways, naturally building on the integrated and coordinated regional basis for developing service incremental plans.

6.44 Encompass gives us the opportunity to develop the 'digital front door' to the HSC in terms of access, triage, support for self-care and even treatment; the urgency of which has been underlined by COVID-19. For example, using the Epic platform, NYU Langone Health[9] expanded video visits on March 2019 to all of its ambulatory care settings, reaching more than 7,000 visits within 10 days and representing more than 70 percent of total ambulatory care volume during this time.

Finance

6.45 The Department's budgetary position continues to be hugely challenging, with the Department facing a funding shortfall in respect of forecast inescapable pressures necessary to maintain existing services. Effectively, this means making difficult choices in the prioritisation of available limited resources to ensure we maintain safe services and achieve the best outcomes for citizens.

6.46 There are ever increasing demands on funding across a range of services. In addition, there are also delivery risks associated with the opportunity to lead on and make progress on significant savings targets across the HSC system in 2020/21. Inescapable cost pressures also exist across the Health Transformation programme. There have been significant additional funding requirements in our response to the unprecedented challenges of COVID-19;

[9] NYU Langone Medical centre is an academic medical centre located in New York, affiliated with New York University. The Medical Centre comprises the NYU School of Medicine and several hospitals.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

the Department has secured additional funding from the Executive to respond to COVID-19 and continues to liaise with the Department of Finance to secure further required funding. Rebuilding health and social care services, whilst simultaneously dealing with the ongoing COVID-19 pandemic will likely require additional resource funding. The incremental service plans will identify further funding requirements.

Capital Investment

6.47 From a capital investment perspective, the COVID-19 outbreak has seen a delay to many of our projects that were under construction, whilst others have been fast-tracked and repurposed to assist with the response.

6.48 With construction workers increasingly returning to sites, it is clear that the timescales for ongoing projects will be extended, not just because of the inherent delay but because the need for social distancing will reduce the number of people who can safely work on sites at one time. The impact of this will only become clear once work recommences and timeframes can be reassessed in the light of experience of working with these adjustments.

6.49 Similarly, plans for new developments have been delayed whilst staff across the HSC have been focusing efforts on the immediate needs of the pandemic. This work will now need to be reinvigorated and clear priorities set to ensure that our efforts are collectively applied to move key projects forward. This will enable us to make the best use of the capital funding we have in 2020/21 and to bring forward plans for 2021/22 and beyond so that we are ready to maximise the use of future allocations. The incremental plans will identify any further capital investment requirements.

HSC Governance

6.50 Given the unprecedented challenges posed by COVID-19 and in order to achieve the mission set out in Section 3, a number of changes to the governance framework will also be implemented. The Department, through temporary amendments to the Framework Document, and the establishment of a new management board, will give clear direction to the Health and Social Care Board (HSCB), Public Health Agency (PHA), Health and Social Care Trusts and the Business Services Organisation (BSO) to reflect the Minister's priorities. These revised governance arrangements are intended to be in place over the next two years to facilitate rapid decision making in rebuilding HSC services.

6.51 The rebuilding of services will take some time and will require a response that is both agile and adaptable to ensure the system can respond to further surges of COVID-19, whilst optimising its ability to stabilise and move forward. The HSC system will continue to be significantly constrained in the delivery of services due to the ongoing prevalence of COVID-19. In this context the

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

analysis of performance levels against pre-COVID-19 indicators and targets would be not be an appropriate basis for performance monitoring and management in the current environment.

6.52 The performance targets will therefore need to be reviewed by the Department to determine the optimum method for assessing the performance of Trusts in the delivery of services during the years 2020/21 and 2021/22.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

7. EXAMPLE PATHWAYS

Introduction

7.1 This section provides illustrative examples to show how the delivery of a number of key services may be impacted over the next three months. Each example describes the previous pathway, the new constraints and opportunities that need to be considered by service providers, the possible revised pathway and the anticipated activity in the three months period from July to September 2020.

Urology Red Flag Pathway

Previous Pathway

7.2 Red Flag referrals were previously triaged by a consultant and at time of triage the consultant would indicate what diagnostics would be required for the patient's visit. This clinical work up could involve a range of diagnostics including bloods, urinalysis, flexible cystoscopy, biopsy and ultrasound. The patient was then added to an outpatient waiting list where the wait for an appointment depended on the clinical priority of the patient.

7.3 At the start of the clinic, the clinical team would meet and discuss the treatment plan for each patient. The nursing staff would then see the patient and undertake the relevant diagnostic tests. The Consultant/Registrar would then see the patient, discuss the findings of the diagnostic test and discuss the treatment options and next steps. Often this would result in patients being added to waiting lists for treatment or sent for further diagnostic tests. Again this would result in a lengthy wait for the patient.

Key Constraints & Opportunities

7.4 The key constraints pertaining to the well-publicised risks associated with the COVID-19 pandemic and availability of capacity in all aspects of the pathway ultimately resulted in long waits and delayed diagnosis.

7.5 The availability of new technology, the willingness to embrace this technology and the challenges presented by the COVID-19 pandemic have provided the key opportunities to change the clinical pathway. The clinical team had already started adopting the virtual triage model and the embedding of this new pathway was reinforced further once traditional face-to-face clinics ceased due to COVID-19. The pandemic has also provided the opportunity for cross Trust working which is helping equalise waiting lists.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

The Revised Pathway

7.6 The new pathways were implemented in line with guidelines agreed and provided by the British Association of Urological Surgeons (BAUS). All new red flag referrals are reviewed via electronic triage by one consultant, with back-up during times of leave. The non-red flags referrals are triaged by other consultants within the team.

7.7 The outcome from this triage can result in the patient being sent direct to test or managed virtually using a telephone clinic slot. Where it is deemed that a patient needs further diagnostic tests, new pathways have been established to allow safe and accessible treatment.

7.8 *Cross Trust Working*- Working across Trust boundaries has continued to expand with teams working collegially to help reduce patient waiting times. Southern Trust patients are now being sent to the South Eastern Trust (SET) for their Transperineal (TP) biopsy, under anaesthetic. This work has been able to proceed as the SET TP machine has been set up in a separate clean unit which has allow elective procedures to continue in a COVID-19 free environment.

7.9 *Cross site Working*- The new pathways have been developed in response to the challenges presented by staff being redeployed to support ICUs and the risk of COVID-19 infection on the Craigavon site. Flexible Cystoscopies are now being undertaken in Daisy Hill Hospital following the closure of the day surgery units in Craigavon and South Tyrone.

7.10 *Results reporting* - Where possible, the consultant will now telephone the patient with their cancer results and this will be followed by a clinic letter. This new pathway helps reduce the waiting times for cancer results, avoid unnecessary outpatient attendances and reduce the risk of infection.

Anticipated Activity: 3 months to 30 September 2020

7.11 It is anticipated that the 'new' pathway will continue for the next number of months due to the need for social-distancing and reduction of face to face. This will have an impact on the waiting times of those patients who are not deemed as an urgent patient. It is planned that as staff become available to reopen day surgery facilities then more flexible cystoscopies can be carried out for those patients deemed 'less' urgent, and it is hoped that the SET will continue to facilitate the TP biopsies.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Introduction of Faecal Immunochemical Testing (FIT) for Suspected Bowel Cancer Outpatient & Colonoscopy Referral Triage

Previous Pathway

7.12 Patients with suspect bowel cancer 'red flag' symptoms are referred into Secondary Care from Primary Care according to the Northern Ireland Referral Guidance for Suspected Cancer (https://nican.hscni.net/wp-content/uploads/2019/11/NICaN-GP-Referral-Guidance-2019.pdf). Following consultant triage, patients would either attend outpatients or, if appropriate, be referred direct to test. NICE guidance states that colonoscopy is considered to be the gold standard for diagnosing colorectal cancer. CT colonography (CTC) can be offered as an alternative for people with comorbidities that make colonoscopy unsuitable.

Constraints and Opportunities

7.13 In response to the COVID-19 pandemic the British Society of Gastroenterology (BSG) developed guidance on 'GI Endoscopy Activity and COVID-19: Next steps – Updated 3 April 2020'[10] which advised stopping all non-emergency, non-essential endoscopy immediately. In addition, the majority of patients referred as a suspected cancer referral during COVID-19 are assessed virtually/by telephone.

7.14 Within NI there were already patients waiting for an outpatient appointment or for an endoscopy procedure / CTC having been referred by their GP for suspected bowel cancer. Given the constraints on endoscopy related to the response to the COVID-19 pandemic, there are grave concerns of long waits and delayed diagnosis of cancer.

7.15 Most outpatient red flags/urgent referrals will not have cancer. The current NICE guidelines are based on a Positive Predictive Value threshold of 3% for symptoms being caused by cancer. Following the guidance on stopping non-emergency colonoscopy during the COVID-19 pandemic, the British Society of Gastrointestinal and Abdominal Radiology (BSGAR)[11] produced guidance for patients requiring investigation for possible colorectal cancer. They suggest that under a 2 week wait referral pathway, patients should be risk-stratified using symptoms and faecal immunochemical (FIT) testing.

7.16 FIT tests are designed to detect small amounts of blood in stool samples using antibodies specific to human haemoglobin. They have been developed as an

[10] https://www.bsg.org.uk/COVID-19-advice/gi-endoscopy-activity-and-COVID-19-next-steps/
[11] https://www.bsgar.org/society/COVID-19-and-bsgar-updates-1/

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

alternative to guaiac-based FOB tests, but as the faecal immunochemical tests are designed to specifically detect human haemoglobin, they may give more accurate test results than guaiac-based tests.

7.17 FIT testing was to be introduced for the Bowel Cancer Screening Programme in the first quarter of 2020. The availability of this test and the willingness of the NICaN Colorectal Clinical Reference Group provided the key opportunities to determine a regionally agreed process for the use of FIT to support the risk stratification of patients in Secondary Care during the response to COVID.

Revised Pathway

7.18 Patients waiting for colonoscopy / CTC or red flag / urgent referrals are identified by Secondary Care and sent a FIT testing kit for completion. The kit is returned via Primary Care and transferred to a central lab for processing. The Consultant will review the chart and the patients FIT results, which will allow risk stratification according to different regionally agreed categories. If the FIT <10, the referring Consultant will review the chart and if patient not anaemic consider discharge, with advice to return to their GP if persistent symptoms. If FIT>10, the patients remain on the waiting list but prioritised in order of highest FIT to lowest and imaged as per available resource.

Anticipated Activity: 3 Months to 30 September 2020

7.19 Funding is currently in place to support the use of FIT testing to allow risk stratification of urgent and suspect cancer patients until the end of June 2020. A proposal is being developed which subject to funding availability, will allow for that process to continue for the remainder of the financial year. NI is the first region in UK to use this technology in such an innovative way which offers the potential to make best use of reduced endoscopy capacity.

7.20 A phased restoration of cancer screening programmes will commence as quickly and safely as possible. It is obviously important that this is aligned to and is consistent with restoration of capacity and addressing any backlogs in the parts of the cancer screening pathways which sit in primary care (cervical screening ‘smear’ taking) and secondary care (breast assessment and breast cancer treatment services, bowel colonoscopy and bowel cancer treatment services and cervical colposcopy and cervical cancer treatment services).

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Breast and Cervical Cancer Screening

Previous Pathways

7.21 Cancer screening programmes play a key role in the early detection of disease.

7.22 The NI breast screening programme calls women aged 50-70 who do not have symptoms for a mammography scan every three years. Where necessary (in around one in four cases) they are recalled for a screening assessment. Around 4% of those recalled for assessment will receive a cancer diagnosis and be placed on a treatment pathway. Breast screening mammography and assessment clinics are currently provided across four Trust sites: Altnagelvin, Antrim, Craigavon and Linenhall Street, Belfast. Women in a higher risk group from across the region are screened at the higher risk screening unit in Antrim Area Hospital.

7.23 Cervical Screening aims to prevent cervical cancer by detecting early pre-cancerous changes in the cells that line the cervix. It is recommended that all women aged between 25 and 64 years, who have ever been sexually active, have regular screening tests. Women aged 25-49 are invited every three years, while those aged 50-64 are invited every five years. Most women's test results show that everything is normal, but for around 1 in 10 women the test will show some abnormal changes in the cells of the cervix. Screening is carried out by a nurse or doctor at your GP practice or at a sexual and reproductive health (family planning) clinic.

Constraints and Opportunities

7.24 Screening programmes were paused from the second week of March 2020 in response to the COVID-19 pandemic. The purpose in pausing these programmes was to ensure that adequate healthcare and laboratory resources could be redirected to the pandemic response and to reduce the risk of COVID-19 infection in people eligible for screening programmes, many of whom are in population groups vulnerable to serious adverse health outcomes due to coronavirus infection.

7.25 Public Health England (PHE) has stated that disruption to screening programmes will most likely lead to an increasing disease burden and an increase in health inequalities, in addition to having a negative impact on the economy due to increased morbidity. In light of this, rebuilding NI screening services is a priority for the Department of Health.

7.26 Work is underway by the PHA in Northern Ireland to plan for the restoration of each of the paused programmes as quickly as possible, however the rate of rebuilding will be impacted by the need for social distancing and PPE, as well as the interdependency with other key diagnostic (imaging and laboratories) and treatment services across Trusts. In most instances it would not be

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

appropriate to offer a screening test if the remainder of the screening pathway (diagnostics and treatment) is not available for those who receive a positive screening test result.

7.27 Furthermore, the cohorts eligible for a number of the programmes include people who are at increased risk of severe COVID-19 if they become infected, because of underlying conditions (such as diabetes) and/or age.

7.28 Staff absence in provider services has increased due to the requirement to self-isolate because of staff or household symptoms. Some staff have been redeployed, some staff are in the vulnerable or shielding group and some staff have been or are currently ill.

7.29 Consideration will also need to be given to the availability and suitability of some screening venues in terms of hygiene and social distancing measures.

7.30 In light of these constraints, return to pre-COVID levels of activity and clearing the backlog of people who have missed out on the offer of screening during the pause is likely to take many months and will depend on the progress of the pandemic. Typically, based on average 2019 activity levels, around 5,200 breast mammograms and 15,000 cervical tests would be carried out per month across Northern Ireland. The estimated backlog at 31 May 2020, due to the pause in these programmes, is 12,800 mammograms and 45,000 cervical tests.

Revised Pathways

7.31 A risk-based and consistent approach will be adopted in order to make the best use of the available resources, whilst also taking account of the logistical issues and risks specific to each programme. The approach will be underpinned by a number of key principles:

(i) All screening services should prioritise activity to ensure a consistent approach, with emerging capacity used first for people at highest risk.

(ii) Screening should be offered to people where the benefits of screening are greater than the risk of contracting COVID-19 as a result of participating in the programme. This will differ between programmes and between groups of people eligible for each screening programme. The different risks and benefits associated with different programmes will require a phased approach, with some programmes being phased in before others.

(iii) There needs to adequate staffing and facilities for testing, diagnosis, high quality treatment and programme management. This needs to be supported by appropriate quality assurance arrangements to minimise risk and maximise benefits.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Anticipated Activity: 3 Months to 30 September 2020

7.32 Whilst it is relatively straightforward to pause population screening programmes, the task of restarting these programmes and restoring them to previous levels is much more complex and needs to take into account a wide range of variables which are compounded by the ongoing COVID-19 pandemic.

7.33 Breast assessment clinics for women who have previously been recalled for assessment following mammography continue to be held within our screening centres. In addition, women who have been identified as being at higher risk of breast cancer will continue to receive invitations to attend for surveillance screening at the regional higher risk screening unit at Antrim Area Hospital.

7.34 Colposcopy clinics offering further assessment following a cervical screening test are still being held where possible at the moment. Tests for people who have recently been screened will continue to be processed and results sent to GPs for onward communication to patients.

7.35 Those considered to be in the extremely vulnerable group, those who have, or had symptoms of COVID-19 and are self-isolating, and those who are currently self-isolating due to a household member having symptoms are advised not to attend these clinics. Alternative appointments may be made by contacting the clinic.

7.36 The restoration of cancer screening programmes will commence as quickly as possible. This will be aligned to and consistent with restoration of capacity and addressing any backlogs in the parts of the cancer screening pathways which sit in primary care and secondary care. The PHA, working with HSCB and Trusts, will lead a process to develop a phased plan for the restoration of each of the five paused screening programmes using a risk based approach. The plan will consider effective action that can be taken in the short, medium and long-term. This plan will be based on the principles outlined above and take into consideration the actions required in relation to the screening, diagnostic and treatment components of screening programmes, as part of the wider primary and secondary care recovery plans.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Cataracts – Belfast Health and Social Care Trust (BHSCT)

Previous Pathway

7.37 Prior to the COVID-19 Pandemic, the NI Cataract Pathway reform was well underway. The BHSCT surgical waiting lists stands at some 8000 patients, with some 9500 on the outpatient waiting list. The cataract surgical and outpatient waiting lists have been successfully amalgamated for BHSCT, Northern Health and Social Care Trust and South Eastern Health and Social Care Trust, therefore helping to establish equity of access.

Opportunities and Constraints

7.38 As the waiting lists in Northern Ireland are very long, a list of patients who were "certifiably blind" due to cataract was identified and these patients were prioritised for surgery (in limited numbers) in Kingsbridge Hospital and Ulster Independent Clinic during lockdown. This approach was constrained as some patients were unwilling to attend.

7.39 This allowed the service the opportunity to test the cataract surgery pathway in the COVID-19 climate. This has resulted in BHSCT maintaining approximately 15% of cataract surgical activity through Lockdown.

Revised Pathway

7.40 Cataract surgery has now had to adopt new processes and approaches as follows:

- Prioritisation of patients in terms of visual requirement and COVID-19 risk status.
- Contact patient to ascertain if prepared to attend (very time consuming)
- Attend 48 hours prior to scheduled surgery for COVID-19 testing, pre-assessment and biometry, if required.
- Self-isolation was not a requirement during lockdown but is now a requirement.
- Reduced surgical lists from 7 to 5 during lockdown but have strategies to improve flow once routine theatres open.
- Post-operative reviews carried out by telephone in most cases.

7.41 Improvements in flow have been made by staggering the arrival of patients on the list to avoid contact with others and the surgical day visit can be shortened by giving patients drops for self-dilation when they come for their COVID-19 testing.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Anticipated Activity: 3 Months to 30 September 2020

7.42 Pre-COVID capacity for BHSCT cataract surgery was 5418 patients per annum.

7.43 Currently the BHSCT is operating at 12% of cataract capacity. This can expand rapidly if the Day Case Elective Care Centre open for surgery. Going forward BHSCT has applied for the services of two medical students to help with prioritisation of cataract patients on the surgical waiting list, so that surgical capacity is used in the most effective manner.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Urgent & Emergency Care

7.44 Prior to COVID-19, there was clear evidence that our urgent and emergency care services were under increasing pressure with growing numbers of people experiencing long waits to be seen in overcrowded Emergency Departments (EDs). This was already an unsustainable position requiring radical transformation.

7.45 However, the impact of COVID-19 and the accompanying focus on infection prevention and social distancing, have driven home the urgency of ensuring that we do not allow EDs or hospitals to reach these levels of crowding in future. The way we provide care must change to prevent this.

Opportunities and Constraints

7.46 Attendances at EDs dropped during the first two months of the pandemic but numbers are starting to rise again and it is expected that they will eventually rise to pre-pandemic levels. Even with reduced numbers, our EDs are encountering difficulties with social distancing in waiting areas and, particularly, in ambulance turnaround times. Crowded EDs are unsafe for staff and patients.

Revised pathway

7.47 EDs are having to adopt new ways of working order to ensure that they do not become overcrowded. Some of the new approaches include:

- Segregation and streaming of patients to separate those more likely to have COVID-19 from those less likely;
- Closer working with primary care – including scheduled access to some urgent services;
- Maximum occupancy thresholds in all areas to allow for adequate social distancing;
- Walk-in patients triaged as low risk to wait in cars or nearby until called;
- Increasing the use of telemedicine and remote consultations;
- Expansion of anticipatory care models and acute care at home to prevent unnecessary or inappropriate attendance;
- Patients under active specialist care to be managed by their existing specialist team;
- Patients discharged as soon as they are medically fit.

7.48 Further areas to be explored include the establishment of a regional telephone triage system, alternative pathways for urgent patients including access to scheduled appointments.

7.49 As we move towards the busier winter period, it will be essential to consider more radical transformation of urgent and emergency care services. EDs must

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

be able to provide their core purpose of assessing and stabilising seriously ill and urgent patients.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

SH:24 Pilot – Sexually Transmitted Infection (STI) Testing

Existing pathway

7.50 People in Northern Ireland that are either concerned about, or symptomatic with, a possible STI can either attend a Genitourinary Medicine (GUM) clinic or consult their GP for testing. Many do not do so either out of embarrassment, limited access to appointments, or other reasons like not knowing where to go and obstacles to travel. This contributes to ongoing transmission of STIs and rising STI levels in the population.

7.51 This imposes costs for treatments and in managing the long term consequences of STIs like birth defects, fertility problems, persistent pain, comorbidities and palliative care. For example, the life time costs of treating an HIV patient are estimated to be £380,000. Until recently approximately 100 people were newly diagnosed in Northern Ireland with HIV every year. The most effective way of reducing STI transmission is testing and treatment of those who are diagnosed with an STI. However, in Northern Ireland due to clinic and laboratory constraints the number of STI tests performed annually has not increased significantly over the last five years.

Revised Pathway

7.52 In response to this, PHA, HSCB and Health and Social Care Trusts commenced a six month pilot in October 2019 with SH:24, an online STI testing service provider. SH:24 is a not for profit community interest enterprise developed by clinicians and service designers. It offers testing for Chlamydia, Syphilis, Gonorrhoea, HIV and Hepatitis B and C.

7.53 The patient pathway is individualised, rapid and convenient. The costs are lower than for face-to-face consultations and the quality of the service is consistently high. Sophisticated algorithms analyse the information provided by the patient via their phone or other digital communication device and determine what kind of test kits are needed. These are discreetly posted to the patient with instructions on how to take swabs, urine and blood tests. The patient returns these by post to a designated highly accredited laboratory outside Northern Ireland and receives the results usually within 24 hours by text or telephone. Effective safeguarding mechanisms for children or sexually assaulted adults are also in place. Details of patients testing positive for STIs are shared with the relevant Trust GUM team, who takes over the management of complex patients. Simple STIs like Chlamydia can be treated via SH:24 through a postal of kiosk click and collect local pharmacy service without local GUM team involvement.

7.54 During the six months pilot October 2019- March 2020, nearly 7000 people accessed SH:24 online testing, which exceeded originally anticipated demand

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

by over 100%. Over 40% of NI SH:24 users had never been to a GUM clinic, and a further 15% had not been to one in over a year. This means that SH:24 reached a different group of people than traditional GUM services.

Constraints and Opportunities

7.55 Experience during COVID-19 in Belfast Health and Social Care Trust (BHSCT), to date shows that between April 1st and May 15th 2020, patient contacts reduced from an average of 1500 to 528 for the six week period. Of these, only 30 needed a face-to-face consultation. This means that 93% of the usual demand for GUM services in BHSCT could have been dealt with through SH:24.

7.56 BHSCT estimates that its service capacity will remain less than 50% of its pre-COVID-19 capacity due to staff redeployment, shielding and sickness absence, the requirements of social distancing and use of PPE during unavoidable face to face patient contact.

7.57 SH:24 provides an opportunity to ensure a safe, continued STI testing provision through the COVID-19 pandemic.

Anticipated activity to 30 September 2020.

7.58 Without advertising, it is estimated that SH:24 STI testing service will be accessed by 1500-2000 patients per month between April and June 2020 inclusive. Thereafter this is likely to stabilise at 2000 per month but could rise further. Monthly monitoring will help to determine this in coming weeks and months.

7.59 Service continuation beyond June 2020 is subject to funding being made available.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

ANNEX A: ACTION LIST

Section 5 in the 'Rebuilding Health and Social Care Services Framework' document sets out the overarching approach to developing service stabilisation plans, with the aim to maximise activity in the context of the constraints and issues that COVID-19 presents. This will lead to incremental service activity plans and targets being developed for each programme of care / specialty to be updated in three monthly cycles for the period June 2020 to March 2022. If possible the planning cycles will be extended if the prevalence of Covid-19 in the community improves. The following actions will underpin the planning to be taken forward over the next two years.

Cancer Care

- Work has now started to implement the reset of the full range of cancer services whilst taking into account the need for the HSC to respond to further Covid-19 surge(s) in 2020 and the existing capacity constraints in HSC. This work will be taken forward by the Covid-19 Regional Cancer Reset Cell.

- The Belfast Trust has recommenced specialist surgery in Belfast City Hospital now that the Nightingale Hospital has been stood down.

- The Northern Ireland Cancer Network (NICaN) has produced regional guidelines for cancer care and changes to pathways have been implemented accordingly.

- NICaN and MCRN have collaborated to produce guidelines to support decisions around the prioritisation of patients in the event of a reduction in capacity due to the COVID-19 response.

- Regional guidance documents were compiled to support doctors in their decision-making and treatment planning across both haematology and oncology.

- Some patients' treatments plans have been modified in light of the current pandemic, in line with the regional NICaN guidelines.

- A testing protocol has also been developed for use within cancer services and incorporated into the regional testing protocol.

- NICaN has produced a patient information leaflet.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Adult Social Care

- The learning from the new and innovative ways of working adopted by adult social care services in response to the pandemic, such as the use of technology to connect care home residents with their families, will be utilised to further transform the delivery of this service.

- Across adult social care there will need to be a separation into groups of service users to try to minimise infection control risks, ongoing use of PPE and other mechanisms to minimise risks. This will include Trusts continuing to support unpaid carers, providing PPE when needed, and ensure they have the support they need to continue providing care. Sector specific guidance will be issued providing more details on the approaches to be adopted.

- Careful consideration will be given to the delivery of long term adult care services – both those delivered in institutional settings such as care homes, and in people's own homes, which serve many of those who are most vulnerable to the virus. There will need to be a careful balance struck between continuing to protect people and ensuring that other aspects of people's health and wellbeing – and their rights – are respected and looked after. There is also a continued reliance on unpaid carers, and the support of family and friends, alongside our formal health and social care services. Making sure this support can continue, or re-start, safely is as important as re-opening any hospital-based service.

Capital Investment

- Plans for new developments have been delayed whilst staff across the HSC have been focussing efforts on the immediate needs of the pandemic. This work will be reinvigorated and clear priorities set to ensure that our efforts are collectively applied to move key projects forward. This will enable us to make the best use of the capital funding we have in 2020/21 and to bring forward plans for 2021/22 and beyond so that we are ready to maximise the use of future allocations. The incremental plans will identify any further capital investment requirements.

Children's Social Care Services

- Planning for the rebuilding of children's social care services is underway, which will align with the Executive's 5-stage plan and will be guided by up-to-date medical and scientific evidence.

Co-production

- The incremental service rebuilding plans will be developed through the application of co-production principles as far as that is possible. The speed at

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

which these plans will need to be developed and adapted will undoubtedly act as a constraint on applying full co-production principles. However, where at all possible, service providers should engage in a timely manner as widely as possible in the development of their incremental service plans.

Encompass Programme

- The Encompass digital healthcare programme working with Epic, alongside frontline staff, operational management, and patients and carers, will implement a single Digital Care Record for every citizen, including a fully integrated patient portal. This will enable services to consolidate standardised digital workflows and revised patient pathways, naturally building on the integrated and coordinated regional basis for developing service incremental plans.

EU Exit

- Action will be taken to ensure that the HSC will be ready for EU Exit ahead of the end of the transition period on 31 December 2020. This includes understanding the implications for the health and social care sector of the implementation of the Northern Ireland Protocol and ensuring that the sector is prepared and risks are managed in areas such as workforce, health security and healthcare supplies.

Governance of the HSC

- Given the unprecedented challenges posed by COVID-19, a number of changes to the governance framework will be implemented. The Department, through temporary amendments to the Framework Document, and the establishment of a new management board, will give clear direction to the Health and Social Care Board (HSCB), Public Health Agency (PHA), Health and Social Care Trusts and the Business Services Organisation (BSO) to reflect the Minister's priorities. These revised governance arrangements are intended to be in place over the next two years to facilitate rapid decision making in rebuilding HSC services. This arrangement will be kept under review on a 6 monthly basis

- Service delivery performance targets will be reviewed by the Department to determine the optimum method for assessing the performance of Trusts in the delivery of services during the years 2020/21 and 2021/22.

Managing planned Non-Covid-19 services in hospital settings during COVID-19

- As we increase the amount of planned activity in hospitals over time, we will adopt the following principles:

    - The HSC will immediately start to step up services on a prioritised basis while maintaining the necessary level of care for COVID-19 patients;

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

- Patients across Northern Ireland should have equitable access to specialist services according to their clinical need;
- In order to minimise the risk of infection, COVID-19 patients and staff providing care to them should be separated from non-covid patients and staff where possible;
- The volume of planned activity to be delivered will align with other dependencies such as testing capacity, medicines supply, and PPE.
- The HSC will need to retain the capacity to quickly repurpose and 'surge' capacity if required.

- HSC Trusts will aim to minimise the transmission of COVID-19 infection within hospitals.

- All Trusts have taken steps to put in place effective safe zoning plans in order to maintain safety of patients and staff on sites where elective care is delivered alongside urgent and emergency care. Where possible, we will also consider the possibility of physical separation of staff and patients delivering planned care from those dealing with unscheduled care.

- The use of telephone triage and video consultations will be expanded within secondary care.

- The use of virtual clinics will be expanded within secondary care.

- Further work will be carried out to explore the feasibility of establishing dedicated elective care centres to potentially facilitate the continuation of some planned activity in the event of increasing demand for COVID-19 treatment arising from a second wave of the pandemic.

- The potential to continue the use of Independent Sector facilities to maintain the most urgent planned elective care will be explored.

Mental Health Services

- The remote ways of working introduced to support mental health services during the pandemic will be reviewed to explore the potential to further improve the efficiency of services.

- The library of health and wellbeing Apps to allow clinicians and wider professionals to "prescribe" and allocate apps to clients for mental health services will be further developed.

- The potential for Multidisciplinary Teams (MDTs) in primary care to enhance their focus on delivering mental health services, to help meet the need emerging in the post lockdown period, will be explored.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

- As part of the COVID-19 Mental Health Response Plan published on 19 May 2020 review mechanisms will ensure that learning from alternative ways of working will be incorporated in service developments moving forward.

General Ophthalmic Services

- The learning from the innovations introduced in Ophthalmology patient pathways and communication with patients during the pandemic will be utilised to further strengthen patient access to this service.

- The Department and the HSCB will work with the Optometry NI to rebuild the services provide by Ophthalmic Practices guided by the available medical and scientific guidance.

General Dental Services

- The Department and the HSCB will work with the British Dental Association to rebuild the services provided by General Dental Practitioners guided by the available medical and scientific guidance. The restrictions on dental services are due to be eased on a phased basis with the first stage, starting from 8 June, being the extension of face to face urgent dental care to all practices where possible. In the second phase, non-urgent care is due to be provided with the exception of treatments involving Aerosol Generating Procedures (AGPs). The range of available treatments will be extended to include AGPs under the third phase.

Other Allied Health Professions

- The Department and the HSCB will work with relevant professional bodies in respect of other Allied health professions such as physiotherapists, chiropodists etc. to rebuild services guided by the available medical and scientific guidance.

Patient Pathways

- All HSC service providers will adopt a systematic and consistent approach to developing service specific incremental plans to increase capacity. This will involve mandating the wide range of existing managerial clinical networks, project boards, task and finish groups or other service improvement vehicles to produce service specific incremental plans for their respective areas on an integrated and coordinated regional basis.

- The existing patient and client pathways will be reviewed, applying a range of COVID-19 factors, summarised in the Checklist, producing revised patient

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

pathways to implement rebuilding of services within the context of prevailing COVID-19 conditions.

Pharmacy

- The learning from the new approaches in working practices and the use of technology, introduced in Community Pharmacy and HSC Trust Pharmacy to respond to the pandemic, will be utilised to identify opportunities to build upon these innovations to further transform pharmacy services.

- The learning from the new pharmacy support services provided to Care Homes during the pandemic will be utilised to identify opportunities to build upon these innovations to further transform the services provided to the care homes sector.

Planning for a Further Potential Covid-19 Surge

- Planning will continue to ensure that the HSC will be ready to respond to further potential surges of the Covid-19 pandemic.

- HSC Trusts will retain critical care capacity in line with the NI Critical Care Network's 'Low Surge' scenario, providing the recommended 112 critical care beds capacity.

Primary Care

- The Department will aim to continue to provide the primary care COVID-19 Centres in the short to medium term subject to some changes in configuration to respond to the emergent contours of the pandemic.

- The learning from the COVID-19 Centre approach will be utilised by identifying opportunities to build upon the benefits of this service delivery model to support the further transformation of HSC services by strengthening the effectiveness of the primary care partnership with secondary care through joint working and resource sharing.

- The Department and HSCB will discuss with the BMA and RCGPNI the future use of COVID-19 Centres.

- The use of telephone triage and video consultations will be expanded within primary care.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

- The potential to use telecommunications in primary care to work more closely with secondary care, for example, with video consultations between patients, GPs and hospital specialists, will be explored.

- The primary care sector will be asked to produce proposals to expand the role of Multi-Disciplinary Teams (MDTs) in the future delivery of health services, in particular during the rebuilding phase to bring mental health support to the community level, accessible directly through GPs.

Prioritisation / Delivery of Health Services

- Hospital services will be planned to ensure that treatments that have the highest impact on reducing mortality and morbidity are prioritised. Ensuring patient safety is paramount and that equity of service across Northern Ireland must be ensured as far as possible.

- Where possible service plans will be developed on a regional basis to ensure equity of provision across Northern Ireland.

Testing Strategy

- Service providers should deliver services taking account of testing priorities established in the Interim Protocol. The Protocol will continue to be reviewed on an ongoing basis and will be adjusted over time as further capacity becomes available and as priorities for testing change as the pandemic evolves.

Workforce

- The HSC workforce has been under significant strain during the pandemic and it will be necessary to continue to consider the implications for staff with mental health issues, ensuring appropriate support.

- Induction and training will be provided for staff members who are re-deployed to areas outside their normal practice or working environment.

- Employers must ensure that proper risk assessments are carried out for all staff. This will include application of social distancing, to help avoid contact with COVID-19 wherever possible and to manage that contact safely when there is no alternative. This should include particular risk factors for staff who are shielding; Black, Asian or Minority Ethnic; pregnant etc. and proper training for managers.

- Employers should engage with trade union representatives in a timely manner on all workforce issues.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

- Early consideration will be given to utilising learning from the COVID-19 response in relation to recruitment, resourcing and job banding. Potential improvements to childcare and 7-day working patterns will also be considered. The existing work on safe staffing, and agency and locum reduction will be incorporated within the rebuilding services agenda.

- Clarity will be provided on the means and timing of re-establishing pre-registration training and education for those disciplines that have had training disrupted by the pandemic.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

APPENDIX B – IMPACT OF COVID-19 ON SECONDARY CARE SERVICES

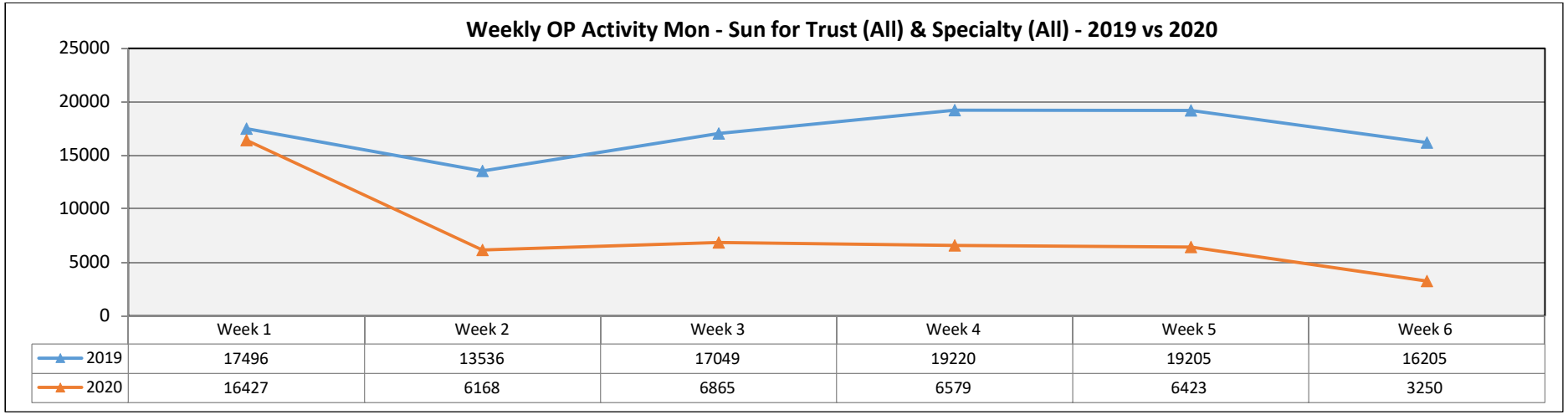
INDEX

	Page
OUTPATIENT ACTIVITY	
Routine	**2**
Red Flag	**3**
Urgent	**4**
INPATIENT ACTIVITY	
Routine	**5**
Red Flag	**6**
Urgent	**7**
ADMISSIONS SUMMARY BY TRUST	**8**
DAYCASES SUMMARY BY TRUST	**9**
EMERGENCY DEPARTMENT ACTIVITY	**10**
IMPACT ON WAITING LISTS	
Inpatient Waiting List	**11**
Outpatient Waiting List	**12**
PROJECTED ACTIVITY TO END JUNE	**13**

Given the urgency in developing this Strategic Framework and associated service rebuilding plans, the data has not been subject to any detailed data verification processes. The data is therefore provisional only and is subject to change. It has nevertheless been published in the spirit of openness and transparency. Please note that waiting times figures include only what was available on the Patient Administration System at the time of reporting. The following Trust data is not included: Belfast - Community Paediatrics, Rehabilitation, Learning Disability, Old Age Psychiatry, Genito-urinary Medicine; Northern – Community Paediatrics; Southern – Genito-urinary Medicine; and Western – Learning Disability, Genito-urinary Medicine.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

OUTPATIENT ACTIVITY – ROUTINE



	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6
2019	17496	13536	17049	19220	19205	16205
2020	16427	6168	6865	6579	6423	3250

Notes

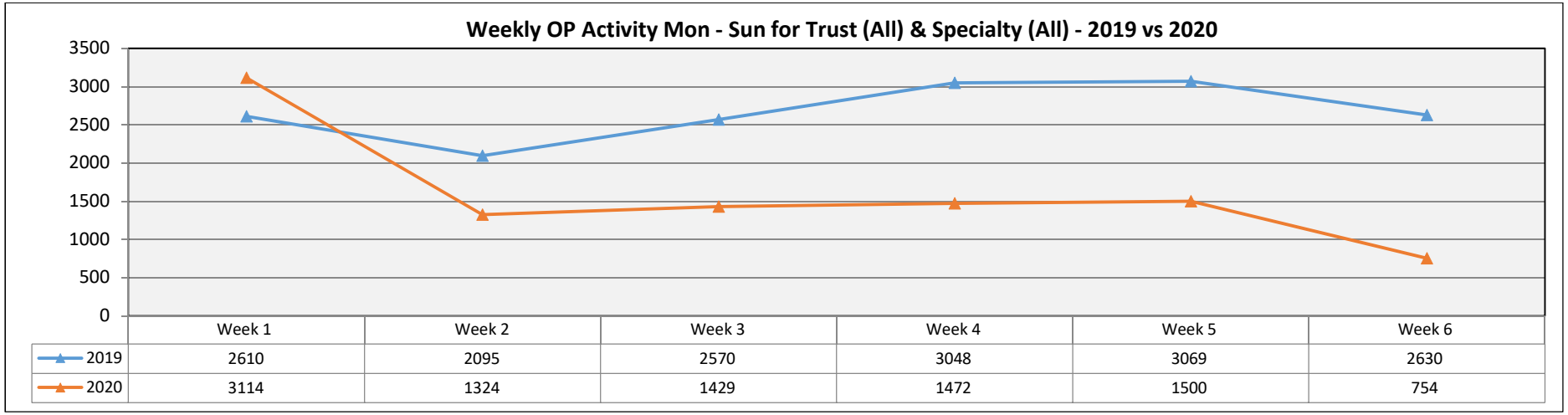
Week 1: 11/3/2019; and 9/3/2020

Week 6: 15/4/2019; and 13/4/2020

	2019: Week 1 6	2020: Week 1 6	% Change
Total Activity	102711	45712	**-55%**

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

OUTPATIENT ACTIVITY – RED FLAG (CANCER)



	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6
2019	2610	2095	2570	3048	3069	2630
2020	3114	1324	1429	1472	1500	754

Notes:

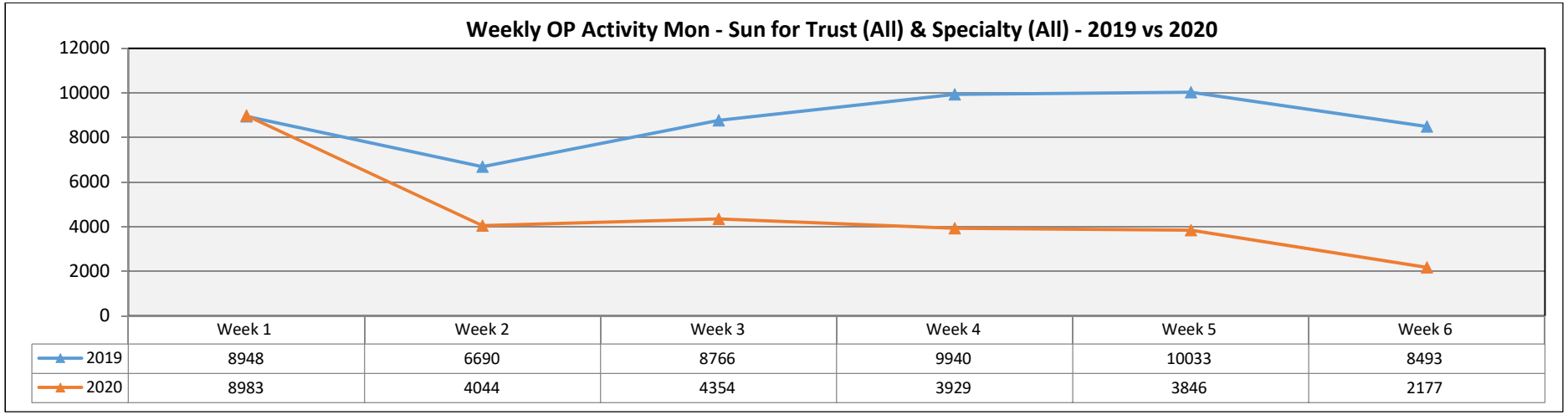
Week 1: 11/3/2019; and 9/3/2020

Week 6: 15/4/2019; and 13/4/2020

	2019: Week 1 6	2020: Week 1 6	% Change
Total Activity	16022	9593	**-40%**

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

OUTPATIENT ACTIVITY – URGENT



	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6
2019	8948	6690	8766	9940	10033	8493
2020	8983	4044	4354	3929	3846	2177

Notes:

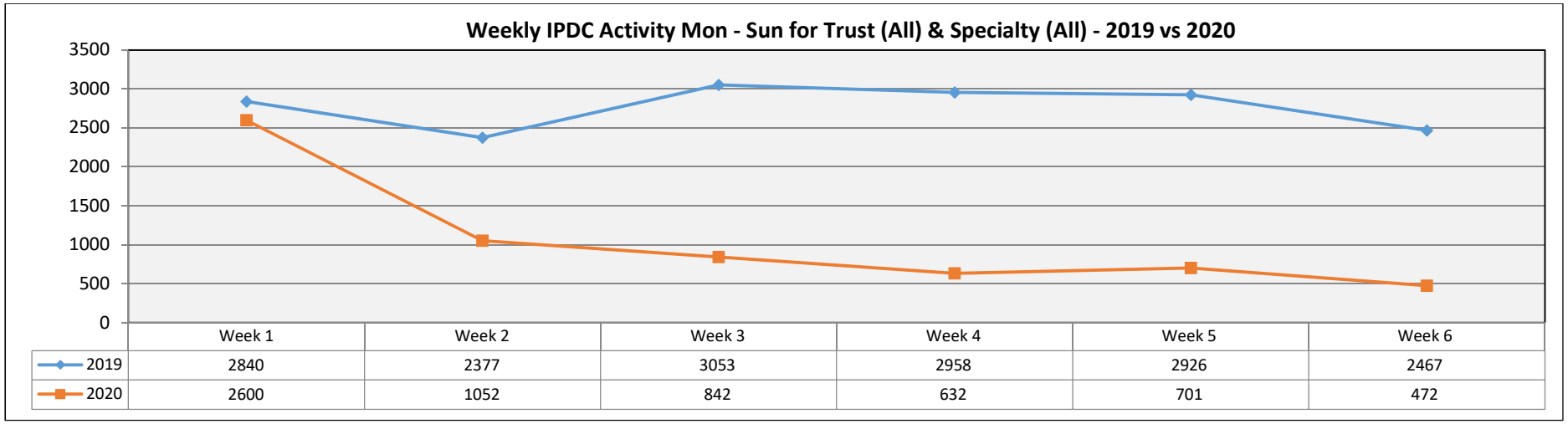
Week 1: 11/3/2019; and 9/3/2020

Week 6: 15/4/2019; and 13/4/2020

	2019: Week 1 6	2020: Week 1 6	% Change
Total Activity	52870	27333	**-48%**

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

INPATIENT ACTIVITY – ROUTINE



Notes:

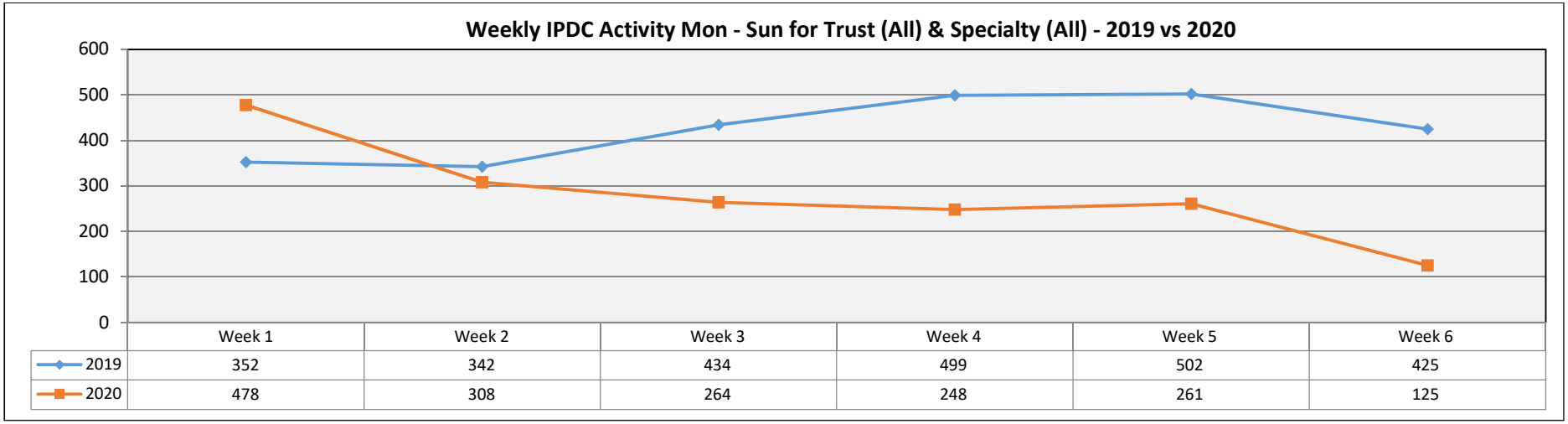
Week 1: 11/3/2019; and 9/3/2020

Week 6: 15/4/2019; and 13/4/2020

	2019; Week 1 6	2020: Week 1 6	% Change
Total Activity	16621	6299	**-62%**

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

INPATIENT ACTIVITY – SUSPECT CANCER



Notes:

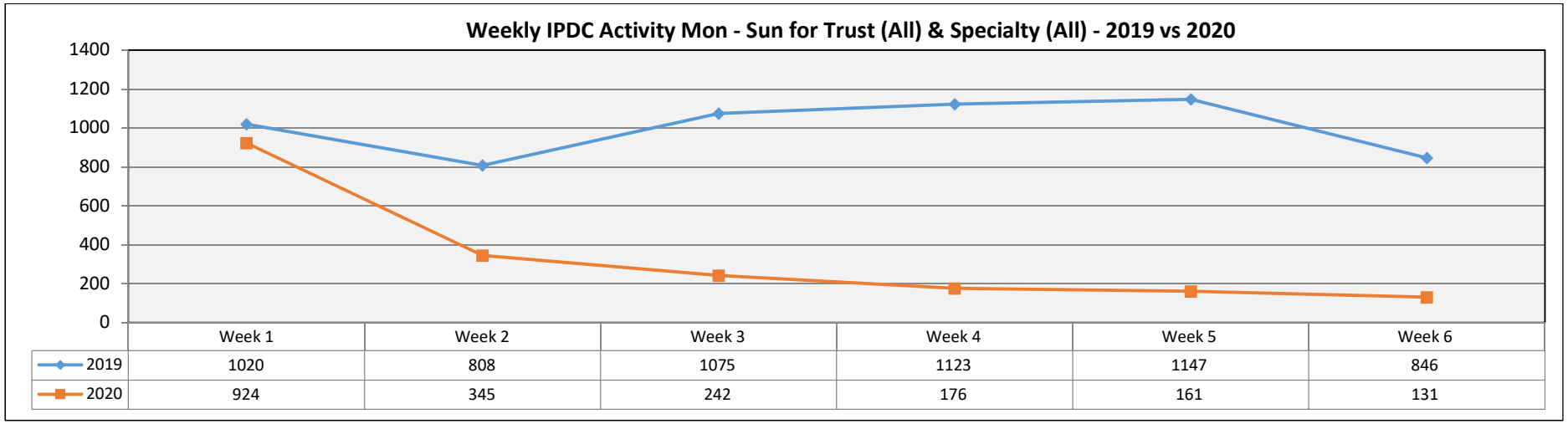
Week 1: 11/3/2019; and 9/3/2020

Week 6: 15/4/2019; and 13/4/2020

	2019; Week 1 6	2020: Week 1 6	% Change
Total Activity	2554	1684	**-34%**

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

INPATIENT ACTIVITY – URGENT



Notes:

Week 1: 11/3/2019; and 9/3/2020

Week 6: 15/4/2019; and 13/4/2020

	2019: Week 1 6	2020: Week 1 6	% Change
Total Activity	6019	1979	**-67%**

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

ADMISSIONS: SUMMARY BY TRUST

Trust	2019	2020	% Change
Belfast	2785	1204	**-57%**
Northern	403	193	**-52%**
South Eastern	492	268	**-46%**
Southern	527	185	**-65%**
Western	874	343	**-61%**

Notes:

6 week Period comparison:

11/3/2019 to 15/4/2019

9/3/2020 to 13/4/2020

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

DAY CASES: SUMMARY BY TRUST

Trust	2019	2020	% Change
Belfast	8785	3540	**-60%**
Northern	2011	691	**-66%**
South Eastern	3114	1455	**-53%**
Southern	3484	1162	**-67%**
Western	2719	921	**-66%**

Notes:

6 week Period comparison:

11/3/2019 to 15/4/2019

9/3/2020 to 13/4/2020

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

EMERGENCY DEPARTMENT ACTIVITY

Department	9th March 2019 17th April 2019	9th March 2020 17th April 2020
Mater	5,589	1,857
RVH	11,095	6,945
Eye	1,831	679
RBHSC	4,939	2,452
BHSCT	**23,454**	**11,933**
Antrim Area	10,230	6,593
Causeway	5,551	2,853
Mid-Ulster	1,305	530
NHSCT	**17,086**	**9,976**
Ards MIU	1,395	851
Bangor MIU	1,224	166
Downe	2,697	815
Lagan Valley	3,039	1,515
Ulster	10,933	6,491
SEHSCT	**19,288**	**9,838**
Craigavon Area	9,768	6,601
Daisy Hill	6,500	1,842
South Tyrone	3,962	1,664
SHSCT	**20,230**	**10,107**
Altnagelvin Area	8,082	4,247
South West Acute	4,181	2,650
Omagh	2,098	812
WHSCT	**14,361**	**7,709**
Northern Ireland	**94,419**	**49,563**

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

INPATIENTS WAITING LIST

Routine

Trust	Waiting at 30 April 2019	Waiting at 30 April 2020	% Change
Belfast	27935	29185	**4%**
Northern	5391	6173	**15%**
South Eastern	5731	5852	**2%**
Southern	7916	8304	**5%**
Western	13428	13988	**4%**
Total NI	60401	63502	**5%**

Urgent

Trust	Waiting at 30 April 2019	Waiting at 30 April 2020	% Change
Belfast	10562	12429	**18%**
Northern	3550	4929	**39%**
South Eastern	3450	4097	**19%**
Southern	5214	8037	**54%**
Western	4567	6269	**37%**
Total NI	27343	35761	**31%**

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

OUTPATIENTS WAITING LIST

Routine

Trust	Waiting at 30 April 2019	Waiting at 30 April 2020	% Change
Belfast	76876	86267	**12%**
Northern	33589	37252	**11%**
South Eastern	55801	52161	**-7%**
Southern	37613	35466	**-6%**
Western	32853	34714	**6%**
Total NI	236732	245860	**4%**

Urgent

Trust	Waiting at 30 April 2019	Waiting at 30 April 2020	% Change
Belfast	16636	16447	**-1%**
Northern	9320	9448	**1%**
South Eastern	14019	13469	**-4%**
Southern	8816	8614	**-2%**
Western	5977	6305	**5%**
Total NI	54768	54283	**-1%**

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

PROJECTED ACTIVITY TO 30 JUNE

Activity (All providers) delivered between 18th April and 30th June 2019 & Activity projected for the same period in 2020 (based on the % reduction in activity delivered between 9th March and 17th April 2020 and 11th March and 19th April 2019)

Trust	New Outpatients	% Reduction	Expected Delivery for same period 2020
Belfast	33,418	59%	13,701
Northern	14,466	59%	5,931
South Eastern	19,173	59%	7,861
Southern	15,011	59%	6,155
Western	16,789	59%	6,883
Region	**98,857**		**40,531**

Trust	Review Outpatients	% Reduction	Expected Delivery for same period 2020
Belfast	78,976	48%	41,068
Northern	23,324	48%	12,128
South Eastern	26,369	48%	13,712
Southern	26,894	48%	13,985
Western	27,932	48%	14,525
Region	**183,495**		**95,417**

Trust	Inpatients	% Reduction	Expected Delivery for same period 2020
Belfast	4,331	57%	1,862
Northern	630	57%	271
South Eastern	867	57%	373
Southern	843	57%	362
Western	1,644	57%	707
Region	**8,315**		**3,575**

Trust	Daycases	% Reduction	Expected Delivery for same period 2020
Belfast	13,759	61%	5,366
Northern	2,241	61%	874
South Eastern	4,881	61%	1,904
Southern	5,447	61%	2,124
Western	4,990	61%	1,946
Region	**31,318**		**12,214**

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

APPENDIX C: COVID-19 IMPACT ON PROGRAMMES AND PROJECTS

Index:

CHIEF MEDICAL OFFICER'S GROUP	Page
Pharmacy	2
Quality Regulation and Improvement Unit	5
Population Health	6
Safety Strategy Unit	9
HEALTH POLICY GROUP	
Secondary Care	11
Primary Care	12
Workforce Policy	13
Hospital Services Reform	14
Regional Health Services Transformation	17
RESOURCES AND PERFORMANCE MANAGEMENT GROUP	
Corporate Management	20
Investment	22
SOCIAL SERVICES POLICY GROUP	
Family and Children's Policy	27
Reform of Adult Social Care	34
Mental health, disability and older people	35
TRANSFORMATION PLANNING & PERFORMANCE GROUP	
Transformation	38
CHIEF NURSING OFFICER	
Nursing, Midwifery and Allied Health Professionals	43

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Directorate: Pharmacy

Programme / Project	Number of weeks lost: 9 March 17 April 2020	Projected number of weeks lost: 18 April 30 June 2020	Risks to Delivery	Risk Rating (Green / Amber / Red)	High Level Budget Impact
Medicines Safety Collaborative	6	10	Extensive work has gone into developing a range of strategic commitments in response to the WHO Third Global Patient Safety Challenge, "Medication without Harm". Plans to establish a joint HSCB / PHA led Medicines Safety Collaborative to implement these commitments and reduce preventable medication related harm have not been able to be progressed.	Red	£0.5m pro-rata Legacy transformation initiative Funding was not confirmed
Pharmacy workforce review	6	10	Work to develop an action plan to implement the recommendations of the Pharmacy Workforce Review has not been able to be progressed, with consequent negative impact on the capacity and capability of the pharmacy workforce to deliver on strategic objectives	Red	£1.0m pro-rata Legacy transformation initiative Funding was not confirmed
New Models of Prescribing	6	10	The implementation plan for New Models of Prescribing has been finalised but funding is required to retain HSCB staff to progress this work during 2020/21. An outline business case for a technical solution for NMOP (further development of NIECR) has been submitted for funding to HSCB Digital Health Innovation group. Confirmation around both aspects of funding is required for work to re-commence.		£0.15m pro-rata Legacy transformation initiative Funding was not confirmed
Medicines Optimisation Regional Efficiency (MORE)	6	10	Risk of failing to meet £20m medicines efficiency target for 20/21 due to increased drug prices and demand for medicines. There will also be some risk to 2019/20 efficiencies due to the impact of COVID on primary care prescribing at the end of March 2020	Red	£20m
Drug Tariff Reform programme	6	10	Work to develop shared arrangements with community pharmacies for delivering medicines efficiencies to the HSC has been put on hold.	Red	0
Human Medicines Regulations – prescribers rights	6	10	Delay in launching UK-wide consultations will impact on providing additional prescribing rights to AHPs	Amber	0

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

			and ultimately impact on speed of transformational change.		
EU Exit/NI Protocol	6	10	There is continued uncertainty around the potential impact of the NI Protocol on medicines supply and regulation in Northern Ireland following the end of the current EU transition period in December 2020. Engagement with DHSC and MHRA to work through the implications of this was paused by all parties due to redirection of resource to the COVID-19 pandemic.	**Red**	0
Pharmacy Needs Assessment	6	10	The project was about to complete the first stage which would have led to a consultation to inform policy and regulatory changes.	**Red**	0
E-pharmacy	6	10	Programme was due to be initiated in March but commencement has been deferred as capacity has had to be prioritised to support other IT projects. E-pharmacy would have been a valuable asset in the context of COVID. No immediate impact but the continued absence of IT enablement for pharmacy issues reduces capacity for GP practices and community pharmacies	**Red**	0
Pharmacy inspections	6	10	Routine inspections of community pharmacy were paused due to social isolation restrictions. This will result in a backlog which will need to be addressed. Inspectors are re-deployed in COVID-19 projects	**Red**	0
CDRP	6	10	New project on controlled drugs reconciliation was not started, staff re-deployed in COVID-19 projects,	**Red**	0
CD Licensing	6	10	All new applications for CD licences have been paused. The regional compliance plan has also been stalled which presents an operational risk	**Red**	0
MOUs/SLAs	6	10	The Department has a numerous MOUs and SLAs with partner agencies including Home Office, MHRA and VMD. These agencies perform Departmental functions on the Department's behalf using SLAs and MOUs. These Agreements are due for review and renewal but work has been postponed.	**Red**	0 – potential resource implications if SLAs are not renewed
Misuse of Drugs legislation	6	~10	Various amendments to Misuse of Drugs legislation have been stalled due to work pressures and the need to progress amendments relating to the pandemic.	**Amber**	0

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

			Delay in launching UK-wide consultations will impact on providing additional prescribing rights to AHPs and ultimately impact on speed of transformational change. This will be UK wide		
Investigations and Enforcement Actions	6	10	Numerous investigations require a visit to premises and/or residence. This has not been possible during the pandemic. MRG are prioritising high risk cases which we can progress during this time	**Red**	0
Pharmaceutical Society Premises Standards	6	10	Work alongside the Pharmaceutical Society to develop and introduce new premises standards has stalled	**Amber**	0

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Directorate: Quality Regulation and Improvement Unit

Programme / Project	Number of weeks lost: 9 March 17 April 2020	Projected number of weeks lost: 18 April 30 June 2020	Risks to Delivery	Risk Rating (Green / Amber / Red)	High Level Budget Impact
IHRD Implementation	5	10	Delay in the implementation of recommendations arising out of high-profile Inquiry into Hyponatraemia-Related Deaths. This includes: - Delay in publishing proposals to implement a statutory Duty of Candour and subsequent public consultation. - Pilots to develop options for an Independent Medical Examiner have been paused. This will impact on the timescale for introduction of IME service. - A number of recommendations were due to be implemented between April and June 2020. These have been delayed.	Amber	None
Review of Regulation – 2003 Order	6	10	Delay in launching public consultation on Phase 1 of the Review of Regulation.	Amber	None
Review of Fees and Frequency of RQIA inspections - proposed amendments to regulations	6	10	Delay in reviewing the original evidence paper and option appraisal, therefore subsequent delay in bringing proposals to Minister for approval.	Amber	None

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Directorate: Population Health

Programme / Project	Number of weeks lost: 9 March 17 April 2020	Projected number of weeks lost: 18 April 30 June 2020	Risks to Delivery	Risk Rating (Green / Amber / Red)	High Level Budget Impact
Development of new Substance Use Strategy consultation document	3 weeks	10 weeks	Strategy development work paused, and stakeholder engagement co-production workshops planned April/May cancelled. Impact on timescale to deliver on NDNA commitment for Executive to publish new Substance Use Strategy.	**Red**	
Making Life Better Mid-term Review	6 weeks	10 weeks	All associated meetings of the Making Life Better Mid-term Review Group, the All Departments Officials Group (ADOG) and other relevant stakeholders have had to be postponed. There will be an impact on finalising the Mid-term Review Report and revised Action Plan.	**Red**	
Decontamination strategy	12 + weeks (since 27 January)		Work had been due to commence to review current decontamination guidance for NI based on NHS England guidance for the initial management of self presenters from incidents involving hazardous material. Initial discussions had been had at UK level. Timescales to carry out this work have not been scoped but will be delayed by the diversion of resource into the COVID response.	**Red**	
Critical National Infrastructure (CNI) assessment			Work with HSC to assess health estate to establish if any buildings should be on the UK asset register as critical national infrastructure. Timescales to carry out this work have not been scoped but will be delayed by the diversion of resource into the COVID response.	**Red**	
Protect Life 2 Commissioning	Approx. 6 weeks lost	Local leads of suicide prevention meeting on 28th April to look at how this can progress	The face to face engagement for Protect Life has been postponed. However a plan is underway to look at alternative ways of engaging communities to allow the commissioning process to recommence.	**Red**	Services that are currently delivering PL Services will be continued so

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

					there is no impact on budget
Introduction of FIT testing to the bowel cancer screening programme	6 weeks	6 weeks	Delayed implementation of this policy development (was scheduled to commence from June 2020).	Red	Reduced funding required in year - £500k released.
Screening governance review	4 weeks	11 weeks	Delayed implementation of commissioning and conducting this work.	Red	
Preparation for the 2020/21 seasonal flu programme.	3 weeks	0 weeks	Work continues but with less staff resource. Effective introduction is vital to reduce incidence of respiratory infection due to seasonal flu at a time when COVID-19 is still prevalent.	Red	
Development of a Hepatitis B & C elimination action plan	3 weeks	6 weeks	Delayed introduction of the action plan and associated reduction in the incidence of these diseases.	Red	
Review of Home Accident Prevention Strategy	2 weeks	5 weeks	This has been delayed given the need to refocus on COVID-19 priorities by key stakeholders	Red	
AMR (Antimicrobial Resistance) Programme	Approx. 3 weeks lost	7 weeks lost: project implementation work and Programme Board planning at NI and UK wide level have been suspended	The Action Plan implementation has been delayed and the work at a UK level has also been delayed by suspension of action plan. The major risk is to the delivery of the required AMR actions, budget and implementation timescales.	Red	Planning work for the next Spending Review is on hold at present
Immunisation/Vaccination Programme delivery	Mainly focusing on COVID-19 response with other staff working on the Imm/Vacc programme delivery.	Mainly focusing on COVID-19 response with other staff working on the Imm/Vacc programme delivery.	Trust staff working on the COVID-19 response may have an impact on the delivery of the immunisation and vaccination programme delivery.	Red	Nil
HCAI Programme	Mainly focusing on the COVID-19 response.	Mainly focusing on the COVID-19 response.	The main focus is on the HP COVID-19 response. Other work areas are providing the continued ongoing HCAI programme delivery.	Red	Nil

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Duty Room Acute Response Delivery	Acute response provided with additional works on COVID-19 response.	Acute response provided with additional works on COVID-19 response.	The duty room is stretched with the ongoing acute response and the support required to the COVID-19 service response.	**Red**	Nil
AMR Programme	Staff focusing on the COVID-19 response.	Staff focusing on the COVID-19 response.	The AMR programme is currently on hold as staff are now working on the COVID-19 surveillance response.	**Red**	Nil
HP Surveillance	Mainly focusing on the COVID-19 response.	Mainly focusing on the COVID-19 response.	HP surveillance staff mainly working on the COVID-19 response. Other surveillance staff continuing to provide a reduced service.	**Red**	Nil.
OOH On-Call HP	COVID-19 OOH Response	COVID-19 OOH Response	Enhanced OOH Health Protection work as a result of the increased out of hours activity consequent to COVID-19.	**Red**	Additional costs will need to be put through COVID-19 cost centre K9HP22.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Directorate: Safety Strategy Unit

Programme / Project	Number of weeks lost: 9 March 17 April 2020	Projected number of weeks lost: 18 April 30 June 2020	Risks to Delivery	Risk Rating (Green / Amber / Red)	High Level Budget Impact
Northern Ireland's participation in the Breast & Cosmetic Implant Register (BCIR)	5	10	Delay in Request letter from Perm Sec being issued by end of April 2020. Therefore budget 22k has not been spent. Data Sharing Agreement not signed off, therefore delay in completion. Engagement with Trusts, Independent Providers & BSO has not continued, so reporting process not established.	Amber	None
SAI process review (dependent on resource)	5	10	In line with IHRD recommendations, the SAI policy is being updated, in consultation with the HSC. This work has been delayed	Amber	None
HSC Complaints process update re COPNI recommendations	5	10	In line with COPNI recommendations, a refresh of the HSC Complaints policy was due to be completed by end of June 2020. This work has been delayed.	Red	None
Review of National Audits (CORP reports) process and rationalisation	5	10	A review of the Department's approach & oversight of CORP reports has been delayed. Initial investigation & analysis has been completed, but unable to consult with medical colleagues in the Dept & HSC.	Amber	None
Review of Q2020 (dependent on resource), new Quality Improvement Strategy (initial planning in	5	10	The Department's 10 year Quality Strategy Q2020 is due to be reviewed and consultation sought on the way forward. The review was in the planning stages but has not been moved forward. A new QI strategy & the development of a Patient Safety Strategy will also be considered as this project progresses.	Amber	None

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

2020/2021 but dependent on resource) and the development of Patient Safety Strategy (initial planning in 2020/2021 but dependent on resource)			Delay experienced in the start of all of this work.		
Regional Decontamination Strategy 2	5	10	Delay in starting engagement with HSC and development of initial outline plans	**Amber**	None
Participation in the National Medical Device Registry – Pelvic Floor	5	10	Delay in engagement with NHS Digital and HSC for NI participation in registry. Development work by NHS Digital underway.	**Amber**	None

Directorate: Secondary Care

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Programme / Project	Number of weeks lost: 9 March 17 April 2020	Projected number of weeks lost: 18 April 30 June 2020	Risks to Delivery	Risk Rating (Green / Amber / Red)	High Level Budget Impact
NDNA Commitment to extend publicly funded IVF cycles from 1 to 3	6	All (10.5)	The Minister announced his intention to set up a Project Board to take forward this commitment. However, until the pandemic is over and representatives are available to undertake the necessary project work, it will not be possible to move forward on this. A further risk is if the budget to deliver the additional cycles is not received. There are also issues with lack of capacity (staffing and facilities) in the Regional Fertility Centre to deliver on this commitment, but the project was intended to scope out whether there would be other suitable options, such as using the independent sector. This is therefore unknown at this time but may be a risk.	Amber (on the basis that no project end date had been announced; however, the project has not progressed)	None at this stage as no budget has been announced for this commitment. Bid of £8.1m submitted (at time of writing). If the funding is made available but the project is still delayed, the money is unlikely to be (fully) spent in-year.
NDNA Commitment to the development of a Cancer Strategy	6	10.5	The Cancer Strategy was on track for delivery by December 2020. However, the Strategy is being developed through co-production with clinicians, sectoral experts, the HSC, charities and user representatives and as such had to be paused as those working on it had to refocus their energies into Covid-19. Pressures across the system make it unlikely that work on the Strategy can continue over the next 6 weeks, particularly as efforts will be focussed on managing the recovery phase for cancer services.	Red – the strategy will not be delivered by December 2020.	The budget bid for this year is £200k. The majority (188k) comprises staffing costs and will still be needed.
Commissioning of abortion services	5	10.5	Suggestions for the delivery of an interim service during the pandemic were put to the Executive, but, to date, no direction has been forthcoming.	Amber – work will probably not resume until there is political agreement.	None – no budget was allocated.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Directorate: Primary Care

Programme / Project	Number of weeks lost: 9 March 17 April 2020	Projected number of weeks lost: 18 April 30 June 2020	Risks to Delivery	Risk Rating (Green / Amber / Red)	High Level Budget Impact
NDNA: Build capacity in general practice through the ongoing rollout of Multi Disciplinary teams to cover a further 100,000 patients by March 2021'	6	6	The NDNA resourcing package has not been confirmed to date and no budget is currently allocated to this project. The shape of the post lockdown HSC could impact on delivery of this commitment.	Amber	No budget secured

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Directorate: Workforce Policy

Programme / Project	Number of weeks lost: 9 March 17 April 2020	Projected number of weeks lost: 18 April 30 June 2020	Risks to Delivery	Risk Rating (Green / Amber / Red)	High Level Budget Impact
Safe staffing	6	6	There is not a hard deadline for this project and its suspension during the COVID-19 response was with the agreement of trade unions. Any delay to delivery will further delay implementation of the January 2020 agreement to end the HSC industrial action.	Amber	Negligible.
Agency and locum reduction	6	6	There is not a hard deadline for this project and its suspension during the COVID-19 response was with the agreement of trade unions. Any delay in delivery could arguably delay savings in agency and locum costs. However, one consequence of the COVID-19 response has been to prove that permanent recruitment can be expedited and streamlined, and this may ultimately help in delivering savings faster than expected.	Amber	Negligible.
Health and social care workforce strategy	6	6	Loss of momentum on the various actions under the Strategy – eg. development of optimum workforce model. Optimistic that time can be regained before strategy end date (2026) although there may be delays to delivery of shorter term actions.	Amber	Negligible.
NDNA commitment to provide an extra 900 nursing and midwifery undergraduate places over 3 years.	0	0	On track for delivery. Approved and first 300 places to be commissioned for September start.	Green	

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Directorate: Hospital Services Reform

Programme / Project	Number of weeks lost: 9 March 17 April 2020	Projected number of weeks lost: 18 April 30 June 2020	Risks to Delivery	Risk Rating (Green / Amber / Red)	High Level Budget Impact
DECCs – Cataracts, Veins, Phase 2 Day Case Elective Care Review Improvements will be made in stroke, breast assessment, urgent and emergency care and **day case elective care** by the end of 2020.	6	10.5	• Prototypes in place with ongoing evaluation. Progress will be slowed due to Covid-19. • No further progress will be made on the day case elective care review between 09 March and 30 June 2020. • HSC and all of HSRD/RHSTD resources have been redirected towards planning for and managing the impact of COVID-19. • Service reviews are clinically led and require significant clinician input, the projects would not be able to proceed until the impact of COVID-19 reduces significantly. The longer the current situation persists, the more delay will be incurred in respect of all the projects. • Continued social distancing measures could affect future public consultations.	Red Unlikely that Day case elective care review will progress by end 2020.	£1,776,923 (inescapable pressure for cataracts and veins, approx. £592,306)
Regional Obesity Management Service (ROMS)	6	10.5	• No progress will be made on any of the extant / planned projects between 09 March and 30 June 2020. • HSC and all of HSRD/RHSTD resources have been redirected towards planning for and managing the impact of COVID-19. • Service reviews are clinically led and require significant clinician input, the projects would not be able to proceed until the impact of COVID-19 reduces significantly. The longer the current situation persists, the more delay will be incurred in respect of all the projects. • Continued social distancing measures could affect future public consultations.	Amber (If the current situation with COVID-19 continues for a prolonged period of time, then this status should be escalated to RED)	£317,308 (growth)

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Urgent & Emergency Care Review Improvements will be made in stroke, breast assessment, **urgent and emergency care** and day case elective care by the end of 2020.	6	10.5	• No progress will be made on any of the extant / planned projects between 09 March and 30 June 2020. • HSC and all of HSRD/RHSTD resources have been redirected towards planning for and managing the impact of COVID-19. • Service reviews are clinically led and require significant clinician input, the projects would not be able to proceed until the impact of COVID-19 reduces significantly. The longer the current situation persists, the more delay will be incurred in respect of all the projects. • Continued social distancing measures could affect future public consultations.	**Red** Unlikely that significant improvements will be made in Urgent and Emergency Care by end 2020.	£317,308 (growth)
Trauma & Orthopaedics Review	6	10.5	• No progress will be made on any of the extant / planned projects between 09 March and 30 June 2020. • HSC and all of HSRD/RHSTD resources have been redirected towards planning for and managing the impact of COVID-19. • Service reviews are clinically led and require significant clinician input, the projects would not be able to proceed until the impact of COVID-19 reduces significantly. The longer the current situation persists, the more delay will be incurred in respect of all the projects. • Continued social distancing measures could affect future public consultations.	**Amber** (If the current situation with COVID-19 continues for a prolonged period of time, then this status should be escalated to RED)	£158,654 (growth)
Ambulance Service CRM	6	10.5	• The CRM Code Set was introduced 12 November 2019 following Perm Sec permission. • The Strategic Outline Business Case was submitted to the Department on 28th February.	**Amber** (If the current situation with COVID-19 continues for a prolonged period of time, then this status should be escalated to RED)	

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

			• NIAS are currently working through the business case comments made by DOH policy leads and economists. • Covid-19 has slowed this process but the project is still on track with some delay.		

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Directorate: Regional Health Services Transformation

Programme / Project	Number of weeks lost: 9 March 17 April 2020	Projected number of weeks lost: 18 April 30 June 2020	Risks to Delivery	Risk Rating (Green / Amber / Red)	High Level Budget Impact
Pathology Review	6	10.5	• No progress will be made on any of the extant / planned projects between 09 March and 30 June 2020. • HSC and all of HSRD/RHSTD resources have been redirected towards planning for and managing the impact of COVID-19. • Service reviews are clinically led and require significant clinician input, the projects would not be able to proceed until the impact of COVID-19 reduces significantly. The longer the current situation persists, the more delay will be incurred in respect of all the projects. • Continued social distancing measures could affect future public consultations.	Amber (If the current situation with COVID-19 continues for a prolonged period of time, then this status should be escalated to RED)	298,077 (growth)
Neurology Review	6	10.5	• No progress will be made on any of the extant / planned projects between 09 March and 30 June 2020. • HSC and all of HSRD/RHSTD resources have been redirected towards planning for and managing the impact of COVID-19. • Service reviews are clinically led and require significant clinician input, the projects would not be able to proceed until the impact of COVID-19 reduces significantly. The longer the current situation persists, the more delay will be incurred in respect of all the projects. • Continued social distancing measures could affect future public consultations.	Amber (If the current situation with COVID-19 continues for a prolonged period of time, then this status should be escalated to RED)	190385 (growth)

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Stroke Review NDNA Commitment: Improvements will be made in **stroke**, breast assessment, urgent and emergency care and day case elective care by the end of 2020.	6	10.5	• No progress will be made on any of the extant / planned projects between 09 March and 30 June 2020. • HSC and all of HSRD/RHSTD resources have been redirected towards planning for and managing the impact of COVID-19. • Service reviews are clinically led and require significant clinician input, the projects would not be able to proceed until the impact of COVID-19 reduces significantly. The longer the current situation persists, the more delay will be incurred in respect of all the projects.	**Red** Unlikely that stroke reforms will progress by end 2020.	1,015,384 (£50,769 of which would be inescapable)
Breast Assessment Review Improvements will be made in stroke, **breast assessment**, urgent and emergency care and day case elective care by the end of 2020.	6	10.5	• No progress will be made on any of the extant / planned projects between 09 March and 30 June 2020. • HSC and all of HSRD/RHSTD resources have been redirected towards planning for and managing the impact of COVID-19. • Service reviews are clinically led and require significant clinician input, the projects would not be able to proceed until the impact of COVID-19 reduces significantly. The longer the current situation persists, the more delay will be incurred in respect of all the projects.	Red Unlikely that breast assessment reforms will progress by end 2020.	142,788 (inescapable)
Maternity, Obstetrics & Neonatal review	6	10.5	• No progress will be made on any of the extant / planned projects between 09 March and 30 June 2020. • HSC and all of HSRD/RHSTD resources have been redirected towards planning for and managing the impact of COVID-19. • Service reviews are clinically led and require significant clinician input, the projects would not be able to proceed until the impact of COVID-19 reduces significantly. The longer the current situation persists, the more delay will be incurred in respect of all the projects.	**Amber** (If the current situation with COVID-19 continues for a prolonged period of time, then this status should be escalated to RED)	19,038 (growth)

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

			• Continued social distancing measures could affect future public consultations.		
Proposed new reviews: Urology General Surgery Vascular Palliative Care	0	10.5	• No progress will be made on any of the extant / planned projects between 09 March and 30 June 2020. • HSC and all of HSRD/RHSTD resources have been redirected towards planning for and managing the impact of COVID-19. • Service reviews are clinically led and require significant clinician input, the projects would not be able to proceed until the impact of COVID-19 reduces significantly. The longer the current situation persists, the more delay will be incurred in respect of all the projects. • Continued social distancing measures could affect future public consultations.	**Amber** (If the current situation with COVID-19 continues for a prolonged period of time, then this status should be escalated to RED)	Nil return to end June as these projects would only be at early stages (growth)

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Directorate: Corporate Management					
Programme / Project	**Number of weeks lost: 9 March 17 April 2020**	**Projected number of weeks lost: 18 April 30 June 2020**	**Risks to Delivery**	**Risk Rating (Green / Amber / Red)**	**High Level Budget Impact**
Stock & Asset Management system	6 Weeks	19 working days	Go live of phase 1 of the project was scheduled for 24th April. This has now been put back until Sept 2020	Amber	A re-profiling required within the same financial year
2 x MTFA Vehicle build	6 Weeks	19 working days	Impact has not yet been assessed as information on chassis builds are currently unavailable	Green	Whilst the full impacts are unknown at this stage. It is anticipated that this will be a re-profiling within the same financial year
DIM vehicle build	6 Weeks	19 working days	Impact has not yet been assessed as information on chassis builds are currently unavailable	Green	Whilst the full impacts are unknown at this stage. It is anticipated that this will be a re-profiling within the same financial year
Replacement Command & Control Solution (C&C)	6 Weeks	6 weeks	Should current restrictions continue potential further delay of 6-9 months and the impact of a delay of this order particularly on the Functional Analysis and Training phases would result in a delayed go-live date. Should this be the case then NIFRS would need to secure continued support and maintenance for its legacy C&C up until the new go-live date for the Systel solution.	Amber	Potential slippage of £0.2M in the 21/22 budget year. This may create a revenue pressure as NIFRS will need to utilise a direct award contract for continued support & maintenance of the existing C&C system due to this delay, however NIFRS will look at ways this can be mitigated.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

HQ Infrastructural Upgrades and RCC Refurbishment	6 Weeks	6 Weeks	Elongated detailed design stage and delays in tendering works to the market has impacted on programme/timelines resulting in budget slippages.	Amber	£1,552,756 in year spend re-profiled to £571,148 £981,608 slippage
Larne Fire Station Refurbishment	6 weeks	6 weeks	Elongated detailed design stage and delays in tendering works to the market has impacted on programme/timelines resulting in budget slippages.	Amber	£373,940 in year spend re-profiled to £296,848 £77,092 slippage

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Directorate: Investment

Programme / Project	Pre Covid Completion Date	Post Covid Completion Date	Risks to Delivery	Risk Rating (Green / Amber / Red)	High Level Budget Impact
NIFRS LDC Cookstown **Desertcreat – Phase 2**	Construction Start: September 2021	Construction Start: December 2021	The delays to the Programme are at this stage speculative. There are emergent risks arising from Covid-19 with regard to the planning approval process (Mid Ulster District Council is reporting planning process challenges). The design and Integrated Supply Team (IST) procurement may be further delayed if social distancing requirements continue beyond the short / medium term.	Green/ Amber	The project budget will be re-profiled but the total budget requirement remains unchanged.
SEHSCT - Ulster Hospital ASB (inc Level 6)	Handover anticipated: 19th June 2020 Estimated to open to patients Autumn 2021	Unknown at present. Currently estimating August/September 2021. This will be dependent on the exact timing of the resumption of the Level 6 works and will	In response to Covid-19, the SET will accelerate the commissioning of the Acute Services Block as a temporary regional facility should it be required. Project Management Instruction issued to Contractor for Early Possession (EP) Works 2 April 2020. Covers essential works only. Other works deferred until these are complete. There will be an impact in terms of programme and cost. Building will now be commissioned in response to Covid-19, operated / maintained earlier than planned. There may be a need to reinstate some areas once the COVID 19 emergency has	Amber	Impact on budget (capital and revenue) not fully known at this stage. Owing to the continued uncertainty surrounding the Covid-19 pandemic, at present we cannot confirm the full extent of delay to the contract, nor quantify with certainty, the increased costs to the contract. Due to the delay and the revised working practices now being enforced due to Covid 19 we are anticipating some additional costs, in particular due to arrangements such as social-distancing which may have an effect on manpower levels. Other Covid-19 related additional costs associated with commissioning ASB as

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

		be subject to change due to any impact of social-distancing or associated H&S related issues following revised work patterns.	passed and following completion of Level 6 the whole building will be commissioned as per original approved scope.		a temporary regional facility are being confirmed. In respect of the main contractor these are currently being assessed through an open-book accounting arrangement. There will also be additional revenue running costs to Trust due to the early opening of Levels 1-5 through the EP contract. Not all of the associated costs can be accurately determined at this point. Work is ongoing in respect of the EP contract and this will have to be assessed against the works originally planned and included in the original contract to avoid double counting and overpayments. Draft figures may not be available for a number of weeks.
WHSCT Altnagelvin Redevelopment **Phase 5.1**	03/06/2020	20/10/2020 23 weeks and 2 days estimated delay at this stage in initial Design Team review based on paused period and recommencement with reduced working capacity and necessary adjustments to	Social Distancing rules will delay completion and programme timescales Accessibility of Materials & Equipment supply routes and delivery Increased supply chain costs due to pause in production Impact of accelerated use of wards for COVID 19 and recovery patients Availability of staff when required including contract, sub-contract, design team, CPD and project staff Regulatory sign off for all relevant statutory authorities	**Amber** **Amber** **Amber** **Amber** **Green** **Green**	Costs still to be finalised

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

		the works programme			
BHSCT – New Maternity Hospital	Spring 2021	If construction restriction lifted Aug 2020 Completion date for the Main Hospital Phase B1 Autumn 21	• The site was closed on the 25th March 2020 • Contractor planned re-commencement on site on 26th April (New Government Guidance). NB: This will be in a limited capacity. • Programme dependant on supply chain and availability of materials • The Maternity Hospital is on Critical Path for the new Children's' hospital.	Red	Awaiting assessment of the impact of delay / contractual advice
BHSCT – New Children's Hospital	March 2026	Bostock House and enabling works in delay and a month on month impact to the Children's project.	• Limited impact on Design Team's preparation of Tender documentation. This will continue to be reviewed on an ongoing basis. • Tender currently programmed for August 2020 • Construction commencement currently programmed for February 2022 but this date will be directly impacted by any Covid-19 (or other) delays to Bostock demolition/ Enabling works/Maternity. • Enabling contracts in delay due to unavailability of specialist contractors	Red	Awaiting assessment - dependant on inflationary impact.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

BHSCT – Critical Care Building **Level 3 Theatres** **Levels 5 & 6 - ICU**	April 2020 Autumn 2020	Predicted June / July 2020 Autumn 2020	Delayed due to the unavailability of specialist contractors to complete the commissioning of theatres - this work will take approx. 2 weeks once contractors are available Hybrid Theatre is delayed due to the unavailability of the specialist flooring contractor • Emergency work was completed to this area to allow the floors to be used as bed floor for additional Covid -19 patients should the Trust required additional capacity. • Due to the change in NI predicted curve this work was stopped and work continue to restore these floor to the ICU specification. • It is predicted that this work should complete in the Autumn		Awaiting confirmation of programme from specialist contractors and assessment of consequential costs. Awaiting assessment of costs arising from revised on-site working practices
ICT LIMS	Feb 2022	Feb 2022	Procurement consensus day scheduled for 23rd May • Issue invitation to Negotiate scheduled for 15th June • Customer reference calls scheduled W/C 01/06/20 All of the above require core procurement team, Legal Services and PALS to be available during COVID pressures to complete and issue documentation. All currently available	Green	No Impact at Present

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

ICT NIPACS	Dec 20	April 21	• Procurement process requires availability of technical, clinical, PaLS and Legal Services staff. Resources required for next stage are currently available. • Additional time has been added to timeline to allow for some short term unavailability at future stages however will be kept under review if situation changes	**Amber Green** – under review during COVID-19 pressures	No Impact at present
Encompass	FY 30/31	FY 32/33	The onset of Covid-19 has resulted in a delayed start date, a revision to the subsequent implementation schedule and associated spend profile.	**Amber**	Profiled expenditure will change and there is the potential for additional costs due to prolongation of the programme. An assessment of the overall financial impact is ongoing

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Directorate: Family and Children's Policy

Programme / Project	Number of weeks lost: 9 March 17 April 2020	Projected number of weeks lost: 18 April 30 June 2020	Risks to Delivery	Risk Rating (Green / Amber / Red)	High Level Budget Impact
Development of Family and Parenting Support Strategy	6	10	Delayed development will delay publication. Delay does however allow us to take account of the impact of the pandemic upon family life.	**Red** – whilst we have not committed to a specific publication date, the previous family support strategy expired in 2019	No impact as no funding had been committed for the strategy
Review of Childcare Partnerships	6	10	Delay to the review risks the Partnerships continuing to operate without any changes to optimise their efficiency and effectiveness.	**Green** – no date committed for completion	The review encompasses the £1.7m Early Years Development Fund, which will therefore continue to be allocated on a recurrent budget to the HSCB until the review concludes.
Review of Minimum Standards for Childminding and Daycare	6	10	Delay to the review risks the Standards continuing to be implemented without any changes to improve them. Mitigated at present as routine inspection activity has been halted by HSC Trusts.	**Green** – no date committed for completion	No impact
Development of an Online Safety Strategy	6	10	Delays to Executive approval and publishing of the strategy increases the chance it may need revised again before it is published. Alternatively it may shorten the intended 5 year life-span for the strategy.	**Amber** – strategy has been delayed on a number of occasions. Commitment given to publish this year.	Business case in development.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Programme / Project	Number of weeks lost: 9 March 17 April 2020	Projected number of weeks lost: 18 April 30 June 2020	Risks to Delivery	Risk Rating (Green / Amber / Red)	High Level Budget Impact
Development of Information Sharing Guidance and a North South Protocol	3	10	Both the Guidance and the Protocol are intended for use primarily by HSC social work staff involved in inter-jurisdictional cases. The longer the delay to finalising and publishing the documents increases the risk of a case(s) being less effectively handled and possible non-compliance with legislation.	Amber – a North South protocol is in place since 2012.	No impact
Child Death Review in Northern Ireland	6	10	The Department is coming under increasing pressure to introduce child death review as a result of the findings and recommendations of the Hyponatraemia Inquiry. Pressure is also being brought to bear by the Commissioner for Children and Young People.	Amber	No impact
Mother and Baby Homes and Magdalene Laundries	6	10	Delay to key meeting of the IDWG on Mother and Baby Homes, Magdalene Laundries and Historical Clerical Child Abuse. Meeting on 24 March was to agree key priorities and develop recommendations for Executive consideration and approval including Way forward/options paper, publication and Agreement on research report and consequent stakeholder engagement events and consultation.	Amber/Red Likely to be public/key stakeholder and media interest/criticism due to previous delays to the research report publication and way forward/options.	No 2020/2021 budget cover
Review of UNOCINI	6	10	Aim of the review to reduce bureaucracy for social workers in children's services. Anticipated that social workers will be under greater pressure once lockdown ends given the pressures that families are experiencing. The work on reviewing UNOCINI was	Amber	No impact

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Programme / Project	Number of weeks lost: 9 March 17 April 2020	Projected number of weeks lost: 18 April 30 June 2020	Risks to Delivery	Risk Rating (Green / Amber / Red)	High Level Budget Impact
			also to feed into Encompass spec. to ensure it delivers for family and child care.		
Joint DOH /DOJ outworking of findings of SBNI and DOJ CSE Evaluation / report	6	10	Findings of SBNI Evaluation and CJI Report into child sexual exploitation will not be as current. Covid-19 pressures on agencies - social services and PSNI will impact on ability to adapt practice to findings. Increased risk to children from CSE has been highlighted, may be opportunity for vulnerable children and young people's plan to improve service.	Amber	No impact.
Ongoing monitoring of child protection issues and development of guidance, particularly Information Sharing for Child Protection Purposes	6	10	Given current pressures on families, child protection services remains a priority. The guidance on information sharing is needed to help social workers share information confidently and lawfully for child protection purposes. There may be an opportunity to progress dependent on current covid-19 workload.	Amber	No impact.
SBNI Regs	6	10	The regulations are needed to give effect findings of Jay review.	Amber – Jay Review reported in November 2014	No impact
Adoption and Children Bill	6	10	Original timescale for introduction of Bill in Assembly was early Autumn. Work is still required to complete drafting of the Bill and associated costings. A Bill of this size requires sufficient time to complete all Assembly stages (minimum of 12 months – possibly more if Committee stage is extended).	Amber – further delay could result in insufficient time for the Bill to complete all stages of Assembly scrutiny before end of current mandate.	No impact until Bill is implemented

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Programme / Project	Number of weeks lost: 9 March 17 April 2020	Projected number of weeks lost: 18 April 30 June 2020	Risks to Delivery	Risk Rating (Green / Amber / Red)	High Level Budget Impact
Regional Facilities for Children and Young People	3	10	Public consultation was due to take commence for 12 weeks on 7 May, currently postponed due to availability of stakeholders, many of whom will be at the forefront in dealing with the current Covid-19 pandemic. Legislation will also be required to establish new Campus, plan was for this to happen next year.	**Red** – Campus due to be established 2022. Delay in consultation has knocked programme back by at least 6 months.	Programme Team staffing costs jointly funded by DoJ and Transformation funding. Need clarity on availability for Transformation funding for future years staffing costs.
Children's Services Transformation Projects	4	10	Decisions outstanding in relation to continued funding for a number of projects. (13+) Some projects may have continued pending decisions on funding as staff were in post and a service was already being delivered	**Amber**	Continuing costs incurred by those projects which will not proceed in 2020/21, but which cannot yet be notified.
Publication of new DoH/DE Strategy for looked after children, 'A Life Deserved "Caring" for Children and Young People in Northern Ireland'	6	10	The project plan date for publication was 31 March 2020, subject to approvals. Delay will lead to increased risks around managing stakeholder expectations and loss of stakeholder buy-in. It is a key delivery mechanism for the Children and Young People's Strategy and for PfG/Outcomes Delivery Plan commitments to improve outcomes for our looked after children. Delays and budget outcome will require a review of the Strategy narrative before it is published. Delay does however allow us to take account of the impact of the pandemic upon care-experienced children and young people.	**Red**	None at present. Costed implementation plan for the Strategy relies on confirmation of funding for projects trialled through the transformation programme.
Development of proposals for alternative	6	10	A Ministerial action within *Delivering Together* was to explore the options for expanding alternative placements for looked after children. The	**Red**	None at present - costings exercise to be completed.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Programme / Project	Number of weeks lost: 9 March 17 April 2020	Projected number of weeks lost: 18 April 30 June 2020	Risks to Delivery	Risk Rating (Green / Amber / Red)	High Level Budget Impact
placement options for looked after children (The Sky's The Limit Report)			Department asked the HSCB to lead on this work with key stakeholders and an options report - The Sky's The Limit - was submitted to the Department on 28/02/18. This was unable to be progressed during the suspension of the Assembly but recently the HSCB was asked to cost the options in order to inform a submission to Minister for decision on the way forward. This work, however, was suspended during the Covid-19 response. Delay in exploring alternative placement options will mean that existing pressures within the system will persist or could deteriorate – with the potential to lead to detrimental impacts for the wellbeing of the child/young person, their carers/family and those HSC staff who are seeking to manage placements, as well as a range of other negative social and economic impacts		However, delay in progressing this project may mean that more costly placement interventions have to be relied upon to meet placement pressures in the short-term.
Development of the 'Keeping Connected' Scheme to expand placement options to children in care and care-experienced children and young people utilising Departmental capital funding	6	10	This is linked to a new policy proposed in the Strategy. It also closely links to the Sky's the Limit Report by creating additional placement capacity in the system through use of capital funding. Delay in development of the scheme will mean that existing pressures within the system will persist or could deteriorate – with the potential to lead to detrimental impacts for the wellbeing of the child/young person, their carers/family and those HSC staff who are seeking to manage placements, as well as a range of other negative social and economic impacts.	Amber	None at present. This scheme is to be developed on the basis of using Departmental capital slippage monies, as opposed to seeking dedicated project funding.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Programme / Project	Number of weeks lost: 9 March 17 April 2020	Projected number of weeks lost: 18 April 30 June 2020	Risks to Delivery	Risk Rating (Green / Amber / Red)	High Level Budget Impact
Development of new Fostering Placement and Fostering Agency Regulations and development and consultation on draft standards for fostering services			The proposals for the new Regulations were originally consulted on in 2014, with wide support from key stakeholders. Following some deferral of consideration by the Health Committee in 2016 and subsequent dissolution of the Assembly in 2017, the updated project plan included a review of the Regulations and a targeted refresh consultation, with a view to introducing the Regulations by the end of June 2020 (subject to Ministerial approval). Without the introduction of new Regulations, foster carers still can only be approved by HSCTs/some voluntary organisations as opposed to by all Fostering Agencies (ie. those 'not for profit' fostering organisations that are more recent to Northern Ireland). New Regulations will therefore increase capacity within the system for approvals and help expedite the process to facilitate increased placements within a pressured system. In addition, in the absence of the introduction of new Regulations, fostering agencies will continue to fall outside the scope of registration and inspection by the RQIA.	Green	No impact.
Work to scope options for a regional strategic approach to meet the challenges around the increasing numbers of separated and unaccompanied asylum seeking children arriving in Northern Ireland	6	10	Delaying this work could lead to additional significant pressures across an already pressured residential care sector in the event that a large number of unaccompanied asylum seeking children were to arrive in Northern Ireland. There is an added imperative with regard to timely progression of this work, given the deadline for an existing building to be vacated by September 2020. Immediate risks are being managed through contingency planning arrangements, with monies	Amber Immediate risks are being managed through contingency planning/rigorous monitoring.	Bids for specialist foster care and an assessment service have been made. Delays could mean that more costly short-term provision is required to be

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Programme / Project	Number of weeks lost: 9 March 17 April 2020	Projected number of weeks lost: 18 April 30 June 2020	Risks to Delivery	Risk Rating (Green / Amber / Red)	High Level Budget Impact
			secured via the Covid-19 funding (to ensure appropriate self-isolation of young people upon arrival in the country) and ongoing proactive and rigorous monitoring by the HSCB and HSCTs to facilitate moves within the system that meet the immediate needs of the young people in their care.		provided in the interim.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Reform of Adult Social Care

Programme / Project	Number of weeks lost: 9 March 17 April 2020	Projected number of weeks lost: 18 April 30 June 2020	Risks to Delivery	Risk Rating (Green / Amber / Red)	High Level Budget Impact
Reform of Adult Social Care - Stood down on the 16/3/20	6 weeks – it was proposed to have an action plan for Ministers consideration by Spring 2020.	10 weeks - On ministerial approval, it was planned to proceed with the public consultation in June 2020	If the required level of transformation of the Adult Social Care is not delivered or Insufficient funding to enable reforms to be introduced, it will impact directly on those most vulnerable in our society.	RED	Funding for the project remained unspent in 19/20 due to staff being redirected to Covid 19 response. Funding will be require to progress in 20/21.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Directorate: Mental Health, Disability & Older People

Programme / Project	Number of weeks lost: 9 March 17 April 2020	Projected number of weeks lost: 18 April 30 June 2020	Risks to Delivery	Risk Rating (Green / Amber / Red)	High Level Budget Impact
Mental Capacity Act Deprivation of Liberty Safeguards implementation	8	16	DoLS were commenced on 2 December 2019. Delay in monitoring and adjusting system for appropriate delivery. Delay may cause confusion and lack of legal safeguards.	Amber	Delay in some savings
Mental Capacity Act implementation planning	9	18	Delay in commencement of the full Mental Capacity Act.	Amber	None
Mental Health Action Plan	9	18	MH Action Plan was due to be published on 16 March in line with NDNA commitment. Delay in publication poses publicity risks and deliverability of some actions.	Red	None
Mental Health Strategy	8	17	NDNA commitment to publish MH Strategy by end of 2020. Delay makes publication in time impossible.	Red	Failure to deliver strategy may cause loss of savings.
Delivery of actions set out in MAH HSC Action Plan	7	12	HSC resources diverted away from implementation of actions	Amber	None
MAH Leadership and Governance Review	4	6	Review due to report in June, but likely this will be delayed.	Amber	None
Interdepartmental Action Plan – NICCY 'Still Waiting'	6	10	An Interdepartmental Action Plan to improve mental health services and support for children and young people developed for implementation over the next two years; however, work on the Action Plan has been paused in order to	Amber	None

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

			focus efforts on the HSC response to covid-19.		
Regional Trauma Network	6	10	Implementation of RTN is a PfG commitment and Phase 1 planned for launch by Summer 2020. However, Project Governance structures have been stood down. A partnership workshop in April 2020 to address issues has been postponed due to the current covid-19 crisis; and the HSCB RTN Project Team has been temporarily redeployed to focus on the covid-19 response.	Amber	None
Development of adult safeguarding legislation and public consultation paper	6	10	Public consultation delayed.	Amber	None
Year 5 Action Plan for the Stopping Domestic and Sexual Violence and Abuse Strategy	6	10	Publication of Year 5 Action Plan delayed (due in April).	Amber	None
New (Informal) Carers Strategy	6	10	Commencement of new strategy for unpaid carers delayed	Amber	None
Development of revised Autism Strategy.	6	10	Statutory requirement to publish revised strategy in 2021. Stakeholder engagement (including public questionnaire due to issue w/c 30 March) to inform revised strategy now delayed.	Amber	None
Independent Review into events at Dunmurry Manor Care Homes	6	10	Issue of Draft and Final Report delayed Delay to consideration of implementation of recommendations	Red	None

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Completion of Dementia Phase 2 Project	6	10	Issue of Evaluation Report Delays to consideration of impact Regional Dementia Pathway	Red	None
Continuing Health Care	6	10	Delays to submission of options to Minister following 2017 consultation exercise. Delays to formal review of CRAG	Red	
Establish a Disability Forum for those with a Physical, Sensory and Communication Difficulty.	6	10	Delays to analysis of engagement events outcomes, and application process for membership of the Forum.	Amber	None
Exploratory work to re-open the Independent Living Fund in NI.	6	4	Four public listening/engagement events cancelled. Moving to online consultation via ILF Scotland.	Amber	None

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Directorate: Transformation

Programme / Project	Number of weeks lost: 9 March 17 April 2020	Projected number of weeks lost: 18 April 30 June 2020	Risks to Delivery	Risk Rating (Green / Amber / Red)	High Level Budget Impact
HSC Transformation Programme	5	10	The Transformation programme has paused in response to the pandemic, with the Transformation Directorate continuity plan invoked. Strategic oversight groups, the Transformation Implementation Group, Transformation Operational Group, and the Transformation Advisory Group have not met since mid-March 2020. It should also be noted that COVID-19 has impacted on the utilisation of Transformation funding in 2019/20. The final outturn for the Fund was final spend of £114m, an underspend of £2.1m. It is estimated that a significant proportion of the total underspend is linked to the impact of Covid-19. As part of the evaluation of each project further work will be undertaken to understand the impact on a project by project basis. Given this has occurred so close to the end of the financial year, there has been no opportunity to reinvest this underspend in 2019/20. The Department has therefore sought End Year Flexibility in relation to these unspent funds. In addition, a key strategic exercise being undertaken by the HSCB to provide a commissioning direction for Transformation initiatives in 2020/21 has been delayed - and therefore become null and void - due to the HSCB / PHA invoking their continuity plans at the turn of the new financial year. As a result, a significant amount of work has been undertaken to develop an allocation process in the	**Red**	Continuing costs incurred by those projects which will not proceed in 2020/21, but which cannot yet be notified.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

			absence of this key HSCB information, with indicative allocations of Transformation funding delayed by at least 4/5 weeks; the allocations process is based on the best evidence available, but is in essence an informed judgement call, in the absence of a firm commissioning direction. The delay in providing a direction on 2020/21 allocations has also resulted in the system incurring unfunded costs, and work will need to be undertaken to understand and mitigate this risk in the coming months. As the process of sustainability planning was not completed by the HSCB, plans for the long term delivery of projects has not materialised, creating uncertainty for the future funding of c£81m of inescapable Transformation pressures. It is also important to note that, given the impact Covid-19 is having, and is likely to continue to have on the system, the growth of existing projects, or the introduction of new initiatives have not been considered at this time; including key NDNA commitments such as the consultation on the review of Unscheduled Care, the development of DECCs Phase 2, the review of stroke services, as well as high priority areas including funding for Project Life 2. In addition, the Covid-19 response will likely continue to be a priority for the system in the coming months. This will mean that the NDNA priorities which have been recommended for funding in 2020/21, will likely be impacted in terms of staffing levels to deliver these and to meet the commitments outlined with the New Decade, New Approach agreement. This position will be kept under review.		

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

			Work has also been delayed on the three year Transformation programme report, work to evidence change as a result of Transformation, and work to understand the final outturn position for the 19/20 Transformation Fund.		

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Programme / Project	Number of weeks lost: 9 March 17 April 2020	Projected number of weeks lost: 18 April 30 June 2020	Risks to Delivery	Risk Rating (Green / Amber / Red)	High Level Budget Impact
Organisational Change (Closure of the HSCB and Future Planning Model.)	5	10	Work on the closure of the HSCB has paused as staff have been redeployed to focus on the response to the pandemic. A draft early legislative bill to give effect to the closure of the HSCB was made available in late February 2020, with the expectation that a final draft bill would be completed by the end of April 2020. Aligned to this ,Minister Swann, the NI Executive, Health Committee, and the Attorney General's Office were to be engaged during the period April to the end of June, to facilitate introduction of the bill in the autumn Assembly session. Work to move to this anticipated position has not been progressed and there will inevitably be delays to the introduction of the Bill. A new operating model is also required for the successful delivery of operational change, which includes development of appropriate governance and accountability arrangements. All work in this area has also been delayed due to resources being moved to manage the Covid-19 response.	Amber	Nil.
Future Planning Model Commissioning Plan Direction	5	10	Work has been ongoing to scope a future planning model. Progress in this area has been delayed due to the redeployment of staff to the emergency response. Work was also underway to review the current commissioning processes, in the context of the above and HSCB Closure. This work has been	AMBER	Nil.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

			delayed and the development of the Commissioning Plan Direction was suspended. This will now be considered in the context of the ongoing Covid-19 situation.		

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Nursing, Midwifery and Allied Health Professionals

Programme / Project	Number of weeks lost: 9 March 17 April 2020	Projected number of weeks lost: 18 April 30 June 2020	Risks to Delivery	Risk Rating (Green / Amber / Red)	High Level Budget Impact
Launch of Online User Feedback System (Care Opinion)	6	10	The system was due to launch on 1 April 2020 but with Covid-19 this was cancelled.	Amber	None
Partnership Policy	6	10	No progress will be made on the review of the PPI Policy or of the drafting of a Partnership policy between 09 March and 30 June 2020.	Amber	None
Nursing and Midwifery Task Group Framework	6	10	The Nursing and Midwifery Task Group Framework was launched by the Minister on the 13th March 2020 and outlined a 3 phased approach to maximise the contribution of nursing and midwifery, which can be used to guide decision making and measure progress. The progress on the 2020/21 phase has been delayed which will impact on the delivery of the desired outcomes	Amber	None
Delivering Care Policy/Safe staffing	6	10	The work plan on developing further phases has been paused delaying progress in implementing this policy across further fields of nursing practice and midwifery where optimum staffing models have not been developed. Additionality the pause in progress has impacted on taking forward the safe staffing commitments set out in the Framework Agreement	Amber	None
Future Nurse Future Midwife	6	10	All front facing work has been paused i.e. Programme Board, Working Group and work streams. Professional officer support to HSC Trusts has continued. Project outcomes will be reviewed to ensure delivery of this regulatory implementation across Nursing and midwifery.	Green	None
AHP Workforce reviews	6	10	The work plan to progress the outstanding 8 reviews has been paused resulting in incomplete data to support the commissioning of undergraduate programmes and support for a number of	Red	None

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

			transformation projects, service redesign, implementation of the recommendations Additionality the pause in progress has impacted development of regional referral guidance, care pathways and staffing models		
AHP strategy	6	10	No progress has been made in progressing the AHP strategy and the consultation events scheduled between March and June have been stood down	**Green**	None
Interdepartmental Housing review	6	10	No progress has been made in progressing the Recommendations from the Interdepartmental Housing review and recruitment of the Housing Liaison officer post has paused between March and May	**Amber**	none
AHP supervision policy	6	10	A review of The AHP supervision policy which is out of date had commenced but has been paused between March and May	**Green**	None
Learning Disability Nursing Review	6	10	This review was due to complete in May 2020 but has been paused. Implications for commissioning of undergraduate and postgraduate programmes, support for service redesign and implications of recommendations. This is also an action on the Muckamore Departmental Assurance Group Action Plan and therefore will impact delivery of that plan,	**Red**	None
Healthy Child Healthy Future	6	10	The Healthy Child Healthy Future Programme require reviewed and updated in light of the current evidence from Health For All Children.	**Amber**	None
Nursing Now NI – International Year of the Nurse and The Midwife	6	10	Nursing and Midwifery Initiatives and conferences that have been planned to raise the profile and status of nursing and Midwifery have been cancelled or postponed.	**Amber**	None
Nursing (HV and DN) within Multidisciplinary teams in primary care expansion have been delayed.	6	10	Unable to progress the expansion of Health Visiting(HV) and District Nursing(DN) within the primary Care MDTs, resulting in reduced post graduate training places for HV and DN	**Amber**	None

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Department of Health

Management Board for Rebuilding HSC Services

Terms of Reference

1. Introduction

1.1 COVID-19 has presented unprecedented challenges for Health and Social Care (HSC) in Northern Ireland, which already prior to COVID-19 was facing huge strategic challenges in the form of an ageing population, increasing demand, long and growing waiting lists, workforce pressures and the emergence of new and more expensive treatments. Elective and diagnostic services have had to be curtailed with adverse impacts on existing waiting lists. At the end of March 2020 there were some 307,000 patients on the outpatient waiting list, more than 93,000 waiting for inpatient and day case admissions and more than 131,000 patients waiting for diagnostic tests. The existing challenges confronting the social care sector, as described in the 'Power to People' report, have also been compounded by the pandemic. COVID-19 has also identified the need to reassess healthcare needs of citizens and how they are provided and supported in the care home sector.

1.2 The impact of COVID-19 on HSC will be profound and long lasting. Services will not be able to resume as normal for some time due to the continued need to adhere to social distancing and continued need for PPE at volumes not required prior to the pandemic. In addition, the resilience of the health and social care workforce is likely to have been eroded and will continue to be impacted with pressures from the social care sector, which continues to be in the 'surge period'. These issues will likely adversely impact the pace of stabilisation across primary, secondary, community and social care services.

1.3 In addition, given the very significant downturn in health and social care services, many people have not had access to the screening, testing or treatments that they otherwise would have had. In that context, the Department took action to preserve the highest priority essential services to mitigate this impact. Inevitably, however, the downturn in normal business will lead to some diseases going undetected or untreated longer than is desirable with potential impact on long term health outcomes. The uncertainty and concern about the pandemic combined with the impact of the lockdown will also likely have had an adverse on mental health, especially for the most vulnerable in society.

1.4 A further issue that will increasingly come into focus during 2020 is the EU Exit date at the end of the year, which will add further complications not least around ability to attract foreign workforce into the Northern Ireland health and social care system.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

2.0 Statutory Context

2.1 The Department produced the HSC Framework Document, published in September 2011, to meet the statutory requirement placed upon it by the Health and Social Care (Reform) Act (NI) 2009. The Framework Document describes the roles and functions of the various health and social care bodies and the systems that govern their relationships with each other and the Department. In response to the impact of COVID-19, a Memorandum to the Framework Document has been published setting out temporary changes for a period of two years with effect from June 2020 and to be kept under review.

2.2 This Memorandum sets out the creation of a new temporary management board, the 'Management Board for Rebuilding HSC Services' which will come into being in June 2020 for a period of two years to be reviewed thereafter.

2.3 The Management Board and COVID-19 Surge Command Group will operate within the current legislative context and will have due regard to all of the Department's statutory obligations, including in relation Section 75, equality and good relations duties.

3. Rebuilding HSC Services Framework

3.1 The Department has completed an impact assessment, which evaluates the initial impact of COVID-19 on health and social care services as well as other departmental programmes and projects.

3.2 This impact assessment will underpin a new Strategic Framework to rebuild health and social care services. It will identify actions to stabilise HSC service delivery and business operations; new service delivery models and business structures required to stabilise the system; timescales for implementation; oversight structures; areas for priority action; and associated resources required.

3.3 The Framework will also consider the extent to which innovation and new delivery models developed during the emergency response can be permanently incorporated as we resume and develop health and social care services.

3.4 The Framework will provide the Strategic Direction for the work of the Management Board for Rebuilding HSC Services.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

4. Mission Statement

4.1 The mission of the Management Board is: To incrementally increase HSC service capacity as quickly as possible across all programmes of care, within the prevailing COVID-19 conditions. The aim will be to maximise service activity within the context of managing the ongoing COVID-19 situation; embedding innovation and transformation; incorporating the Encompass programme; prioritising services; developing contingencies; and planning for the future all at the same time. Specific service activity targets will be developed for each programme of care.

5. Remit of Management Board for Rebuilding HSC Services

5.1 The Management Board will be chaired by the Department of Health's Permanent Secretary and will report to the Minister of Health. The Management Board's role in relation to other vehicles, such as the Transformation Implementation Group (TIG), will be reviewed in due course. The Management Board will be run as a programme for an initial period of two years commencing in June 2020. The Minister will set the priorities for rebuilding health and social care services. The Management Board will:

- Provide oversight and direction to the Public Health Agency (PHA), the Health and Social Care Trusts and the Business Services Organisation (BSO) on the implementation of the Minister's priorities as reflected in the Department's 'Strategic Framework for Rebuilding HSC Services'. This will include a clear articulation of performance measures and targets.
- Ensure a system wide focus on managing the ongoing COVID-19 situation, developing contingencies, implementing change and planning for the future.
- Have oversight of both COVID-19 and non-COVID-19 activity, including the various cells which currently sit within the Gold/Silver/Bronze emergency planning structure.
- Ensure that in implementing the Framework, transformation continues in an integrated way including embedding innovations that have emerged during the pandemic.
- Provide strategic direction for the implementation of the Department's digital health transformation agenda.
- Co-ordinate bids for additional resources to fund the rebuilding of services.
- Provide challenge and rigour in the decision making process;
- Receive updates on progress against plans to implement the Framework and direct corrective action where required to address slippage.
- Address escalated issues and risks.
- Act as champions at both a regional level, within their organisations and communities, and to the general public as a whole ensuring coherent and consistent messaging.
- Ensure principles of co-production are embedded.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

6. Governance and Operational structure

6.1 The structure of the Management Board is organised on the basis of a two-pillar model. Pillar 1 maintains the DoH emergency planning Gold/Silver/Bronze (GSB) structure mandated to manage the response to the current position (at any point within the emergency period when GSB have been activated) and a planning horizon of 72 hours. Pillar 2 includes the planning for potential future surges of COVID-19 and the HSC services rebuilding programme which governs a number of thematic projects to deliver the strategic rebuilding outcome sustainably over the medium to long term. The two pillars are supported by a shared hub in the Department which provides the overall management and information coordination through combining the elements of a situation room (detailed service provision information up to 72 hours out when GSB has been activated) and a programme management office responsible for the coordination of the delivery of projects and their implementation within the overall HSC services rebuilding programme.

6.2 The two-pillar structure will ensure visibility, coordination and governance across the whole system, eliminating duplication and ensuring agility to prepare for and respond to the next phases of the COVID-19 pandemic; while at the same time planning for the future.

6.3 In order to implement two key elements of RMB's remit, within the context of managing the emerging second surge, from October 2020, which is placing significant increased demand on the HSC's service delivery capacity, the Department will modify Pillar 2 to provide enhanced Departmental oversight of the delivery of HSC services across the region for a period of six months to be reviewed end-March 2021. The two key elements are:

- Ensure a system wide focus on managing the ongoing COVID-19 situation, developing contingencies, implementing change and planning for the future.
- Have oversight of both COVID-19 and non-COVID-19 activity, including the various cells which currently sit within the Gold/Silver/Bronze emergency planning structure.

6.4 The enhanced Departmental oversight will operate on the basis of securing as much business continuity as possible over the six months period. The business continuity model, named as the 'COVID-19 Business Continuity Response Protocol', will include elements of the GSB Emergency infrastructure as required. The structure and functions of the 'COVID-19 Business Continuity Response Protocol' is provided in the attached Annex A.

6.5 The COVID-19 Taskforce (see Annex A attached) will liaise with the Adult Social care surge planning group, led by CNO and CSW, to ensure that the health services and adult social care response to the surge are fully aligned. CNO and CSW are also members of the COVID-19 Gold Command Group (see Annex A attached) which will strengthen the alignment between healthcare and social care in responding to the surge.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

7. RMB Membership

7.1 The core executive membership of the Management Board will be as follows:

- Permanent Secretary, Chair (Peter May)
- Karen Bailey (Chief Executive, Business Services Organisation)
- Michael Bloomfield (Chief Executive, Northern Ireland Ambulance Service Trust)
- Maria O'Kane (Acting Chief Executive, Southern Health & Social Care Trust)
- Sean Holland (Chief Social Services Officer, DoH)
- Sharon Gallagher (Deputy Secretary, DoH Strategic Planning and Performance Group)
- David Gordon (Director of Communications, DoH)
- Cathy Harrison (Chief Pharmaceutical Officer, DoH)
- Dr Cathy Jack (Chief Executive, Belfast Health & Social Care Trust)
- Jim Wilkinson (Deputy Secretary, DoH Healthcare Policy Group)
- Neil Guckian (Chief Executive, Western Health & Social Care Trust)
- Aidan Dawson (Interim Chief Executive, Public Health Agency)
- Maria McIlgorm (Chief Nursing Officer, DoH)
- Dr Michael McBride (Chief Medical Officer, DoH)
- Roisin Coulter (Chief Executive, South Eastern Health & Social Care Trust)
- Dr Margaret O'Brien (Head of General Medical Services, DoH)
- Jennifer Welsh (Chief Executive, Northern Health & Social Care Trust)
- Dan West (Chief Digital Information Officer, DoH)
- Chris Matthews (Deputy Secretary, DoH Resource & Corporate Management Group)

7.2 The Minister's Special Adviser will attend meetings of the Management Board.

7.3 Suzanne Martin (Chief Allied Health Professional) will attend meetings of the Management Board in an observer capacity to participate in meetings and to receive all information provided to members of RMB, but with no accountability for the remit set out in paragraph 5.1 above.

7.4 The Minister and the Management Board will obtain advice from experts working in health and social care fields to inform its work in the rebuilding of HSC services, as required.

8. Governance and Accountability

8.1 The Management Board will operate within the terms of the HSC Framework Document (paragraphs 2.4, 2.38 and 3.7 refer).

8.2 The Management Board will not exercise any other authority in relation to the statutory duties, roles and responsibilities, as specified in the HSC Framework, Document which the Department has delegated to the PHA and a number of other HSC bodies.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

8.3 The Permanent Secretary will act as Senior Responsible Owner (SRO) for the Management Board and will chair the Board. He will be accountable to the Minister for the implementation of the 'Strategic Framework for Rebuilding HSC Services'.

8.4 The Management Board will endorse proposals and will inform the decision making process. Final approvals and decision making rests with the Minister.

8.5 All members of the Management Board are expected to take decisions collaboratively and objectively, declaring any potential conflicts of interest.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

ANNEX A

DEPARTMENT OF HEALTH (NI)

COVID-19 BUSINESS CONTINUITY RESPONSE PROTOCOL

COVID-19 Gold Command Group (C19GCG)

Remit

The remit of the C19GCG is to:

- Ensure a system wide focus on managing the ongoing COVID-19 situation, developing contingencies, implementing change and planning for the future.
- Have oversight of both COVID-19 and non-COVID-19 activity, including the various cells which currently sit within the Gold/Silver/Bronze emergency planning structure.

Functions

The primary functions of the C19GCG are to:

- Facilitate a strategic overview of the health and social care response to the surge.
- Provide and advise on health and social care policy as directed by the Minister.
- Provide strategic direction, on all operational matters related to the management of the surge including resource needs to the HSC.
- Facilitate clear, coordinated, timely decisions and actions.
- Disseminate and implement the Minister's, CMO's or other top management's decisions quickly.
- Provide Ministerial briefings and statements, instil and maintain trust and confidence by ensuring that the public and the media are engaged and well informed and are enabled to take steps to sustain their own safety and wellbeing throughout the surge period.
- Provide a forward look to issues that may arise concerning medium and long-term rebuilding for consideration by the Rebuilding Management Board.
- Liaise with the Department of Health and Social Care (England), Health Departments in Scotland and Wales, Department of Health (ROI) and other NI Executive Departments/Agencies as necessary.
- Liaise with the HSC Trade Unions Joint Secretaries on surge issues related to the HSC workforce, which have an impact upon the HSC at regional level.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Structure

Minister

COVID-19 Gold Command Group

Chair: Permanent Secretary
Members: Chief Medical Officer
Chief Nursing Officer
Chief Social Worker
Deputy Secretary Healthcare Policy
Chief Executive, PHA

COVID-19 Taskforce

COVID-19 Response Directorate	**Surge Directorate**	**Rebuilding Directorate**	**Secondary Care Directorate**	**General Healthcare Policy Dir.**	**SPPG Silver Command**

COVID-19 Operations Centre

COVID-19 Policy Cells

1. **Accommodation**
2. **Adult Social Care**
3. **Cancer Services**
4. **Clinical/Professional Advisory**
5. **Communications**
6. **Contact Tracing**
7. **Dentistry**
8. **Digital/Analytical/Helplines**
9. **Elective Care**
10. **Finance**
11. **Health Protection**
12. **Modelling/Joint Bio Security Centre**
13. **PPE**
14. **Pharmacy/Supplies**
15. **Primary Care**
16. **Testing**
17. **Statutory Regulations**
18. **Surge (Hospitals**
19. **Unscheduled Care (No More Silos)**
20. **Vaccination Programme**
21. **Workforce**

HSC Trusts Bronze Command

Belfast HSC Trust
Northern HSC Trust
NI Ambulance Service HSC Trust
Southern HSC Trust
South Eastern HSC Trust
Western HSC Trust

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Priorities of the COVID-19 Taskforce

The Taskforce Directors will organise and manage their respective functions and responsibilities on the basis of a matrix structure with the five Directors operating as a collective leadership sharing and allocating resources to manage their shared policy workload on the following prioritised basis: (1) COVID-19 Response*; (1) Surge Management*; (2) Elective Care; (3) All other Extant Policy Areas; and, (4) Services Rebuilding. These priorities will be kept under review.

* Equal Priority

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

SUB-00XX-2020

FROM: JACKIE JOHNSTON

DATE: 3 SEPTEMBER 2020

TO: ROBIN SWANN MLA, MINISTER

Copy Distribution List below

SUB-00XX-2020: HSC SERVICE TRANSFORMATION REVIEWS

Summary

Issue	**To seek your approval for the updated programme of HSC service transformation reviews.**
Timeframe	**Routine.**
Financial Implications	**A budget allocation will be needed to fund the project running costs for new service reviews subject to business case approval.**
Legislation Implications	**There are no legislative implications with the proposed approach.**
FoI Implications	**Likely to be disclosed.**
Special Adviser's views	**To be inserted by Private Office**
Executive referral	**Not applicable**
Presentational issues	
Equality Implications	**No major implications anticipated. Equality screening will be carried out as part of each individual service review.**
Recommendation:	**It is recommended that you note the status report and approve the proposed forward work programme.**

Introduction

1. This paper is to provide you with a status report on the HSC service reviews, sponsored by the Transformation Implementation Group (TIG), and to invite you to approve the proposed forward work programme which has been agreed by the Rebuilding Management Board.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

2. There are three categories of service reviews sponsored by TIG: priority 1 reviews recommended in 'Systems not Structures' (Bengoa); priority 2 reviews recommended by Bengoa; and, additional service reviews which TIG decided to endorse. A status report on each review under their respective categories is provided in the attached annex.

3. The Rebuilding Management Board reviewed the status report at its meeting on 19 August 2020 and agreed the following updated programme of service reviews.

Service Reviews Proposed to Resume or Start in the period September 2020 to March 2021 Subject to Available Resources and the Prevailing Covid-19 Conditions

Priority 2 Reviews (Bengoa Report)

Obstetrics, Maternity and Neonatal

Urology (establish whether it would be possible to provide a Neurology Transformation Blueprint, based upon the work already started, similar to the Orthopaedics Blueprint)

Additional Service Reviews Sponsored By TIG

Bariatric

Neurology

Service Reviews Not Yet Started: Timetabling of these to be reviewed in January 2021

Priority 1 Reviews (Bengoa Report)

Primary Care including GP Out of Hours

General Surgery

Vascular

Priority 2 Reviews (Bengoa Report)

Palliative Care

Rehabilitation

Community Based Elderly Care

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Recommendations

4. It is recommended that you note the status report and approve the proposed forward work programme.

Jackie Johnston

Copy Distribution List:
Richard Pengelly
TMG
Alastair Campbell
David Gordon
Peter Jakobsen
Chris Matthews
Ryan Wilson
SpAd

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

ANNEX

HSC SERVICE TRANSFORMATION REVIEWS

Priority 1 Reviews (Bengoa Report)

1. Emergency & Urgent Care - review completed. Initial report scheduled for submission to Minister end-August 2020.
2. Stroke Services – review completed. Report submitted to Minister for decision.
3. Primary Care including GP Out of Hours – review not yet started.
4. General Surgery – review not yet started.
5. Pathology – review completed. Next steps submission scheduled for submission to the Minister in September 2020.
6. Vascular – review not yet started.

Priority 2 Reviews (Bengoa Report)

7. Paediatrics – review completed. Implementation is underway.
8. Palliative Care – review not yet started.
9. Obstetrics – review combined with Maternity and Neonatal Services – TIG endorsed the Review Terms of Reference and the Minister approved them on 5 March 2020. Carolyn Bailie, Consultant Obstetrician, Belfast Trust and Gill Walton, Chief Executive, Royal College of Midwives have agreed to co-chair the review. However, the review has not yet started due to the first wave of Covid-19 intervening with resources diverted to manage the HSC's response.
10. Radiology - review completed. Implementation underway.
11. Maternity and Neonatal - review combined with Obstetrics.
12. Trauma – review completed. Implementation underway.
13. Urology – review not yet started.
14. Rehabilitation – review not yet started.
15. Community Based Elderly Care – review not yet started.
16. Breast Cancer Services – Part 1 of the review completed and report submitted to Minister for decision.

Additional Service Reviews Sponsored By TIG

17. Daycase Elective Care – review completed and approved by the Minister. Implementation underway with the initial DECC to be located in Lagan Valley Hospital.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

18. Neurology - review underway but has been disrupted due to the first wave of Covid-19 intervening with resources diverted to manage the HSC's response.
19. Bariatric Services – review underway but has been disrupted due to the first wave of Covid-19 intervening with resources diverted to manage the HSC's response.
20. Orthopaedics - review completed and approved by the Minister. Implementation underway.
21. Medical Oncology – review completed and subsumed within Rebuilding Stabilisation Plan. Approved by RMB for submission to Minister during August 2020.

Summary Position

Reviews completed and implementation underway: 5

Paediatrics

Radiology

Trauma

Daycase Elective Care

Orthopaedics

Reviews completed and recommendations submitted to the Minister: 2

Stroke Services

Breast Cancer Services Part 1

Reviews completed and reports scheduled for submission to the Minister: 3

Emergency & Urgent Care

Pathology

Medical Oncology

Reviews approved but delayed or paused due to Covid-19: 3

Bariatric

Neurology

Obstetrics, Maternity and Neonatal

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Reviews not yet started: 7

Primary Care including GP Out of Hours

General Surgery

Vascular

Palliative Care

Urology

Rehabilitation

Community Based Elderly Care

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Rebuilding HSC Services Management Board

Wednesday 19 August

10.00am

Note of Meeting

In attendance:

Richard Pengelly RP (Chair)	Maxine Patterson MP
Michael McBride MMcB	Cathy Jack CJ
Jackie Johnston JJ	Valerie Watts VW
Charlotte McArdle CMcA	Alastair Campbell AC
Sean Holland SH	Owen Harkin OW
Peter Jakobsen PJ	Shane Devlin SD
Anne Kilgallen AK	Olive MacLeod OMacL
Cathy Harrison CH	Karen Bailey KB
Roisin Coulter RC	Alan Stout AS
For Agenda Item 3 Eilis McDaniel	Mark Taylor MT
Secretariat	Mark Ovens MO
Lawrence Hyland LH	For Agenda Items 4 & 5 Mark Lee
Neil Sinclair NS	

1. Welcome and Apologies

RP welcomed members to the meeting. Apologies were noted for Deborah McNeilly, Seamus McGoran, Jennifer Walsh and Michael Bloomfield. RC attended the meeting on behalf of Seamus McGoran, OH on behalf of Jennifer Welsh, MP on behalf of Michael Bloomfield.

2. Note of the meeting held on 12 August 2020

The note of the previous meeting was agreed. RP noted that 7 action points required updates which the PMO agreed to follow up on.

Action Point – PMO to obtain updates on outstanding action points.

3. Children's Social Care final report –

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Eilis McDaniel (EMcD) joined the meeting for Agenda Item 3

A Recovery Plan, Monitoring Report, Covid-19 Action Card and Weekly Statistics were circulated with papers prior to the meeting. EMcD provided an overview of the Recovery Plan and explained that there was a robust legal framework governing all services. Some services were suspended, some delivery took longer due to extending the timescales and some were delivered in a different way.

Legislation change took place in May with a view to revoking the change in six months. EMcD commented that the first monitoring report was received on 6 June and that the July report had just been received. Data indicates that there has been a significant increase in the number of referrals to children's social services. EMcD highlighted a number of figures to the board and that the plan was to return to business as usual by the end of September except for Court activity. It was hoped that the modification to the regulations would be revoked by the end of September, two months ahead of schedule, and that data collection would stop by the end of August. EMcD concluded her report by thanking the Health and Social Care Board for all their support.

Board members welcomed the update and discussions highlighted the coordinated work between Trusts and PSNI over the summer period and the significant uptake in service around the 12th holiday period. Members also noted the increase of children taken in to care. SH highlighted a potential significant child health protection case that was ongoing.

The update was noted by the Board.

4. Adult Social Care and Learning Disability Update – M Lee

Adult Social Care

An update paper on Adult Social Care and Learning Disability were circulated prior to the meeting.

ML led the discussion on the updates for Adult Social Care. He highlighted that a new Surge Planning Board has been set up chaired by SH and CMcA. The purpose of the Board is to coordinate and oversee surge planning for care homes, taking account of the Rapid Learning Initiative.

Board members welcomed the update and discussions centred around learning from the first phase and that the wraparound service provided by Trusts to care homes was unique to NI and that the other UK regions view this as enviously.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

CMcA said that numbers would continue to be monitored closely to maintain and improve on 1st surge. MMcB commented that NI has fared much better than other regions for a number of reasons but that the pandemic continues to be a challenge.

Capacity in care homes was discussed. Normally spare capacity was around 7% but at the moment this was around 10% or about 450 beds.

Data regarding discharges was discussed and a comparative study on discharges up to 15 March some months ago had concluded that numbers were no different than last year.

The update was noted by the Board.

Learning Disability

ML explained the contents of the paper highlighting admission numbers, community services, capacity tracking, practicalities of expansion and respite care. He stated that COVID-19 related learning disability deaths in NI were comparably lower than in England. He explained that there were a number of significant challenges to getting services back to normal. Autism and SEN assessments provided within the statutory timeframes continues to prove difficult due to current situation and this will have a major knock on effect on waiting lists.

Board members welcomed the update. Discussions took place around the lack of facilities due to the current situation and the effect that it was having on both carers and staff.

The Board noted the contents of the paper.

5. Mental Health Update

ML introduced the update paper stating that HSCB/PHA have developed a regional Service Recovery Plan for Adult Mental Health Services. They meet fortnightly to discuss the ongoing situation. He stated that inpatient services had not been greatly affected and that psychotherapy continued. There has also been some movement to online rather than face to face consultations. There are significant concerns that COVID-19 has exacerbated an already stretched to breaking point service. ML voiced some concerns around the physical clinic space and the need to adhere to social distancing measures hence the need for a greater uptake of online talking therapies and the use of digital solutions.

Board members welcomed the update and discussions centred around the lack of mental health beds being a pinch point and that the coming surge of mental health referrals would need to be managed. Digital solutions were discussed with issues being raised that digital interaction was not ideal in the most severe cases but that

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

younger people being treated under CAMHS were more receptive to digital interaction.

The board noted the contents of the paper.

6. COVID-19 Nightingale

A number of papers were circulated prior to the meeting including a cover paper and template; Funding and Approval Proforma; and an associated Business Case.

CMcA explained that there had been a lot of discussion around this paper and the general consensus was that the Whiteabbey 100 bed step down facility was the best way forward. She asked the board to note the high level findings from the work of the Nightingale project board as well as financial implications. She reminded the board that in strengthening the business case through further engagement with economist and finance colleagues would impact adversely on delivery times. CMcA also underlined the need to be ready for 2nd wave sooner rather than later. She asked the board to endorse the paper for ministerial approval.

Board members discussed the proposal and raised the concern that in essence they would be signing off on the proposal without Business Case approval and that this risk needed to be highlighted. A key issue will continue to be the potential staffing pressures that would be faced going forward.

AK highlighted that the reference in the briefing note to 60 beds coming online in Altnagelvin in October 2020 was factually incorrect. Relevant details had been sent to Ernst & Young for their preparation of the business case. AK also highlighted that 52 beds were currently closed in Altnagelvin due to a lack of staff and a workforce plan would be required to ensure there was no double counting of staff.

RP commented that going forward without full business case sign off is a risk, however, this needs to be balanced against a narrow window of opportunity to enable the facility to be ready in time. The risks highlighted by Board members would be flagged up to the Minister in the submission.

The board agreed to recommend the Whiteabbey Nightingale facility to the Minister.

Action Point – CMcA to draft submission to the Minister recommending the Whiteabbey Nightingale facility.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

7. Rebuilding HSC Services PID

PJ advised that the PID had been updated to take into account the discussions held around the Forward Work Programme and to incorporate the new Winter Pressure Sub-Group. Once agreed the PID would be submitted to the Minister for approval.

The Board also took the opportunity to record its congratulations to Peter Wilson on his success in the Director of Operations competition within BSO.

Board members agreed the revisions to the PID.

Action Point – PJ to submit the revised PID to the Minister for his approval.

8. TIG Service Reviews Programme

Following on from last week's discussions, JJ outlined the proposed approach to recommencing service reviews. The paper distributed before the meeting sought to pull together the numerous conversations around the restarting of various service reviews.

The board agreed the proposed approach.

Action Point – JJ to submit proposals to the Minister.

9. Date of next meeting.

Date of next meeting planned for Wednesday 26th August at 10.00.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

From: Gallagher, Sharon
To: Johnston, Jackie (DoH); McNeilly, Deborah
Cc: Pengelly, Richard; Holland, Sean; McArdle, Charlotte; McBride, Michael; West, Dan; Campbell, Alastair; Dolan, Ciara; Jakobsen, Peter; Matthews, Chris (G5); Wilson, Ryan (DoH); DoH SpAd; DoH Private Office; DoH Press Office
Subject: SUB/1819/2020 : Comments from SG - Service Transformation Reviews
Date: 04 September 2020 09:21:20

Jackie,
Agree we need to keep focus on change but human resource implications will also factor heavily. We still rely on a diminished and ever diminishing resource in the Department but also HSCB and BSO, it is difficult to fathom how these might stretch further given rebuild, winter pressures and anticipated surge.
Regards,
Sharon

-----Original Message-----
From: Johnston, Jackie (DoH)
Sent: 03 September 2020 20:04
To: McNeilly, Deborah [redacted]
Cc: Pengelly, Richard [redacted]; Gallagher, Sharon [redacted] Holland, Sean [redacted]; McArdle, Charlotte [redacted] McBride, Michael [redacted]; West, Dan [redacted]; Campbell, Alastair [redacted]; Dolan, Ciara [redacted]; Jakobsen, Peter [redacted]; Matthews, Chris (G5) [redacted]; Wilson, Ryan (DoH) [redacted]; DoH SpAd [redacted]; DoH Private Office [redacted]; DoH Press Office [redacted]
Subject: RE: SUB-XXX-2020 - Service Transformation Reviews

Deborah

Thank you. At this stage I'm asking the Minister to approve the forward programme. If he agrees to this individual decision subs for each review including TOR, project running costs, business case, etc., would need to be prepared. Therefore difficult to provide an overall estimated cost at this stage as costs of each review and timing of launch will vary.

Regards

Jackie

-----Original Message-----
From: McNeilly, Deborah
Sent: 03 September 2020 19:52
To: Johnston, Jackie (DoH) [redacted]; DoH Private Office [redacted] DoH Press Office
Cc: Pengelly, Richard [redacted]; Gallagher, Sharon [redacted] Holland, Sean [redacted]; McArdle, Charlotte [redacted]; McBride, Michael [redacted]; West, Dan [redacted]; Campbell, Alastair [redacted]; Dolan, Ciara [redacted]; Jakobsen, Peter [redacted]; Matthews, Chris (G5) [redacted]; Wilson, Ryan (DoH) [redacted]; DoH SpAd [redacted]
Subject: RE: SUB-XXX-2020 - Service Transformation Reviews

Jackie

Helpful if the budget allocation required to take forward the reviews was set out and over what timeframe. We have a pressure on the mainstream budget in 2020/21 to resolve, transformation funding has been wholly allocated and I am not clear if we could reasonably fund from Covid monies.

Thanks

Deborah
Deborah McNeilly
Deputy Secretary, Resource and Corporate Management Group, DoH
Tel: Personal Information redacted by the USI
Ext: Personal Information redacted by
Email: Personal Information redacted by the USI Please ensure that all email correspondence to me is also copied to Personal Information redacted by the USI

CLICK LINK BELOW FOR DOH GUIDANCE ON GDPR AND DATA PROTECTION
http://nics.intranet.nigov.net/health/articles/gdpr-data-protection

-----Original Message-----
From: Johnston, Jackie (DoH)
Sent: 03 September 2020 17:32
To: DoH Private Office Personal Information redacted by the USI; DoH Press Office Personal Information redacted
Cc: Pengelly, Richard Personal Information redacted by the USI; Gallagher, Sharon Personal Information redacted by the Holland, Sean Personal Information redacted by the USI; McArdle, Charlotte Personal Information redacted by the USI; McBride, Michael Personal Information redacted by the USI; McNeilly, Deborah Personal Information redacted by the USI; West, Dan Personal Information redacted by the USI; Campbell, Alastair Personal Information redacted by the USI; Dolan, Ciara Personal Information redacted by the USI; Jakobsen, Peter Personal Information redacted by the USI; Matthews, Chris (G5) Personal Information redacted by the USI; Wilson, Ryan (DoH) Personal Information redacted by the USI; DoH SpAd Personal Information redacted by the USI; Johnston, Jackie (DoH) Personal Information redacted by the USI
Subject: SUB-XXX-2020 - Service Transformation Reviews

Press Office - could you insert the presentational line please.

Regards

Jackie Johnston

------< HPE Records Manager record Information >------

Record Number : HE1/20/422506
Title : SUB-XXX-2020 - Service Transformation Reviews

From:	DoH Private Office
To:	Johnston, Jackie (DoH)
Cc:	Jakobsen, Peter; Holland, Sean; Wilson, Ryan (DoH); Pengelly, Richard; Gallagher, Sharon; DoH Private Office; McNeilly, Deborah; Campbell, Alastair; DoH Press Office; Burns, Kim; McArdle, Charlotte; Matthews, Chris (G5); DoH SpAd; Gordon, David; DoH CMO Office; DoH CDIO
Subject:	Submission Decision SUB-1819-2020 : HSC SERVICE TRANSFORMATION REVIEWS
Date:	09 September 2020 13:31:29
Attachments:	SUB-1819-2020 COVER NOTE.pdf

Classification: Official
Timing: Routine
Reference: SUB-1819-2020

Subject: SUB-1819-2020 : HSC SERVICE TRANSFORMATION REVIEWS

To: JACKIE JOHNSTON
Date: 09/09/2020

The following comment has been made to your submission of 03/09/2020:

Noted.

We need an update on both the review of stroke and part 1 of breast cancer services. They were submitted for decision as the annex indicates, but further information was sought at the time.

Why hadn't the review of general surgery not started by March? Was it a case of capacity or DOH assessed priority etc.

For further information etc. contact:
Suzanne Ferris
Private Office and Coordination
Personal Information redacted by

Copied To For Information:
Jakobsen, Peter; Holland, Sean; Wilson, Ryan (DoH); Pengelly, Richard; Gallagher, Sharon; DoH Private Office; McNeilly, Deborah; Campbell, Alastair; DoH Press Office; Burns, Kim; McArdle, Charlotte; Matthews, Chris (G5); DoH SpAd; Gordon, David; DoH CMO Office; DoH CDIO

Approved	
Noted	✓
Meeting with Officials	
Further Information Required	

Department of Health
An Roinn Sláinte
Márnystrie O Poustie

Deadline: Routine

Title: HSC Service Transformation Reviews

Ref: SUB-1819-2020

To PS/Minister: KG 4/9/2020

Comments from Special Adviser:

We need an update on both the review of Stroke and part 1 of breast cancer services. They were submitted for decision as the annex indicates, but further information was sought at the time.

Why hadn't the review of general surgery not started by March? Was it a case of capacity or OoH assessed priority etc.

SPAD Signed: Personal Information redacted by the USI

Date: 09.09.20

Comments from Minister:

Minister Signed: Personal Information redacted by the USI

Date: 9/9/20

PTO for further comments

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

From:	DoH Private Office
To:	Johnston, Jackie (DoH)
Cc:	Jakobsen, Peter; Wilson, Ryan (DoH); DoH Private Office; Campbell, Alastair; Burns, Kim; Matthews, Chris (G5); DoH SpAd; Holland, Sean; Montgomery, Laverne; Johnston, Jackie (DoH); Gallagher, Sharon; McNeilly, Deborah; McArdle, Charlotte; Gordon, David; DoH CMO Office; DoH CDIO
Subject:	Submission Decision SUB-2271-2020 : HSC SERVICE TRANSFORMATION REVIEWS
Date:	15 December 2020 16:53:53
Attachments:	SUB-2271-2020 - Service Transformation Reviews.msg

Classification: Official
Timing: Routine
Reference: SUB-2271-2020

Subject: SUB-2271-2020 : HSC SERVICE TRANSFORMATION REVIEWS

To: JACKIE JOHNSTON
Date: 15/12/2020

The following comment has been made to your submission of 15/12/2020:

Approved.

For further information etc. contact:
Suzanne Ferris
Private Office and Coordination
Personal Information redacted by

Copied To For Information:
Jakobsen, Peter; Wilson, Ryan (DoH); DoH Private Office; Campbell, Alastair; Burns, Kim; Matthews, Chris (G5); DoH SpAd; DoH TMG (sub)

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

From:	Tullin, Frances
To:	DoH Private Office
Cc:	Pengelly, Richard; DoH SpAd; Carson, Jane; Clarke, Helen; DoH CMO Office; DoH CDIO; Davidson, Joy; Dawson, Alison; Donaldson, Hayley; Doran, Laura; "Gallagher, Sharon"; Gordon, Lesley; "Gourley, Agnes"; Holland, Sean; McArdle, Charlotte; McNeilly, Deborah; Meredith, Karina; DoH Press Office; Montgomery, Laverne; Saulters, Jayne; Irvine, Annette; Johnston, Jackie (DoH); Campbell, Alastair; Gordon, David; Matthews, Chris (G5); Wilson, Ryan (DoH); Greenwood, Victoria; Magee, Aisling; Jakobsen, Peter; Mort, Paula
Subject:	SUB-2271-2020 - Service Transformation Reviews
Date:	15 December 2020 13:23:30
Attachments:	SUB-1819-2020 Service Transformation Review.tr5 SUB-1819-2020 Service Transformation Review.DOCX

Private Office

Please see attached submission for Minister's consideration

Kind regards

Frances Tullin
Personal Secretary to Jackie Johnston
Deputy Secretary, Healthcare Policy Group
Department of Health
Block C5.21 Castle Buildings
Stormont
BELFAST BT4 3SQ

T Personal Information redacted by the USI (internal x Personal Information redacted by the USI)
E Personal Information redacted by the USI

Work pattern: Tuesday, Wednesday Thursday

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

SUB-1819-2020

FROM: JACKIE JOHNSTON

DATE: 15 DECEMBER 2020

TO: ROBIN SWANN MLA, MINISTER

Copy Distribution List below

SUB-1819-2020: HSC SERVICE TRANSFORMATION REVIEWS

Summary

Issue	**To seek your approval for the updated programme of HSC service transformation reviews.**
Timeframe	**Routine.**
Financial Implications	**A budget allocation will be needed to fund the project running costs for new service reviews subject to business case approval.**
Legislation Implications	**There are no legislative implications with the proposed approach.**
FoI Implications	**Likely to be disclosed.**
Special Adviser's views	**To be inserted by Private Office**
Executive referral	**Not applicable**
Presentational issues	
Equality Implications	**No major implications anticipated. Equality screening will be carried out as part of each individual service review.**
Recommendation:	**It is recommended that you approve the updated forward work programme of proposed HSC service transformation reviews. Draft terms of reference for the proposed General Surgery service review will be submitted to you for approval in due course.**

Introduction

1. You approved the proposals in my submission of 3 September 2020 (copy attached for ease of reference) which provided an updated forward work

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

programme for HSC Transformation Service Reviews which were agreed by the Rebuilding Management Board (RMB).

2. RMB reviewed the forward work programme at its meeting on 9 December 2020 and agreed that the proposed General Surgery service review should be given a higher priority and added to the list of reviews that we would propose to resume or restart in the period to March 2021.

3. It should be noted that due to pressures on staff resources we have not yet managed to start or resume the reviews listed in my submission of 3 September 2020. Therefore starting or resuming these reviews is conditional on identifying the necessary staff resources (project management, clinical leads, managerial leads and administrative support) to lead and participate in forming the necessary review groups.

4. The proposal to bring forward the review of General Surgery has been prompted by the pressures on providing surgical rota cover within SWAH for which the HSC has developed a short-term solution. Similar pressures in other hospitals located in peripheral geographical areas, such as Daisy Hill Hospital, continue to arise. The proposed review would therefore identify potential options for strengthening the regional commissioning of General Surgical services in order to more closely integrate the planning of service delivery across the entire HSC hospital network with the aim of maximising available staffing and infrastructure resources to deliver a standardised regional service specification. This would be a logical follow-on to the work on establishing DECCs which is now being implemented.

Service Reviews Proposed to Resume or Start in the period December 2020 to March 2021 Subject to Available Resources and the Prevailing Covid-19 Conditions

<u>Priority 1 Reviews (Bengoa Report)</u>

General Surgery

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Priority 2 Reviews (Bengoa Report)

Obstetrics, Maternity and Neonatal

Urology (establish whether it would be possible to provide a Neurology Transformation Blueprint based upon the work already started)

Additional Service Reviews Sponsored By TIG

Bariatric

Neurology

Service Reviews Not Yet Started: Timetabling of these to be reviewed in January 2021

Priority 1 Reviews (Bengoa Report)

Primary Care including GP Out of Hours

Vascular

Priority 2 Reviews (Bengoa Report)

Palliative Care

Rehabilitation

Community Based Elderly Care

Recommendations

5. It is recommended that you approve the updated forward work programme of proposed HSC service transformation reviews. Draft terms of reference for the proposed General Surgery service review will be submitted to you for approval in due course.

Jackie Johnston

Copy Distribution List:

Richard Pengelly
TMG
Alastair Campbell
David Gordon
Peter Jakobsen
Chris Matthews
Ryan Wilson
SpAd

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Rebuilding HSC Services Management Board

Wednesday 09 December 2020

10.00am – 11.15 am

Note of Meeting

In attendance:

Richard Pengelly RP (Chair)	Cathy Jack CJ
David Gordon DG	Jennifer Welsh JW
Dan West DW	Seamus McGoran SMcG
Jenny Keane JK	Shane Devlin SD
Jackie Johnston JJ	Anne Kilgallen AK
Alastair Campbell AC	Margaret O'Brien MOB
Chris Matthews CM	Michael Bloomfield MB
Sharon Gallagher SG	Karen Bailey KB
	Alan Stout AS
	Mark Taylor MT
Secretariat	**For Agenda Item 4**
Dean Looney DL	Lisa McWilliams LMcW
Lawrence Hyland LH	**For Agenda Item 5**
Tracey Hawthorne TH	John Maxwell JM
	For Agenda Item 6
	Shane Breen SB
	Michelle Laverty ML

1. Welcome and Apologies

RP welcomed members to the meeting. Apologies were received from Deborah McNeilly, Michael McBride, Charlotte McArdle, Cathy Harrison, Olive MacLeod, Peter Jakobsen, Mark Ovens and Sean Holland.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

2. Note of the meeting held on 02 December 2020

The note of the previous meeting was agreed. Members noted the status of the action points, all of which have been closed.

3. Delivering Together Transformation Service Reviews

An update paper was circulated in advance of the meeting.

JJ provided a synopsis of the paper, following RMB endorsement on 17 August 2020 and subsequent Ministerial approval, of the proposed programme of service reviews. JJ advised that the proposals to recommence service reviews have been kept under constant review, however, due to the current pressures on staff resources, it has not been possible to restart any programmes of work.

The update paper proposes a further updated programme of service reviews, to reorder the priorities agreed in August and to bring forward the General Surgery service review to the list of reviews proposed to commence in the period to March 2021. This will be subject to the availability of the necessary staff resources. This has been prompted by the pressures on providing surgical rota cover at SWAH. Whilst a short term solution has been developed in SWAH, the position beyond March will be problematic. Similar pressures have been experienced in other peripheral hospitals and a more integrated regional structure is required to support services in NI. The proposal would then be to submit the recommendations to the Minister for approval and, in turn, to engage with Trust Chief Executives, the HSCB and DoH colleagues to scope out and develop the appropriate Terms of Reference for the General Surgery review.

JJ advised that an overarching post Covid assessment would be beneficial, in the Spring of 2021, of the proposed programme of service reviews, given the innovation and change which has been developed and implemented over the last 9 months.

The proposal and direction of travel was strongly welcomed and supported by members.

Discussion recognised the importance of general surgery, which is fundamental to the core functions of hospitals throughout the region. MT emphasised the difficulty in resourcing multi-disciplinary surgeons for general surgery and the link to the No More Silos Network, Rapid Access, Urgent and Emergency Care, DECCs and the Elective restart cell. SD recognised that, the provision of unscheduled care across the region, would promote public confidence.

The Management Board endorsed the updated programme of service reviews which should be submitted to the Minister for approval.

4. Trust performance Report – October 2020

The October 2020 performance report was circulated in advance of the meeting.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

LMcW provided an overview of the report. Whilst the Phase 3 plans were not published, due to the onset of the second surge of Covid-19, the HSCB has continued to monitor Trusts' progress to deliver the forecasted volumes of activity. LMcW cautioned around predicting levels of activity in the current context of Covid.

Overall regionally, the volume of activity has exceeded the level planned for the period across the majority of the key indicators. The number of patients waiting longer than 9 weeks for an outpatient assessment has remained steady, the number waiting longer that 9/26 weeks for a diagnostic test has reduced, the numbers waiting longer that 13 weeks for treatment and the numbers waiting longer than 52 weeks for assessment and treatment have increased slightly. In areas demonstrating over delivery against projected volumes of activity, this has been attributed to staff absence being lower than anticipated and the increase of virtual and telephone assessments.

LMcW advised that not all Trusts have included activity projections for all of the community indicators. Not all Trusts deliver all of the services nor were all services in all Trusts included in the activity projections. It was noted that the collation of monitoring data for community indicators is a manual process, which may result in a reporting delay. Barr two indicators (Home births and MHLD admissions), an overall increase in activity was recognised. PSMI have discussed every matrix with individual Trusts.

Focusing on Cancer services, the 14-day breast cancer performance, at a regional level, is below the planned position for October, primarily as a result of workforce challenges. Trusts are undertaking a number of actions to improve performance against the 14 day target (Para.18 of the Trust Performance report). LMcW advised that PMNI are keen to provide regional support. Whilst the 62-day target performance regionally is being maintained at a steady level and has improved compared to last year, this is likely due to the reduction in referrals as a result of pandemic-related concerns. This is being picked up with all Trusts by the cancer reset cell.

LMcW further highlighted the Independent Sector metrics, with 1276 procedures undertaken between 29 June and 15 November 2020. SG queried if this was in line with the projected position. LMcW advised that this was probably not the case, however, advised that new processes were in place to work through all the available capacity to ensure fair assessment and allocation of slots, noting that the Independent Sector faced challenges with competing private demand. SG advised that this should continue to be monitored.

AK emphasised that the Management Board has an important role to play in ensuring the equity of access to services for the population in NI, highlighting a recent publication of comparative data on waiting times, indicating a huge disparity between the Western and Belfast Trusts. LMcW advised that this had been picked up by the IAD and caveated that the information published was based on how it had been recorded. LMcW further advised that, going forward, this would be rectified.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

The Management Board noted the status of the Performance report.

5. No More Silos (NMS)

An update report together with a new dashboard was circulated in advance of the meeting.

MOB provided an update on the progress of the NMS Network and the implementation of the 10 Key Actions from the NMS Urgent and Emergency Care review. MOB recognised the work put in by the Local Implementation Groups (LIG) in reporting through the new NMS Dashboard which included documenting; financial summaries, timescales, RAG status, progress reports, escalated risks and issues and lessons learnt.

MOB summarised the progress to date in respect of the establishment of Urgent Care Centres (UCC). She advised that the 'Phone First' assessment service has been established in the Northern and Southern Trust areas and that, thus far, this has been demonstrable in making a difference by redirecting to self-care and pharmacy care. Initial data indicates a positive impact, with a marked increase in the 4 hour service turnaround target and reduction in ED patient numbers, further noting improved outcomes for patients as supported by positive feedback from the LIGs. A shared learning event has been launched and a regional Communications sub group and a regional ICT group have been established. MOB also advised that the timelines for delivery of the Key Actions were populated on the new dashboard.

MOB highlighted the programme risks and issues. A lack of commitment taking forward the Key Actions was noted, due to concerns in relation to recurrent funding (whilst being cognisant to the competing priorities across the service), this, in turn was impacting on delivery of actions against anticipated timelines. MOB advised that Directors of Finance were reluctant to commit to taking forward the 10 Key Actions in the absence of assurance of funding. MOB advised of the need to refocus priorities and give assurance to Trust colleagues and Directors of Finance.

JM highlighted the problems around discharge procedures and the exit block and flow out of EDs, noting that the average length of stay time is higher here than in England. JM further highlighted Key Action 10 as a priority action, whilst cognisant of the reduction in ED front door services, the overall flow system through hospitals would need to be examined. Work would need to be developed on lowering admission rates, length of stay and bed occupancy in alignment with workforce challenges. JM further advised that consideration should be given to the development of; an operating policy, a criteria to reside policy, a regional professional standards policy and a discharge to assess policy. SMcG highlighted the need for extra dedicated work to drive forward Action 10. MOB acknowledged the level of work that would be required to deliver in terms of timely discharge of patients

Discussions recognised that an overall strategic reprioritisation of the Key Actions would be needed. Consideration of the 10 Key Actions in totality would be required.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Going forward, performance management would be integral, LMcW's team indicated a keenness to work with the project to develop indicators.

RP summarised that whilst the NMS Network was still in its infancy, the overarching objective is to improve UEC in both the primary and secondary care sectors. A sense of balance is required between the 10 Key Actions, aligned with transformational change. There will be a need to evolve a helicopter view to determine that the overall strategic objective will be achieved.

MOB advised that feedback was being sought from the LIGs, and that, at a regional level, this will be assessed and will form part of the evaluation, which, in turn, will contribute to the development of the next steps. Cultural and service change across the region will be integral.

RP advised of a need for a proportionate balance on future updates and delivery. MOB agreed discuss this and the way forward and agreed to feedback to the PMO.

The Management Board noted the update.

6. Updated Intermediate Care PID

Following on from last week's meeting, an updated Project Initiation Document (PID) was circulated in advance.

SB summarised the amendments to the PID, which reflected recommendations for inclusion of a number of elements, to include the development of a timeline against key project stages, key project deliverables updated to incorporate regional streamlined governance and assurance systems and inclusion of innovations in practice and delivery to fully utilise current and future informatics platforms and to update the Project interfaces to include the transformation initiative and associated evaluations and new models of prescribing.

The Management Board approved the amended PID.

7. Update Papers

Update papers on Orthopaedics, Hospital Visiting and Mental Health outlining progress to date against key objectives, were circulated in advance. The Board noted the written updates.

8. AOB

No other business was raised.

9. Date of next meeting

RP suggested that, due to current pressures, unless any critical issues needed to be addressed, the Rebuilding Management Board would reconvene in the New Year.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

A Cancer Strategy for Northern Ireland 2022-2032

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



Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Minister's Foreword



My vision is to ensure that everyone in Northern Ireland, wherever they live, has equitable and timely access to the most effective, evidence-based referral, diagnosis, treatment, support and person-centred cancer care.

Over time, cancer impacts on the lives of all of us. The number of cancer cases diagnosed in Northern Ireland has increased 54% over the past 25 years and is projected to double by 2040. While there have been many advances in the diagnosis, treatment and care of people over recent years we know that, with many more people surviving cancer combined with a rapidly ageing population, our current system is unsustainable.

I believe we can do better for people of all ages, including children, teenagers and young adults, who have cancer. Transformational change is needed if we are to provide evidence-based, high-quality care for all those who need it in the future.

Cancer services were challenged before the pandemic and there continues to be significant capacity and workforce challenges across a range of areas. There is a need to move forward urgently to implement the actions outlined in this Strategy to rebuild and transform our services in the short, medium and longer term. The Cancer Strategy affords us the opportunity to look forward 10 years to identify and implement what will really make a difference for people living with cancer.

Reducing health inequalities is integral to the implementation of this Strategy. Social deprivation and health inequalities are a major contributory factor in the development of the majority of cancers. This means that there are potentially avoidable variations in outcomes, patient experience and survival across Northern Ireland. Tackling inequalities goes far beyond the remit of my Department and will require a concerted, coordinated focus across Government Departments. Improving cancer services for the people of Northern Ireland must be a major priority for the whole Executive in the years ahead.

At the heart of the many successes of cancer services is the hard work and dedication of our staff, in every band and role, who are delivering care at higher levels than ever before. In addition to maintaining oncology services throughout the pandemic, many staff from a wide range of professions have been involved in the development of this Strategy.

The successful delivery of this Strategy will require collaboration. It will involve maintaining and building on the many successful developments over the past years in response to the pandemic and learning from what could

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

have been done better. Collaboration between HSC organisations, across sectors and with patients, families and carers, will be a key enabler to effecting meaningful change.

This Strategy has been co-produced with people living with cancer and staff providing treatment and care under the leadership of Professor Charlotte McArdle and Ivan McMinn MBE. As we move towards implementation, we will ensure that this collaborative working continues.

This 10-year Strategy is ambitious. Significant recurrent funding is therefore required if we are to deliver these recommendations to improve diagnosis, treatment and care for all those who need it now and in the years ahead.



Robin Swann
Minister of Health

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Contents

Minister's Foreword 1
Contents 3
Developing a Cancer Strategy for Northern Ireland 5
Why we need a Cancer Strategy 5
Strategy Development 6
Cancer in Northern Ireland 7
Key Aims of Building Back; Rebuilding Better 7
Cases 7
Deaths 9
Prevalence 9
Survival 10
Health Inequalities 10
Theme 1: Preventing Cancer 12
Making Life Better 12
Cancer Risk Factors 15
Chemoprevention 23
Secondary Prevention 24
Theme 2: Diagnosing and Treating Cancer 25
Diagnosing Cancer 25
Pathways to Diagnosis 25
Reducing Late-stage Diagnosis 26
Raising Awareness 27
Screening 28
Targeted Surveillance 32
Referral Guidance 33
Targets 35
People with Vague but Worrying Symptoms 37
Diagnostic Centres 38
Diagnosis of Haematological Malignancies 40
Theme 2: Diagnosing and Treating Cancer 41
Treating Cancer 41
Prehabilitation 41
Surgery 43
Enhanced Recovery After Surgery 45
Radiotherapy 46
Systemic Anti-cancer Treatment 48
Pharmacy 51

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Acute Oncology Services 52
Cancer of Unknown Primary (CUP) 53
Metastatic Spinal Cord Compression (MSCC) 54
Precision Medicine 55
Haematological Cancers 56
Older People with Cancer 58
Adults with Learning Disabilities, Communication Needs and Chronic Mental Health Problems 60
Rare Cancers 61
Metastatic Cancer 62
Children and Young People 63
Teenagers and Young Adults (TYA) 67
Transition 69
Multi-disciplinary Teams (MDTs) 70
Theme 3: Supporting People to Live Well and Die Well 71
Supporting People 71
Risk-stratified Follow Up 76
Support from Clinical Nurse Specialists 79
Mental Health and Wellbeing Support 80
Information and Therapeutic Support 82
Carers 85
Supporting People to Live Well 86
Caring When Cancer Can't be Cured 94
Theme 4: Implementing the Strategy 103
Workforce and Training 103
Communicating with People Affected by Cancer 106
Research 107
Clinical Trials / Clinical Research 107
Understanding the Experience of People Living with Cancer 110
Data 112
Funding and Next Steps 114
Appendix 1: Cancer Strategy Actions 117
Appendix 2: Bibliography 123
Appendix 3: Glossary of Terms 129
Appendix 4: Abbreviations 132
Appendix 5: Steering Group Members 134
Appendix 6: Diagrams 135

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Developing a Cancer Strategy for Northern Ireland

Why we need a Cancer Strategy

Cancer is a common condition. In Northern Ireland one in two people born since 1960 will be diagnosed with some form of cancer in their lifetime. Survival has improved for many cancers over recent years and now over half of people will live ten years or longer following diagnosis and treatment. This is largely due to earlier detection, improvements in treatments and changes in exposure to risk factors. The number of people diagnosed is, however, expected to continue to rise, largely due to our ageing population.

More than 26 people in Northern Ireland are diagnosed with cancer every day, and almost 10,000 people are diagnosed with cancer annually. The number of cancer cases diagnosed increased by 54% over the past 25 years and is projected to double by 2040 (45% for males and 58% for females). Large increases are predicted for many cancers with poor survival rates including pancreatic and liver cancers and lung cancer in females with only stomach and cervical cancer numbers projected to decrease.

This brings considerable challenges to health services in meeting the ever-growing demand for diagnostic services, screening programmes, treatment, follow-up surveillance, supportive and palliative care. Increased demands will be felt across the entire health and social care system as many people diagnosed with cancer are also living with multiple other long-term conditions.

Although cancer survival in Northern Ireland has improved over the years, it still lags behind other comparable countries both in Europe and internationally. The International Cancer Benchmarking Project (ICBP) Module 1 report showed cancer survival in Northern Ireland to be behind other parts of the UK, Australia, Canada, Denmark, the Republic of Ireland, New Zealand and Norway. Northern Ireland consistently ranked between 8th and 10th out of the 12 jurisdictions involved.

Recently published ICBP Module 21 evidence shows that the UK as a whole had the lowest one- and five-year survival rates from 2010–2014 for four of the seven cancer types reviewed.

Cancer has accounted for over 20% of all deaths in Northern Ireland every year since 1987. In 2018, the most recent year for which detailed statistics are available, cancer was the leading cause of death – accounting for 28% of all deaths. Unsurprisingly, death rates from cancer are usually higher among those aged 85+ than any other age group among both men and women.[1]

1 Macmillan (2021) 'Statistics Fact Sheet' https://www.macmillan.org.uk/_images/cancer-statistics-factsheet_tcm9-260514.pdf

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

England, Scotland and Wales and the Republic of Ireland have, in recent years, produced new cancer strategies for their respective jurisdictions designed to further improve the outcomes for people affected by cancer.

These strategies have all identified new approaches to service planning and delivery as well as prevention.

The New Decade, New Approach Agreement gave a commitment that the Executive would develop a new Cancer Strategy by the end of December 2020; however, this deadline had to be pushed back due to the COVID-19 pandemic.

The Cancer Strategy affords us the opportunity to look forward 10 years to identify and implement what will really make a difference for cancer patients in Northern Ireland. This will require a comprehensive approach to prioritisation – making rapid change early where possible and laying the groundwork for truly revolutionary evidence-based interventions where we know this could transform outcomes.

Strategy Development

The development of the Strategy has been based on co-production which has brought together people with lived experience of cancer and healthcare professionals from across all the Health and Social Care Trusts (HSC), the Public Health Agency (PHA), Health and Social Care Board (HSCB), Primary Care, policy makers and cancer charities. The Strategy aims to place Northern Ireland at the forefront of world-class cancer prevention, treatment and patient experience.

A Steering Group was established to oversee the development, supported by seven sub-groups: prevention; diagnosis and screening; treatment; care and support; living well; palliative and end of life care, children and young people.

The aims of the Strategy are threefold:

- to reduce the number of people diagnosed with preventable cancers;
- to improve survival; and
- to improve the experience of people diagnosed with cancer.

This process is illustrated in Driver Diagram [2] – Developing a Strategy in Appendix 6.

2 'Progress in cancer survival, mortality, and incidence in seven high-income countries 1995–2014 (ICBP SURVMARK-2): A population-based study', The Lancet Oncology, 2019.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Cancer in Northern Ireland

Cancer services were challenged before the pandemic with unacceptable waiting times and significant capacity and workforce challenges across a range of areas. COVID-19 has led to a worsening waiting times position, resulting in considerable anxiety for patients and staff.

A Cancer Recovery Plan, Building Back; Rebuilding Better was published on 24 June 2021 to address the immediate issues in adult cancer services with the aim of getting us to a place where services are stronger than before.

Over this time period, the focus will be on stabilising existing cancer services, supporting and growing the workforce and improving data collection and analysis to enable the implementation of longer-term actions. In parallel there is an urgent and compelling need to innovate, develop, test and adopt new ways of working using technology.

Key Aims of Building Back; Rebuilding Better

- To adopt a regional approach for Northern Ireland, where appropriate, to ensure patients receive equitable access to diagnostics, care, treatment and support.
- To create smoother and more efficient patient pathways from initial referral, through diagnosis and treatment encompassing the appropriate care and support during and after treatment with the aim of improving cancer waiting times and patient outcomes and patient experience.
- To invest in cancer services and enable new, more sustainable, models of care that will be resilient to potential future surges of COVID-19 and to the projected increase in cases of cancer.
- To learn from the impact of COVID-19 on cancer services and the wider HSC and adopt successful innovations for the future.

The aims of the Recovery Plan are subsumed in the Strategy. Therefore going forward, implementation of the Recovery Plan will be through the implementation of the Strategy.

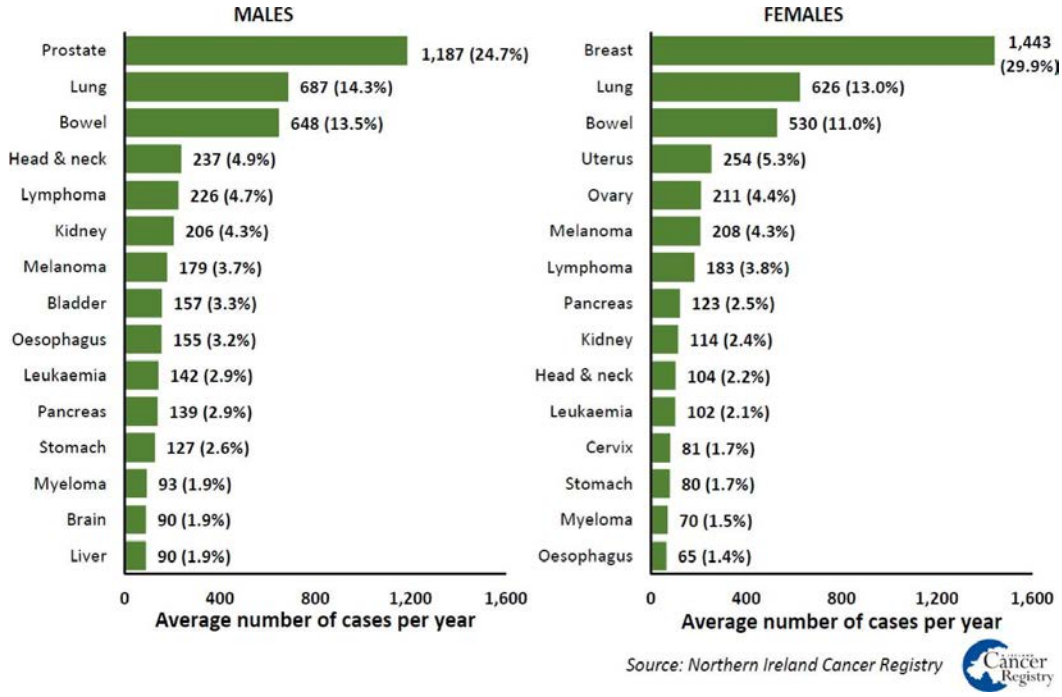
Cases

In 2018, cancer was diagnosed in 13,452 people from Northern Ireland; 3,823 of these were Non-Melanoma Skin Cancer (NMSC), a disease that is easily treated and causes few deaths but which uses health service resources and also causes a lot of concern and trauma to patients. This Strategy takes account of these conditions but focuses on the more serious, almost 10,000

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

per year, cancers which are a major cause of cancer deaths. The most common cancer in men (excluding NMSC) was prostate (1,187 cases per year, 25%), and in women was breast cancer (1,443 cases per year, 30%). Lung (1,313 cases per year) and colorectal cancers (1,178 cases per year) were common in both genders (see Figure 2.) Blood cancers (lymphoma, leukaemia and myeloma) combined account for around 800 new cancer cases per year and collectively make blood cancer the 5th most common cancer in Northern Ireland.

Figure 1: Average number of cancers diagnosed per year by sex and cancer type: All cancers (ex. NMSC), 2014-2018



The risk of developing cancer increases with age, with two thirds (67%) of cases in men, and over half (58%) in women diagnosed over age 65. This compares to 11% of cases (ex. NMSC) diagnosed in those under 50 years. Those living in socio-economically deprived areas had overall cancer levels 15% higher than the Northern Ireland average, with especially higher rates for lung (70% higher per year), liver, head and neck, cervical and stomach cancers. Those living in higher socio-economic areas had levels 6% lower than the Northern Ireland average overall, but higher levels of prostate cancer and melanoma.

The number of cancer cases diagnosed has increased by 54% over the past 25 years and is projected to double by 2040 (45% for males and 58% for females).

This projected rise is due primarily to population ageing. Large increases are predicted for the cancers with poor survival (pancreas, liver and, especially in

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

women, lung cancers), with only stomach and cervical cancer numbers projected to decrease. Cancers which are largely preventable and predicted to increase include melanoma and lung cancer.

Every year in Northern Ireland, around 60 children under 16 years of age and 80 teenagers and young adults aged 16–24 years are diagnosed with cancer. While there is variation year to year, these numbers have remained stable over the past 20 years.

The most common types of cancer diagnosed in the 0–15 age group are blood cancers and brain tumours.

Teenagers and Young Adults refers to people aged 16 up to their 25th birthday. The numbers of cancers diagnosed are low and the most common cancers in this age group are lymphoma and leukaemia, testicular, ovarian, brain and colorectal cancers.

Deaths

Cancer was the largest cause of death in Northern Ireland during 2018, with 2,326 male (30%) and 2,122 female (26%) deaths per year. The most common causes of cancer death among men were lung (554, 24%), prostate (276, 12%) and bowel (232, 10%), and among women were lung (469, 22%), breast (314, 15%) and bowel (207, 10%).

Prevalence

The number of people living at the end of 2018 after a diagnosis of cancer (prevalence) is estimated at 97,807 (including 37,894 with NMSC) with 12% of these diagnosed in the previous year. The most common cancer types prevalent (ex. NMSC) in men were prostate (10,938) and bowel (4,713), with breast (16,462) and bowel (4,048) the most common among female survivors.

By 2033, the number of cancer survivors in the population is projected to increase by over 40%. Many patients will be cured, others will live for many years with cancer as a long-term condition and for others the disease will progress.

Although many more people will be cured from their cancer, not all continue to live well and for many, the late effects and consequences of treatment will present life-long problems. Cardiac problems due to some chemotherapy drugs, bowel problems post-pelvic radiotherapy and osteoporosis due to hormonal therapies and prolonged use of steroids are some of the many ongoing problems survivors have to deal with.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Survival

Cancer survival is a key measure of the effectiveness of cancer services, reflecting preventive initiatives such as vaccinations (HPV), screening, early detection, access to timely diagnostics and rapid and effective treatment by specialists. Stage at diagnosis is important. Currently 48% of pancreatic, 44% of lung and a fifth of cancers overall are diagnosed at a late stage when the treatment options are limited and survival is poor.

Five-year survival varies considerably by cancer site. In addition to poor survival for lung cancer (12%), survival is very low for other tobacco-related cancers (e.g. pancreatic, stomach and oesophageal cancers). Changes in tobacco use could have the greatest impact on cancer incidence and survival. Cancer survival rates in Northern Ireland, like the rest of the UK, fall short when compared internationally. While year-on-year improvements in survival have been documented, the COVID-19 pandemic is likely to reduce survival.

Improvements in treatment seen in the past five decades mean that around 80% of children 0–16 years diagnosed with cancer in the UK will survive their cancer for at least five years. This means there is a growing population of children and young adults who have experienced cancer and treatment as children. Most will require ongoing follow up and support and some will require this for life.

Health Inequalities

It is well established that those living with social and economic disadvantage are more likely to experience poorer health outcomes, have reduced access to healthcare services and have a lower life expectancy and this is also true for cancer patients. According to Cancer Research UK (2020),[3] at every step of the pathway, the most deprived populations have higher risk, worse experiences and poorer outcomes than the least deprived.

Inequalities in cancer outcomes are likely to be compounded by the effects of the COVID-19 pandemic with vulnerable subgroups of the population more negatively affected.

Inequalities in health arise because of inequalities in the conditions in which people are born, grow, live, work and age. These conditions influence the ability of individuals, families and communities to take control over their lives and choices, and whether they are enabled and supported to lead long, healthy, active lives.

Health inequalities are associated with lower symptom awareness, later presentation and lower uptake of services including screening. Inequality across Northern Ireland means there are potentially avoidable variations in

3 Cancer Research UK (2020). 'Cancer in the UK 2020: Socio-economic deprivation, s.l: Cancer Research UK' https://www.cancerresearchuk.org/sites/default/files/cancer_inequalities_in_the_uk.pdf

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

outcomes, patient experience and survival. The majority of cancer types have much higher incidence in more deprived areas. There is strong evidence linking risk factors, which are more common in areas of deprivation with higher incidence of cancer, including smoking, obesity and poor diet. Addressing health inequalities cannot be achieved by the recommendations of this Strategy alone and will require a concerted cross-departmental approach.

Low levels of health literacy are associated with poorer access to health services, poorer communication with healthcare professionals, lower adherence to treatment and poorer self-management of health conditions. Better health literacy could therefore contribute to reducing health inequalities and improve healthcare efficiency.

Major strides have been made in the development of relationships with many community and voluntary sector organisations as a result of the pandemic. We need to learn from the COVID-19 experience and continue engagement with lesser heard communities, including ethnic minority groups, people with learning disabilities, communication difficulties and those for whom English is not their first language, to ensure equality of access to cancer services across the pathway and to information and support services.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Theme 1: Preventing Cancer

Making Life Better

From the evidence, it is clear that reducing the number of preventable cancers in Northern Ireland will require a concerted focus across government. Policy responsibility for a range of areas including air pollution, radon, environmental exposure and use of chemicals lies within other government Departments.

Making Life Better (MLB) is the overarching strategic framework for public health through which the Executive committed to creating the conditions for individuals, families and communities to take greater control over their lives, and be enabled and supported to lead healthy lives.

The All Department's Officials Group (ADOG) is a key part of the structures for co-ordinating the implementation of MLB. Its key function is to bring together senior officials from all Departments and to inform and support the Executive's Ministerial Committee for Public Health in carrying out their role of providing strategic leadership and cross-government coherence effectively. ADOG could therefore be used as the mechanism to engage with other Government Departments and Agencies in addressing the wider social determinants of cancer, and ensuring that government policy aligns to prevent cancers developing in the first place.

The proportion of cancer incidence in Northern Ireland attributable to modifiable lifestyle and environmental factors is estimated to be in the 30% to 40% range. A population approach, supported by policy and legislative measures, is required to encourage and support people to live healthier lives and reduce the prevalence of cancer risk factors such as tobacco and alcohol consumption, obesity, lack of physical activity and UV radiation exposure.

Cancers in children are largely driven by growth and development. Thus we see an increase in germ cell tumours in adolescents linked to genital growth, an increase in bone tumours throughout childhood with spurts in adolescence linked to bone growth, peaks in acute lymphatic leukaemia linked to lymphoid tissue growth, and peaks in brain tumours in childhood and adolescence linked to neural growth.

Like other European countries, the number of cancers in Northern Ireland is increasingly driven by an ageing population, changes in exposure to risk factors and improved survival as a result of earlier detection and better treatments. Recommendations for individuals to reduce their risk of developing cancer are outlined in the European Code Against Cancer in Appendix 6.

There is evidence to suggest that the pace of change in reducing the risk factors underpinning these cancers is not sufficient. Ultimately, this

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

highlights the real need to maintain focus on tackling preventable cancers, and the urgency for accelerating change. Although death rates for cancer are falling, the total number of cancer deaths continue to rise due to an increase in the numbers of older people in the age range when the cancer typically occurs. This brings considerable challenges to health services in meeting the demand for care as well as the impact on the individuals affected. Treatment services alone cannot address the burden of cancer care. Prevention must be a key focus of this Strategy as it offers the most long-term, cost-effective approach; however it will take time before the impact can be realised.

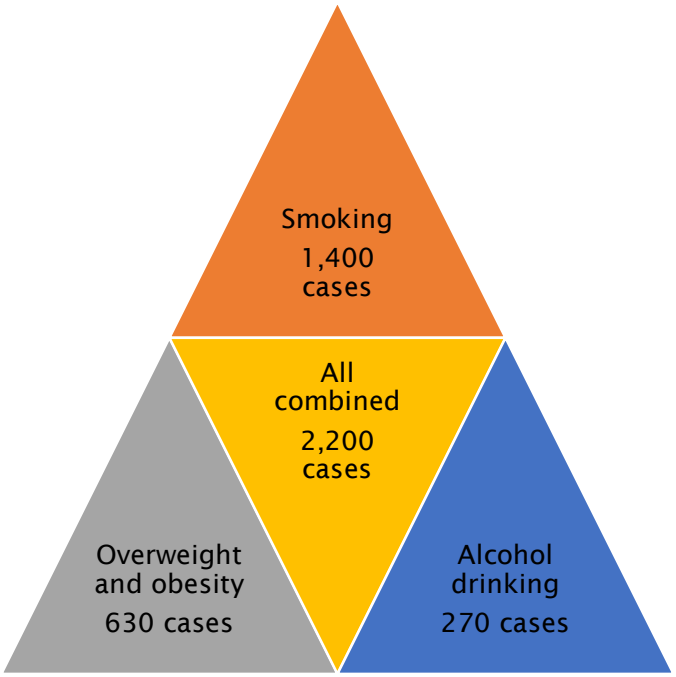
By implementing robust prevention strategies not only can we reduce the risk of cancer by up to 40% but also up to 75% of new cases of heart disease, stroke and type 2 diabetes, and significantly reduce the risk of dementia.

Figure 2: Main Known Modifiable Risk Factors



Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Figure 3: Estimation of Preventable Cancer Cases in Northern Ireland



- Nearly 4 in 10 cancer cases could be prevented.
- It can take years for the cancers caused by modifiable risk factors to exhibit. The impact of current / new prevention measures may not be seen in the short term.
- Not all modifiable risk factors have the same impact on cancer.

Smoking, overweight and obesity and alcohol drinking cause around 1,100 cases in men and 1,100 cases in women every year.



Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Cancer Risk Factors

Smoking

The numbers of new cases of lung cancer are falling as a result of the decrease in smoking prevalence over several decades. Tobacco use, however, continues to be a significant factor in many cancers and cancer deaths. There are over 1,300 cancer deaths per year caused by smoking. It is the main cause of preventable death from cancer in Northern Ireland.

The vast majority of lung cancers and over half of all head and neck cancers (oral cavity, oesophageal, laryngeal and pharyngeal) can be attributed to smoking. Smoking is also a contributory factor in many other cancers including kidney, bladder, liver, pancreas and cervix. Public awareness of the links between smoking and lung cancer are strong but there are low levels of awareness of the wide range of other preventable cancers caused by smoking.

Smoking prevalence has fallen
24% in 2010/11
17% in 2019/20



Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Obesity

Obesity is responsible for almost 600 cases of cancer each year in Northern Ireland. It is a key contributory factor associated with cancer risk and mortality, including breast, uterus, liver, gall bladder, colorectal and kidney cancers.

Obesity is the second biggest preventable cause of cancer in Northern Ireland.

65% of adults are overweight or obese with around a quarter of children aged 2-15 either overweight (20%) or obese (6%). Trend analysis shows that there are no indications of a decrease in rates of overweight or obesity. There is a low level of understanding amongst the general public of the links between obesity and cancer.

There is no single action that will solve Northern Ireland's high obesity and overweight prevalence; a combination of actions is required to address the food environment and ensure that people are supported to live healthier lives.

People need to be supported to make healthier food choices, removing triggers to purchase unhealthy food, and ultimately reduce prevalence of overweight and obesity. This in turn will lead to fewer obesity-related cancers.

Overweight and obesity rates are rising
62% in 2018/19
65% in 2019/20



Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Diet and Physical Activity

The importance of lifestyle factors including physical activity, sedentary behaviour and diet, and their association with cancer has been recognised in recent years.

Breastfeeding is the best start for baby and has a protective effect for the mother. Breastfeeding for 12 months reduces the risk of developing breast cancer in the future by over 4%. In 2020, it is encouraging to note that breastfeeding was attempted for around six out of ten births (62.5%) in Northern Ireland, a 5.7% increase from 2015. There is however a deprivation gap with 48% of mothers living in the most deprived areas reporting as attempting to breastfeed compared to 76% from the least deprived areas. Efforts to increase breastfeeding must be supported across a range of programmes both in midwifery units and in the community.

High consumption of processed meats is a major contributory factor to bowel cancer. Conversely a diet high in fruit and vegetables reduces the risk of many cancers including bowel, stomach and oesophagus.

Health Survey data 2017/18 shows that 17% of adults ate processed meats most days of the week. This is an increase from 15% in 2010/11. There is a gender differential with more men than women eating processed meats on most days of the week (23% v 13%) and a deprivation gap between the most and least deprived (26% v 13%).

In 2019/2020, 56% of adults ate less than the recommended five portions of fruit and vegetables per day, down from 68% in 2010/11. The proportion of those eating five or more portions was lower for men and for those living in the most deprived areas.

Sedentary behaviour is associated with a higher risk of many cancers but most notably, colon, endometrial and breast cancer.

Health Survey data for 2016/17 shows that 43% of adults did not meet the recommended levels for physical activity. There is a gender differential with more women than men not meeting the guidelines (48% v 37%) and a deprivation gap between the most and least deprived (55% v 35%).

39% of those living in the most deprived areas reported eating five or more portions of fruit and vegetables compared with 54% of those in the least deprived areas.



Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Ultraviolet Radiation

Skin cancer is the most common form of cancer in Northern Ireland. Incidence has trebled since the mid-1980s. By 2040, a further 82–149% increase in malignant melanoma cases and a further 99–132% increase in non-melanoma skin cancer cases are predicted.

The main cause of skin cancer is over exposure to UV radiation from the sun or artificial tanning devices. Health survey results (2016/17) indicate that 4% of females and 1% of males currently use sunbeds, and 31% of females and 12% of males have used sunbeds in the past. The number of sunbed premises has more than doubled in 10 years, to 19.6 sunbed businesses per 100,000 population in 2019.

The Health Survey 2016/17 reported that 34% of adults in Northern Ireland never check for any changes in their skin which could indicate skin cancer and 22% reported having had sunburn in the previous year.

Sunbed use poses a specific risk for melanoma, independent of skin type and of solar exposure. Melanoma risk increases with younger age of first sunbed use and with greater lifetime use of sunbeds. Sunbed use has also been associated with increased risk of non-melanoma skin cancers and ocular melanoma (cancer of the eye), especially for those who started artificial tanning at a younger age.

Development of any new version of the skin cancer prevention Strategy should give consideration to including a specific focus on occupational skin cancer. The World Health Organisation (WHO) is expected to introduce a new 1CD-11 code for skin cancer of occupational origin in 2022.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Alcohol

Drinking alcohol causes almost 300 cases of cancer a year in Northern Ireland. Alcohol causes a variety of types of cancer: mouth, upper throat (pharynx), larynx, oesophageal, breast, bowel and liver. These encompass some of the most common cancer types and some of the most difficult to treat. The risk of some of these cancer types is increased even at low levels, e.g. oesophageal, oral cancers and breast cancer, while others are only increased at moderate to heavy consumption, e.g. bowel and liver respectively. When combined with smoking, the risks are increased significantly. Awareness amongst the public of the relationship between alcohol and cancer is low.

There is an opportunity for alcohol consumption to be highlighted as a significant risk factor during the implementation of the new 10-year Substance Use Strategy, 'Preventing Harm, Empowering Recovery' launched by Minister Swann in September 2021.

Around 80% of adults 18 and older drink alcohol.



Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Infections

Several specific infections are implicated in the development of some cancers including H pylori, hepatitis B and C and the human papilloma virus (HPV). H pylori is associated with an increased risk of stomach cancer; however, it is no longer common in the UK and for most people it is successfully treated with antibiotics and will not cause any further problems.

Chronic infections with hepatitis B and C are associated with an increased risk of developing liver cancer. Laboratory confirmed cases of both hepatitis B and C have increased significantly in the past decade. A hepatitis B immunisation programme for young children was introduced in 2017 which will subsequently reduce the risk of developing cancer in the future.

HPV is one of the most common sexually transmitted infections. Infections with HPV cause the vast majority of cervical cancers, most anal cancers and a significant proportion of oropharyngeal, vaginal, vulval and penile cancers. The HPV vaccination programme for both adolescent girls and more recently boys has been very successful in reducing sexually transmitted infections. As a consequence, this will reduce the numbers of these cancers in the future. To date this programme has successfully almost eliminated cervical cancer in women born since 1995.

Men having sex with men, aged under 45 and who are attending genitourinary clinics, can also avail of HPV vaccinations.

Going forward, it is crucial that we maintain the high uptake rates for these vaccination programmes.

In addition, comprehensive sex education and awareness programmes must be developed and implemented to reduce the number of sexually transmitted infections which could lead to the development of a preventable cancer.



Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Oral Health

Cancer of the oral cavity is on the increase, particularly among our younger population. This includes cancers of the lip, tongue and oropharynx.

Attendance for routine examination and care is an ideal time for 'opportunistic' screening. In addition, dentists also have a key role to play in supporting many people having treatment for cancer.

The established risk factors for developing mouth cancer are smoking (or using tobacco in other ways for example chewing tobacco), drinking alcohol and infection with the human papilloma virus (HPV). The risk of developing oral cancer for those who use tobacco and drink alcohol is greater than the sum of the separate risks (i.e. the risk is multiplied not added). Oral cancers caused by HPV tend to affect younger individuals than those associated with alcohol and tobacco.

In 2019, 273 people in Northern Ireland were diagnosed with oral cancer, 182 males and 91 females. The median age at diagnosis was 63 for both males and females. Over the 25 year period from 1993 to 2019, the number of people diagnosed with oral cancer in Northern Ireland has increased by almost 80%.

Unfortunately, the majority of oral cancers in Northern Ireland are diagnosed at stage IV which has a significant impact on survival. Five year survival rate for oral cancer in Northern Ireland is approximately 45% overall but is almost 69% for those diagnosed at stage I and only 24% for those diagnosed at stage IV. Like many other cancers, studies indicate there is a socio-economic gradient with oral cancer – the risk of developing oral cancer is significantly greater among those from deprived communities.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Environmental Pollution and Radon

In 2013, the International Agency for Research on Cancer (IARC) confirmed that outdoor air pollution is a cause of cancer. In Northern Ireland, around 70 cases of cancer each year are caused by exposure to outdoor air pollution.[4] The smallest particles known as PM10 and PM2.5 are linked to lung cancer.

Air pollution in Northern Ireland comes from a variety of sources. Domestic combustion (burning wood and open fires) is one of the biggest sources of PM10 (27%) and PM2.5 (44%) in the UK.[5] Road transport is responsible for 11% both of PM10 and PM2.5 emissions across the UK,[6] of which 27% to 43% is from vehicle exhaust emissions and the remaining is from tyre and brake pad wear.[7]

Radon is a radioactive gas which is naturally produced in the ground from uranium which is present in small quantities in soil and rocks. Most radiation exposure from radon arises from inhaling its short-lived solid radioactive decay products rather that radon itself. Radon is recognised by the International Agency for Research into Cancer (IARC) as a Class 1 carcinogen (IARC, 2012). In the UK, exposure to indoor radon is responsible for an estimated 1,100 lung cancer deaths each year with smokers and ex-smokers at the greatest individual risk. There is currently no strong evidence to link radon exposure to cancers other than lung cancer or to other diseases. The Department of Agriculture, Environment and Rural Affairs and other agencies are contributing to a UK National Radon Action Plan.

Action 1. **Increase public awareness of cancer-related risk factors through specific strategies on tobacco, substance use, skin cancer prevention, and overweight and obesity – including diet and physical exercise.**

Action 2. **Support the development and delivery of strategies to improve public health.**

---

4 Northern Ireland Department of Agriculture, Environment and Rural Affairs (2020) Clean Air Strategy for Northern Ireland – Public Discussion Document (pdf) https://www.daera-ni.gov.uk/sites/default/files/consultations/daera/20.21.066%20Draft%20Clean%20Air%20Strategy%20for%20NI%20-%20Public%20Discussion%20Doc%20Final%20V6.PDF.

5 UK Department for Environment, Food and Rural Affairs (2020) National Statistics - Emissions of air pollutants in the UK, 1970 to 2018 – Particulate matter (PM10 and PM2.5) ((https://www.gov.uk/government/statistics/emissions-of-air-pollutants/emissions-of-air-pollutants-in-the-uk-particulate-matter-pm10-and-pm25).

6 UK Department for Environment, Food and Rural Affairs (2020) National Statistics - Emissions of air pollutants in the UK, 1970 to 2018 – Particulate matter (PM10 and PM2.5) (https://www.gov.uk/government/statistics/emissions-of-air-pollutants/emissions-of-air-pollutants-in-the-uk-particulate-matter-pm10-and-pm25).

7 UK Air Quality Expert Group (2019) Non-Exhaust Emissions from Road Traffic (pdf)

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Chemoprevention

Chemoprevention is the use of medication to prevent the development of cancer and is a relatively new approach to cancer prevention. Its use is primarily focused on those known to be at a significantly higher risk of developing cancer, for example those with a strong family history or diagnosis of a pre-malignant or predisposing condition. Guidelines produced by the National Institute for Health and Care Excellence (NICE) for familial breast cancer recommend that women at an increased risk of breast cancer should be offered medication to reduce their risk.

There is also emerging evidence of the protective effect of aspirin in Lynch Syndrome. Going forward, as new evidence emerges, chemoprevention is likely to play a greater role inthe prevention of more cancers.

Action 3. Develop a co-ordinated approach towards chemoprevention in line with NICE recommendations.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Secondary Prevention

There is a long-established evidence base showing that certain behaviours are linked to the development of cancer (smoking, being overweight/obese, drinking at harmful levels, diet and exposure to UV without protection). People who have developed cancers arising from these factors may worry about the cancers returning, and could be at an increased risk of recurrence without behavioural changes. Multiple studies have demonstrated strong evidence for the benefits of physical activity in reducing the risks of both cancer recurrence and death from cancer for a variety of tumour types. It is known from feedback from patients and health professionals that people who have been diagnosed with cancer would like more information, tailored to their individual needs on how to make diet and lifestyle changes.

Trusts must offer advice to all people treated for cancer, tailored to their individual circumstances and risk level, on how to improve their lifestyle. Advice should be relevant to the person being treated could include healthy eating, weight control, physical activity, smoking cessation and alcohol consumption, to help prevent secondary cancers and reduce the risk of recurrence. People treated for cancer should be signposted to local services in their community where they can be supported in making their lifestyle changes.

Action 4. All people diagnosed with cancer must be offered appropriate and targeted information and support to live well.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Theme 2: Diagnosing and Treating Cancer

Diagnosing Cancer

Pathways to Diagnosis

People can receive a cancer diagnosis in a variety of places such as screening centres, GP surgeries, hospital settings including outpatient departments, inpatient wards and emergency departments. Increasingly during the COVID-19 pandemic people received their diagnosis in their own homes by phone. The circumstances under which a person is diagnosed with cancer is strongly associated with their subsequent survival.

The first ever Pathways to a Cancer Diagnosis report for Northern Ireland was published in January 2020.[8] This was a research project between the Health Foundation, Queen's University Belfast (QUB) and Business Support Organisation (BSO) which looked at how and where patients with cancer are diagnosed. It is based on well-established methodology from Public Health England. Information from the Routes-to-Diagnosis in England has helped in the transformation of the cancer patient pathway by focusing attention on awareness raising, early presentation to Primary Care, followed by rapid diagnosis and treatment.

One of the key findings of the work was to highlight the significant proportion of people being diagnosed in the emergency department, the majority of whom are presenting with late stage disease. This includes 28% of blood and lymph cancers, 42% of digestive tract cancers, 27% of upper gastrointestinal tract, 25% of head, neck, brain and eye cancers and 35% of lung cancer. Other key findings were the significant survival differences dependent on the route to diagnosis, with three-year survival highest for screen-detected cancers at 97% compared to three-year survival of 21% for those presenting as an emergency.

It is important that this work is repeated regularly in order to understand how improvements in the system and increased public awareness are impacting on how and where people are presenting, being diagnosed and the stage of disease at diagnosis.

Action 5. Establish routes to diagnosis reporting and analysis on a regular basis to monitor changes to help improve diagnostic pathways and outcomes for patients.

8 HSCNI, Pathways to diagnosis, www.hscbusiness.hscni.net/services/3094.htm.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

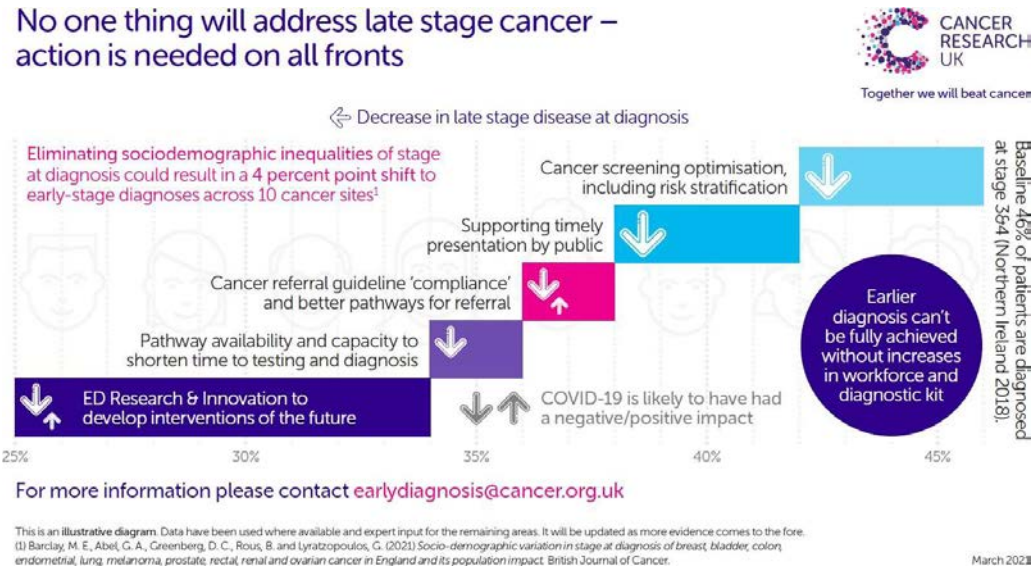
Reducing Late-stage Diagnosis

There is no one thing that will achieve a reduction in late-stage cancer diagnoses; we need to act together across a range of different interventions, and across the diagnostic pathway, in a co-ordinated and considered way.

This includes speedier and more equitable implementation of what we know, and research to identify the innovations and shifts of the future.

This waterfall diagram has been developed by Cancer Research UK and estimates the contribution that acting at different parts of the pathway could contribute to the all cancer stage shift. Originally, it was developed in anticipation of a significant national commitment to early diagnosis in England. In January 2019, the NHS England Long Term Plan outlined an ambition that, by 2028, 75% of cancer patients should be diagnosed at stage I or II. In this iteration of the diagram, we reframe it to focus on reduction in late-stage cancer diagnoses for Northern Ireland. In 2018, 46% of all cancers were diagnosed at stage III or IV (out of those with a known stage at diagnosis.)

Figure 4: Waterfall diagram to highlight early diagnosis need



The potential impact of COVID-19 has been reflected in the diagram. We cannot yet be certain of the actual impact of the pandemic but it is reasonable to assume that disruptions to cancer screening, altered patient and health professional behaviour, reduced availability of tests and protracted pathways will have a negative impact which may translate into poorer patient outcomes. The waterfall also highlights the need for significant progress and rapid translation of early detection and diagnosis research, as well as further service improvements, including investment in the workforce, equipment and other infrastructure. It also notes the importance of addressing inequalities in stage at diagnosis.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Raising Awareness

Early diagnosis is a complex, multifaceted topic dependent on a range of factors including public awareness of symptoms, access to primary care, access to diagnostic services, referral guidelines and pathways. People who recognise abnormal or persistent symptoms and seek medical advice are much more likely to have earlier stage disease and have better outcomes.

Raising public awareness on the signs and symptoms of cancer has been proven to be successful elsewhere in the UK. England and Scotland run regular campaigns designed to raise awareness of the signs and symptoms of different types of cancer and to encourage patients to visit their GP if they experience symptoms or notice changes in their body.

The Public Health Agency (PHA) developed a cancer awareness programme for Northern Ireland, Be Cancer Aware, in 2015. It has a dedicated website but, largely due to funding constraints, there have been no media campaigns run since 2016.

There is evidence that people from lower socio-economic groups often have lower recognition of signs and symptoms of cancer. This is likely to be the case for other seldom-heard and harder to reach groups, particularly those from ethnically diverse backgrounds and those with learning disabilities. Awareness raising campaigns must be co-produced and specifically tailored to be more easily understood. Input from health psychologists to support the development of resources and to evaluate the outcomes and subsequent behavioural change should be considered. Consideration must also be given to translation of resources into other languages and to the provision of appropriate resources for those people with sensory impairment and communication difficulties.

Many cancer charities have a focus on promoting awareness and have developed excellent resources in accessible formats. There is much to be gained in combining efforts and working in partnership with community and voluntary sector organisations which often are more successful in reaching minority populations where the need is greatest.

Action 6. Deliver regular, effective, targeted evidence-based 'Be Cancer Aware' campaigns harnessing the expertise in the community and voluntary sector.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Screening

Screening programmes are targeted at large groups of the population, the majority of whom will have no symptoms of cancer. Screening offers the opportunity to diagnose many more cancers at a much earlier stage leading to better outcomes for patients. Three programmes currently exist in NI, breast, bowel and cervical. There is, however, considerable variation in the uptake of all three programmes, with poorer uptake strongly associated with social deprivation.

The UK National Screening Committee (UK NSC) makes evidence-based recommendations to UK nations regarding population screening programmes. In the past, Northern Ireland has been slower than other nations to adopt some recommendations made by the UK NSC. Going forward we will address this.

Professor Sir Mike Richards recently published his review of adult screening programmes in England. While most of the recommendations were for England specifically, there are a number of things that should be adopted by devolved screening programmes, including those in Northern Ireland. They should include participation in any new UK screening advisory body, annual publication of routine performance data and quality assurance reports for screening programmes, and high priority given to an integrated approach to increasing uptake and coverage.

Going forward, cancer screening programmes will continue to evolve and new programmes will be developed for people at higher risk.

Bowel Screening

Bowel cancer is the third most prevalent cancer in Northern Ireland and the second leading cause of cancer death. The bowel screening programme is offered to people aged 60-74. The programme detects 8.3% of all bowel cancers. 67% of cancers detected through bowel screening are at an early stage. Removal of early polyps detected through screening can very often prevent cancer from returning or developing any further.

The qFIT test is a new easier to use home test for bowel screening which only needs one sample instead of the current three samples. It has been rolled out in all other UK nations and was introduced in Northern Ireland in January 2021. The first confirmed results from Scotland after their introduction of qFIT showed increased uptake of bowel cancer screening from 55.4% to 63.9%. Importantly, this increased uptake was seen in men, areas of higher deprivation, and in difficult to reach audiences. This increase in uptake means more pre-cancerous changes and cancers are likely to be detected – and at an early stage.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Going forward plans will be developed to reduce sensitivity levels incrementally and to extend the age range in line with these recommendations within an agreed timeframe.

The success of the bowel screening programme is highly dependent on access to timely endoscopy services. There are very significant challenges with the capacity of endoscopy services across all Trusts. These must be addressed as a priority to cope with existing demands and to be able to accommodate reductions in sensitivity levels and widening of age bands in the future. There are other emerging tests being rolled out at pace elsewhere in the UK, for example colon capsule endoscopy. Early adoption of such tests may well be key in terms of developing a sustainable response to the ever increasing demand for endoscopy services.

Breast Screening

Breast screening is the most established cancer screening programme in NI. 29% of breast cancers are diagnosed via the screening programme. Mammography for all women aged 50-70 and registered with a GP is carried out every three years via mobile and static units. It is available for women aged over 70 on request. Trials have begun in England to explore broadening the age range from 47-73. This is likely to have a significant impact for Northern Ireland if it is deemed to be successful. The ongoing success of breast screening services is reliant on responsive symptomatic breast cancer services in all Trust areas.

Cervical Screening

Cervical screening is offered to all people with a cervix aged 25-49 every three years and every five years for those aged 50-64. 24% of cervical cancers are detected via the screening programme.

Samples are taken in a GP surgery and are analysed in a laboratory using a process called cytology. If abnormal cells are detected, the sample is then tested for high-risk Human Papilloma Virus (hr-HPV). hr-HPV is the most common cause of cervical cancer.

In 2016, the National Screening Committee recommended that cervical screening programmes switch to testing for hr-HPV as the primary test. Switching to hr-HPV as the primary test does not require anything different at the point of testing but does require some reconfiguration of laboratory services. In the short term, it is expected to increase referrals for colposcopy investigation. In the longer term, HPV testing is a more accurate test than cytology and will ultimately be more cost-effective by enabling a longer interval between tests. It is intended to implement the change in 2022/23.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Pilot studies on self-sampling are underway across the world and in some parts of the UK. This may improve uptake and become more mainstream.

Lung Screening

There are over 1,300 cases of lung cancer diagnosed in Northern Ireland annually and over 1,000 deaths. Five-year survival is very poor at only 12.1%. 35% of lung cancers are diagnosed via emergency presentation, with almost 70% of those diagnosed at late stage (III or IV). People diagnosed at later stages have fewer treatment options and this leads to the disease having a very poor survival rate. Over half of all diagnoses are in the lowest two deprivation areas; incidence is 70% higher in the most socially economically deprived areas than the average.

The NELSON trial is a Dutch Belgian lung cancer screening trial which has shown a 24% reduction in mortality for men and 33% reduction for women after 10 years of screening.

The UK National Screening Committee (UKNSC) is currently considering the introduction of a targeted lung cancer screening programme for the UK which would identify and test those at higher risk of the disease based on an agreed set of criteria including age and smoking status. It has commissioned an external review of screening for lung cancer in individuals at increased risk and it is expected that the public consultation will be launched in 2022. Those invited for a screening would receive a low dose, non-contrast CT scan, which is better at identifying lung cancer than plain film x-ray.

In October 2016, the UK Lung Cancer Coalition published '25 BY 25 – A ten year Strategy to improve lung cancer survival rates'.[9] They recommend that the Public Health Agency should consider evidence from trials for a local pilot for lung cancer screening in Northern Ireland.[10] No pilot currently exists in Northern Ireland.

Action 7. Reduce sensitivity levels and extend the age range for the bowel screening programme.

Action 8. Implement HPV testing in the cervical screening programme.

Action 9. Increase uptake of all cancer screening programmes.

Action 10. Implement all UK National Screening Committee recommendations.

9 UKLCC, 25 by 25A ten year Strategy to improve lung cancer survival rates, 2016, https://www.uklcc.org.uk/our-reports/october-2016/25-25.
10 The New England Journal of Medicine (2020) 'Lung Cancer Screening and Nelson Trial', N Eng J Med 2020, 382: 2164–2166.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Figure 5: Screening for cancer

Cancer screening programmes at a glance

January 2022

Cervix

	England	Scotland	Wales	Northern Ireland
Age	25-64	25-64	25-64	25-64
Frequency	25-49: 3 yearly 50-64: 5 yearly	Intervals based on HPV status: HPV +ve: 1 yearly HPV -ve: 5 yearly	Intervals based on HPV status: HPV +ve: 1 yearly HPV -ve: 5 yearly	25-49: 3 yearly 50-64: 5 yearly
Technology	LBC with HPV triage. HPV primary testing introduced in December 2019	LBC with HPV triage. HPV primary testing introduced in March 2020	HPV primary testing introduced in September 2018	LBC with HPV triage in some circumstances. HPV primary testing TBC
Coverage [a,b]	72%	71%	73%	72%

Bowel

	England	Scotland	Wales	Northern Ireland
Age	60-74 and 56 year olds [e]	50-74	58-74 [e]	60-74
Frequency	2 yearly On request over 74	2 yearly On request over 74	2 yearly	2 yearly
Technology	FIT introduced in June 2019	FIT introduced in November 2017	FIT introduced in September 2019	FIT introduced in January 2021
Threshold	120ug/g	80ug/g	150ug/g	150ug/g
Uptake [b]	66%	63%	57% [c]	59%

Breast

	England	Scotland	Wales	Northern Ireland
Age	50-70 Age extension trial [d] from 47-50 and 70-73	50-70	50-70	50-70
Frequency	3 yearly On request over 70	3 yearly On request over 70	3 yearly On request over 70	3 yearly On request over 70
Technology	Mammography	Mammography	Mammography	Mammography
Uptake [b]	70%	73%	69%	75%

[a] Age appropriate coverage: 25-49, last 3.5 years; 50-64 last 5.5 years

[b] Caution should be taken when making comparisons across countries due to differences in time periods of data, age ranges and/or differences in the definitions of coverage and uptake of screening

[c] Bowel screening uptake data in Wales is likely to be higher as the latest data is for the period prior to the introduction of FIT.

[d] Age extension trial (ages 47-50 and 70-73) not active. Trial results expected 2023.

[e] Some people younger than 60 are beginning to be offered bowel cancer screening in England and Wales as the eligible age range of the programme is expanded.

LBC: Liquid Based Cytology HPV: Human Papillomavirus
FIT: Faecal Immunochemical Test

cruk.org
Together we will beat cancer

CANCER RESEARCH UK

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Targeted Surveillance

Significant research developments are happening at present which will bring changes to the organisation and delivery of services so that patients at higher risk of a condition can be 'targeted' for additional surveillance so that an early diagnosis of cancer can be made for these conditions.

Many precancerous lesions, if detected, can be adequately treated preventing progression to cancer. Progression from precancerous disease to cancer varies by site and there has been limited research following patients with precancerous conditions on a population basis.

In Northern Ireland, research teams at Queen's University Belfast have established the following precancerous databases:

- Barrett's Oesophagus Register – The Northern Ireland Barrett's Oesophagus Register is one of the largest population-based registers of Barrett's Oesophagus worldwide
- Colorectal Polyp Register
- Endometrial Hyperplasia Register
- Monoclonal Gammopathy of Undetermined Significance (MGUS)

These databases are enabling researchers to identify clinical and molecular characteristics that predict progression to cancer that can facilitate service planning and healthcare provision. Expansion of the precancerous databases would enable improved patient outcomes.

Action 11. Create surveillance systems for conditions where there is clear evidence regarding the pre-malignant potential of a particular condition to ensure people are not lost to follow up.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Referral Guidance

In 2015, the National Institute for Health and Care Excellence (NICE) launched their newest 'Suspected cancer: recognition and referral NG12' guidance. These are guidelines for GPs when determining whether/how to refer someone with suspected cancer. England and Wales currently use these NG12 guidelines, and Scotland uses their own guidelines, though there are many similarities to NG12. Northern Ireland has not introduced this NICE-recommended cancer referral guidance NG12, and uses guidelines developed by the Northern Ireland Cancer Network, (NICaN) most recently updated in 2019.

The current 2015 NICE version is widely recognised as being limited in its application for children and young people. The Childhood Cancer and Leukaemia Group has worked with NICE to create a NICE-endorsed supplement for Children & Young People which is linked from the NICE NG-12 Tools and Resources page.[11]

NG12 guidance frames how suspected cancer is dealt with by primary care, by organising guidance by symptom and by cancer site and including information on primary care investigations and safety-netting. This design aims to make guidance easier to interpret and utilise. NG12 was developed using a risk threshold where if the risk of symptoms being caused by cancer is above a certain level then action (investigation or referral) is warranted. In 2015, NICE guidance changed, meaning that more people are referred for tests in an attempt to improve early diagnosis, and they now reflect how non-specific and challenging some cancer symptoms are to detect and manage.

There have been concerns that the introduction of NG12 would lead to increased referrals to diagnostic services, creating further pressure on already stretched services.

NG12 guidelines[12] also include a significantly increased level of GP direct access to some diagnostic tests for certain cancer types. This includes plain film x-ray, computerised tomography (CT), Magnetic Resonance Imaging (MRI), non-obstetric ultrasound (NOUS) and endoscopy. GPs in Northern Ireland have a very low level of direct access to diagnostic tests compared to elsewhere, and there is a wide variation across Northern Ireland and by test modality.

Direct access to tests can speed up access to testing, reduce the number of patient appointments and potentially improve timeliness of diagnosis.

Several new diagnostic tests broadly under the heading of 'liquid biopsy' are in development or testing. Liquid biopsy refers to tests of body fluids

11 Queen's University Belfast (2018) 'Official Stats 2018' https://www.qub.ac.uk/research-centres/nicr/FileStore/OfficialStats2018/ Factsheets2018/Filetoupload,957488,en.pdf.
12 NICE, 2015, Suspected Cancer: Recognition and Referral https://www.nice.org.uk/guidance/ng12/resources

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

including blood, saliva, faeces or urine. One major advantage of tests such as these is that they are much less invasive than a traditional biopsy, for which a sample of a suspected tumour is removed for analysis in the lab, sometimes requiring a general anaesthetic. It is highly likely that one or more of these tests will be approved for use soon.

A liquid biopsy pilot is being undertaken by NHS England. The test claims to be able to diagnose 25 different cancers by checking for molecular changes in cell-free DNA. It is targeted at people aged 50-79 with no symptoms and is designed as a triage test and not a replacement for traditional diagnostic tests. If successful this is likely to be a game changer for the future in helping to diagnose cancers much earlier using less invasive procedures. HSC should monitor development of these tests to be ready to implement them at pace whenever evidence shows their effectiveness.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Targets

Currently Northern Ireland has three measurements for cancer waiting times:

- At least 95% of patients should begin their first treatment for cancer within 62days following an urgent GP referral for suspected cancer
- At least 98% of patients diagnosed with cancer should begin their first definitivetreatment within 31 days of the decision to treat
- All urgent breast cancer referrals should be seen within 14 days

Northern Ireland also measures diagnostic waiting times (75% of patients should wait no longer than nine weeks for a diagnostic test, with no patient waiting longer than 26 weeks). These diagnostic waiting time measures, while they do include cancer tests, can only provide broad information about diagnostics generally.

There is no metric for measuring diagnostic time specifically for cancer, red flags or staging investigations. The 62-day cancer waiting time target is often used as a proxy for cancer diagnostic waiting time, but it actually measures the time from referral to first definitive treatment which is not exclusively diagnostic time, and only applies to those with a red flag referral via a GP. The 62 days include time for patients to have all diagnostic tests required to make their diagnosis of cancer and, while it doesn't track the diagnosis interval exclusively, can provide general information on the performance of cancer diagnostic services. This target was introduced in 2009 but has never been met.

The long-running poor performance against both the 62-day cancer waiting time target and the diagnostic waiting time target would point to a problem with diagnostic services, but the current targets don't allow clear identification of where the key blockages are in the system, and so it has been difficult to identify clear changes that would improve patient diagnostic waiting times.

The current cancer waiting time targets have not been reviewed since they were implemented in 2008. They do not currently apply to recurrent cancers or metastatic disease. Any review of targets must include all people undergoing treatment to ensure the whole cancer pathway is as efficient and responsive as possible.

Wales' new Single Cancer Pathway[13] is unique in that it is the only cancer waiting time measurement which includes all cancer referrals, regardless of source or classification. It includes all suspected cancer referrals from GPs, screening referrals, referrals from emergency departments and other specialty consultants, and combines them all into one single waiting time

13 Wales Cancer Network, http://www.walescanet.wales.nhs.uk/single-cancer-pathway

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

target of 62 days from point of suspicion of cancer to first definitive treatment.

Early diagnosis is extremely relevant to Teenagers and Young Adults who often experience challenges during the pathway to a diagnosis because risks and symptoms are not easily recognised and acted upon.[14] Young people will often navigate through the health system differently to older adults, and this needs consideration to ensure there are effective systems to provide a safety net and ongoing referral.

Consequently this can result in young people presenting later with more advanced disease resulting in the need to provide more "intensive and prolonged therapies, increased toxicities, higher costs to the HSC and families and ultimately poorer outcomes"[15]

We are unlikely to make significant changes to childhood and young adult cancers through prevention approaches and conversely need to focus on awareness campaigns and earlier detection for this age group as a priority. The Childhood Cancer and Leukaemia Group have developed a Child Cancer Smart Early Diagnosis and Awareness Campaign.[16] Together with the existing Head Smart tool[17] for brain tumours, there is the opportunity to raise awareness among healthcare professionals to enable earlier diagnosis.

In general, earlier diagnosis not only significantly increases survival but it is also more cost effective if patients can be treated with less intensive treatments for earlier stage cancers. This is important across all ages and even more so for children and young people.

Action 12. Implement NICE guidance including NG12 and, in the future, the most current NICE referral guidelines.

Action 13. A 28-day standard will be introduced to track the time for all people from first referral for suspected cancer to confirmation of a cancer diagnosis, which includes all diagnostic and staging investigations.

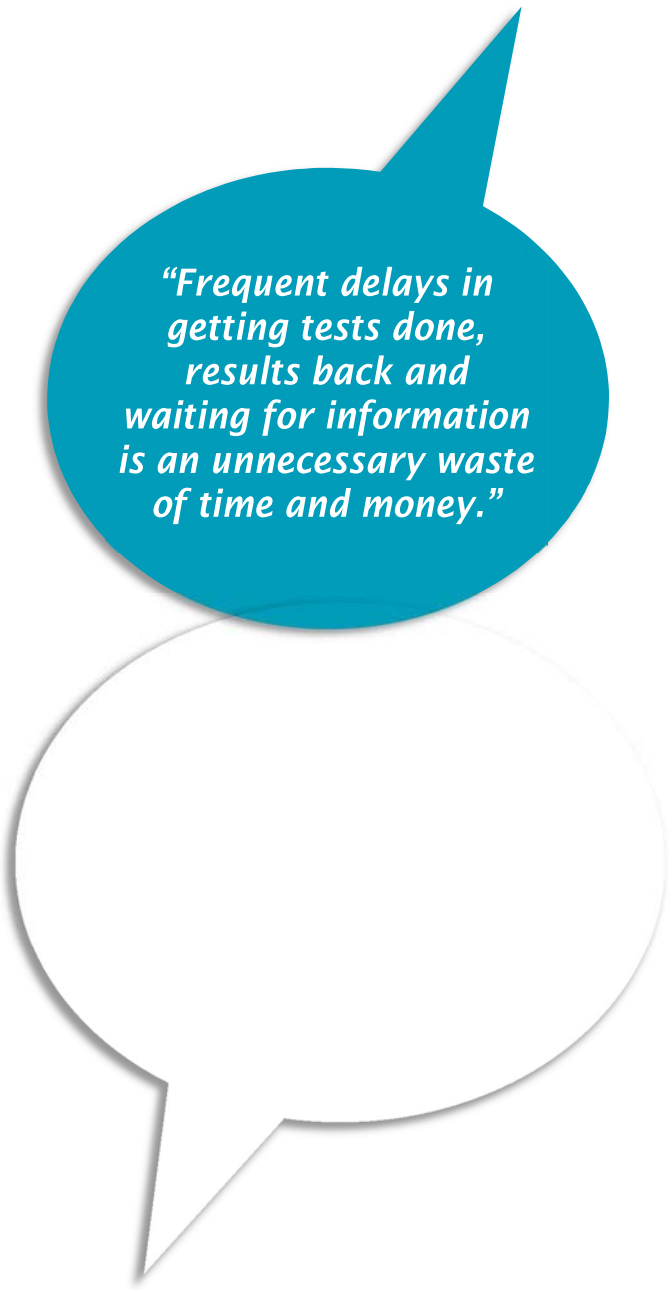
Action 14. Review current targets to ensure equity across the pathway.

14 Dommett, R.M., Pring, H., Cargill, J. et al. Achieving a timely diagnosis for teenagers and young adults with cancer: the ACE "too young to get cancer?" study. BMC Cancer 19, 616 (2019).https://doi.org/10.1186/s12885-019-5776-0
15 Walker, D.A. (2021) 'Helping GPs to diagnose children's cancer', British Journal of General Practise 2021; 71 (705): 151–152.
16 Walker, D.A. (2021) Helping GPs to diagnose children's cancer British Journal of General Practice 2021; 71 (705): 151- 152 https://bjgp.org/content/71/705/151 https://www.cclg.org.uk/ChildCancerSupport.
17 HeadSmart – Early Diagnosis of Brain Tumours, (2022),https://www.headsmart.org.uk/.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

People with Vague but Worrying Symptoms

Arguably some of the most difficult people to diagnose are those who present with vague but concerning symptoms, sometimes several in combination. Their symptoms are often non-specific and can leave the GP without clear guidance on which specialty to refer these patients to. There is currently no clear pathway for these people and they can often be 'bounced' between various consultants,diagnostic tests and general practice in an effort to make a diagnosis. Individuals presenting in this way experience longer times to diagnosis overall and poorer clinical outcomes compared to those with site-specific recognisable symptoms.



The concept of diagnostic hubs for patients with vague but worrying symptoms originated with the Accelerate Coordinate Evaluate (ACE) programme inEngland, facilitated by Cancer Research UK (CRUK) and Macmillan based on models developed in Denmark. Analysis of data from five pilot sites demonstrated a cancer diagnosis for 8% of all people referred. A significant proportion of these would be considered rare or hard-to-diagnose. In addition more than a third of patients were diagnosed with other conditions and referred to the appropriate service.

England, Wales and Scotland have all adopted versions of this specificpathway for patients with vague butworrying symptoms.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Diagnostic Centres

Currently diagnostic tests are done linearly – people are referred for one test which is reported and reviewed before referral for additional tests. We do not currently have the ability to order tests as a cluster – even if the clinician knows in advance that a certain grouping of tests will be required. This results in people having repeat visits to diagnostic facilities for testing which lengthens their diagnostic interval.

There has been no sustained improvement in cancer or diagnostic waiting times over several years, despite efforts by Trusts and others to increase capacity and access to tests. A new approach is required to improve the diagnostic pathways. If change is not made, waiting times will continue to deteriorate and more people could be diagnosed late, impacting the effectiveness of treatment and even survival.

Diagnostic tests are carried out in a wide range of facilities. In many sites, the equipment for diagnostics is also used for acute and emergency presentations, causing potential scheduling issues. In some areas, radiology and endoscopy are not available on the same site. Diagnostic imaging is performed in all acute hospitals across Northern Ireland, though numbers of scanners vary by location. Acute hospitals with only one CT scanner are vulnerable as that scanner must be used for any emergencies. This means diagnostic appointments can be cancelled or delayed. Across the rest of the UK there is a focus on the reconfiguration and consolidation of diagnostic services into larger diagnostic centres or hubs.

Key to these pilots was the establishment of a single hub location where people could attend for a range of tests on the same day. Quick movement through the diagnostic hub is maintained by active and ongoing coordination and clinical liaison by the Clinical Nurse Specialist (CNS) and patient navigators who track and support patients throughout the process.

In Wales and Scotland, diagnostic hubs are currently focused on patients with ‘vague but worrying symptoms’.

Based on results from the ACE pilots in England, there is ongoing expansion of their diagnostic hubs to provide the same services for a wider range of patients including all those with red flag referrals. These larger diagnostic hubs will provide a single point of access to a diagnostic pathway for all people with urgent symptoms that could indicate cancer, and a personalised, accurate and rapid diagnosis of their symptoms by integrating existing diagnostic provision and utilising networked clinical expertise.

NHS England has recently accepted recommendations made by former England National Cancer Director, Sir Mike Richards, for the development of ‘community diagnostic hubs’. His recommendations included the separation of emergency and elective diagnostics to reduce patient delays, consideration of ‘alternative’ sites for diagnostic hubs (including high

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

streets or out-of-town retail parks), increased staff in imaging and endoscopy, and purchase of additional CT scanners.

For Northern Ireland, the introduction of centralised diagnostic hubs, initially for people with vague but concerning symptoms, and then expanded to include all those with a red flag referral for cancer, has the potential to reduce the number of GP, hospital consultant and diagnostic appointments and significantly speed up diagnosis.

The development of these diagnostic hubs would mean easier and more flexible staffing and scheduling, opportunity to utilise newer techniques and technology, facilitation of clinical training and supervision and potential for improved waiting times with centralised lists and locations. Most importantly, there is the opportunity to diagnose more people early and to improve both patient experience and outcomes.

Action 15. Develop new pathways and diagnostic services to improve diagnosis.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Diagnosis of Haematological Malignancies

Malignant haematological diagnoses are based on the analysis of several different specimens (blood and bone marrow) by specialists in multiple laboratory disciplines. Together these results provide an accurate final diagnosis which informs personalised patient management.

NICE guidance NG47, updated in 2016, recommends an accredited Specialist Integrated Haematological Diagnostic Service (SIHMDS) to manage the diagnosis of all haematological malignancies. An SIHMDS for Northern Ireland would be located on a single site, have a full range of specialist diagnostic staff and be the single point of sample analysis and diagnosis for any suspected haematological malignancy. SIMHDSs exist in most other centres across the UK.

NG35[18] (developed in 2016 and updated in 2018) recommends full-body MRI scan as the first line of diagnosis for patients with suspected myeloma. Whole Body MRI (WBMRI) is not routinely offered for patients with suspected or newly diagnosed myeloma. This approach has largely been due to lack of availability of MRI scanning and reporting capacity within Trust imaging services. In the wake of the COVID-19 pandemic and the resultant impact on cancer services, it is recognised that it is no longer tenable for patients not to receive the recommended investigation of WBMRI. In the absence of additional MRI equipment and staffing, this could extend waiting times for other MRI patients and there will be additional requirements in terms of radiographer and radiologist training as well as updating of current MRI protocols.

Action 16. Develop a specialist integrated haematological diagnostics service for Northern Ireland.

18 Myelnoma: Diagnosis and Management, NICE Guideline NG35, 2016, https://www.nice.org.uk/guidance/ng35.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Theme 2: Diagnosing and Treating Cancer

Treating Cancer

Treatment for cancer varies by tumour type, stage of the disease, the person's general health status, age and increasingly genetic and molecular information. Patients may be offered surgery, radiotherapy, hormonal therapy, systemic anti-cancer treatment, which includes chemotherapy, immunotherapy and biologic agents. For many it will be a combination of treatments. Demographic changes in our population will result in an increased demand for high-quality, effective cancer treatments which offer the best possible outcomes.

Regardless of the treatment offered, every person should expect the highest standard of care. If the evidence base indicates that particular procedures or treatments would be optimised by centralisation on fewer sites then services will be reconfigured appropriately.

The current model of delivery for elective surgery, SACT and radiotherapy is based on a Monday to Friday model. Consideration must be given to extended provision over a seven-day model with the recognition that this will have significant implications for the workforce.

Prehabilitation

Prehabilitation enables people with cancer, prior to any type of cancer treatment, to prepare for treatment through assessment and needs-based prescribing for healthy behaviour and follow-up.

The key components are exercise, nutritional management and psychological support. Prehabilitation and rehabilitation are core elements of the pathway of care from diagnosis, and focus on enablement and empowerment. Services are led and delivered by a range of Allied Health Professionals (AHPs).[19]

Although prehabilitation guidelines, developed by the Royal College of Anaesthetists and the National Institute for Health Research Cancer and Nutrition Collaboration, in partnership with Macmillan Cancer Support,[20] were launched by the Department of Health in 2019 there is no planned, coordinated or commissioned prehabilitation service available in Northern Ireland. While some ad hoc pathways, pilot initiatives and models are developing for some tumour groups, there is minimal provision available for

19 Brown, H. et al. (2014) An evaluation of cancer surgery services in the UK, Health Services Management Centre, University of Birmingham, and ICF-GHK consulting.
20 Macmillan (2019) 'Prehabilitation Guidance for People with cancer', www.macmillan.org.uk/assets/prehabilitation-guidance-for-people-with-cancer.pdf.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

prehabilitation despite strong international evidence about the benefits and cost effectiveness.

Research has shown that in the absence of prehabilitation and rehabilitation programmes, functional recovery is delayed (for older patients in particular) so that six months post operatively only 50% have achieved pre-operative functional levels. Prehabilitation and rehabilitation services enable a more proactive and cost-effective care approach, with the potential to reduce the length of hospital stays, need for ICU / HDU admissions, medication and post-treatment complications, whilst enhancing recovery and quality of life overall.[21]

Action 17. Develop and implement prehabilitation and rehabilitation services on a regional basis for all those who will benefit.

21 NHS England NHS England (2018) 'Quick Guide: The role of allied health professionals in supporting people to live well with and beyond cancer. Transforming health, care and wellbeing with allied health professionals', London: Allied Health Professions team, https://www.england.nhs.uk/wp-content/ uploads/2018/10/quick-guide-ahp-cancer.pdf).

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Surgery

Surgery is the cornerstone of treatment in the management of non-haematological cancers and for many cancers it is curative as the sole treatment. In addition, surgery may be undertaken as a preventative measure, for diagnostic purposes, reconstruction or for palliation.

Ideally surgery for cancer should be planned in advance but the reality is that many cancers still present themselves as emergencies often requiring emergency interventions. It is therefore difficult to completely separate planned and emergency cancer surgery. The nature of the most complex elective surgery means that it can never be separated entirely from unscheduled care services. For less complex surgery to be as efficient as possible, there is a strong case for attempting to insulate it from unscheduled care pressures.

The first dedicated elective care centre for Northern Ireland was recently established in South Eastern HSC Trust at Lagan Valley Hospital which has enabled the complete separation of elective and unscheduled services and has supported services to be delivered throughout the pandemic on behalf of the region. This new model continues to evolve but has already demonstrated the benefits of having dedicated elective capacity.

There is a broad consensus that surgical services should be configured to ensure that people receive the highest standard of multidisciplinary care. Evidence from elsewhere demonstrates that specialisation of services and the centralisation of complex surgery on fewer sites results in better patient outcomes for certain procedures. There is, however, a balance to be achieved through maximising resources and scarce clinical skills by specialisation and centralisation with the provision for minimally invasive and day case surgery delivered more locally.

Advances in surgical techniques and new technologies have resulted in less invasive procedures which not only reduce length of stay in hospital but also contribute to improved recovery and experience. New techniques may continue to replace the role of traditional surgical resection. This is partly due to improvements in visualisation, endoscopic and minimally invasive technology and the expanding role of robotics and nano-technology. Robotic surgery has been implemented in Northern Ireland but its use is limited currently to prostate cancer and partial nephrectomy.

Failure to introduce new surgical technologies will significantly impact on both the ability to deliver training for the next generation of surgeons and on the recruitment of new consultant surgeons. Delays in the implementation of new technology may also result in inequitable access to the best standards of care in the future.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Big data, genomics and artificial intelligence will increasingly drive developments in surgery. Increasingly, precision or personalised medicine will be based on an individual patient's genetic, molecular and/or cellular characteristics and specific attributes of their tumour. These revolutionary changes will impact on if and when traditional surgery plays a role in treatment. While the role of surgery may diminish in the primary treatment of some cancers, greater understanding of disease biology is likely to increase the surgery in selected patients with more advanced disease.

The role of prehabilitation, with optimisation of patients prior to treatment combined with less invasive techniques, may increase the proportion of elderly or frail patients suitable for radical treatment.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Enhanced Recovery After Surgery

Enhanced Recovery After Surgery (ERAS) has been described as a paradigm shift in perioperative care, resulting in substantial improvements in both clinical outcomes and cost savings. Originally programmes were developed for colorectal surgery but have now been shown to be advantageous for almost all major surgery.

Examples of evidence-based modern care include changes from overnight fasting to carbohydrate drinks two hours before surgery, minimally invasive approaches instead of large incisions, management of fluids to seek balance rather than large volumes of intravenous fluids, avoidance of, or early removal of drains and tubes, early mobilisation, and serving of drinks and food the day of the operation. ERAS protocols have resulted in shorter length of hospital stay by 30% to 50% and similar reductions in complications, while readmissions and costs are reduced.[22]

ERAS programmes have been implemented in some areas in NI. There is a need to implement programmes regionally and at scale to ensure both enhanced patient outcomes and greater efficiencies.

Action 18. Reconfigure cancer surgical services alongside any future recommendations for the delivery of emergency and elective surgery.

Action 19. Implement Enhanced Recovery After Surgery programmes on a regional basis for all appropriate major cancer surgery.

22 Ljungqvist, O., Scott, M., Fearon, K.C. (2017) 'Enhanced Recovery After Surgery: A Review'. JAMA Surg. Mar 1;152(3): 292–298. doi: 10.1001/jamasurg.2016.4952. PMID: 28097305.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Radiotherapy

Radiotherapy is a vital component of the different treatment options for cancer patients and has widespread uses in both curative treatments and for the treatment of symptoms in palliative patients. Different studies over a number of years have indicated that approximately 50% of people with cancer should receive radiotherapy as part of their primary treatment. There is also a recognised increase in the number of people who will require radiotherapy as part of a re-treatment regime. This is estimated to be approximately 25% of cancer patients, suggesting that more than 60% of people with cancer will require radiotherapy at some point during their care by 2025.[23]

Radiotherapy in Northern Ireland is delivered at two centres: the Northern Ireland Cancer Centre (NICC) at the Belfast HSC Trust and the North West Cancer Centre (NWCC) in the Western HSC Trust at Altnagelvin Hospital. The NWCC additionally provides treatments to patients from parts of the Republic of Ireland under an all-Ireland agreement. The two centres are independent with people undergoing their whole radiotherapy pathway in one or other of the centres. Transfer of patients part way through the radiotherapy pathway is not easily achieved and is subject to increased risk and would require replanning of patients with delays in restarting treatment and additional work for the receiving centre. Moving forward, both centres should work in collaboration to develop common treatment pathways and in partnership with BSO establish compatible treatment planning platforms.

Some people are currently referred for highly specialist treatments such as proton beam radiotherapy to centres in other jurisdictions. It is unlikely that the population of Northern Ireland will ever be large enough to sustain these treatments and, going forward, we will explore all-Ireland solutions for these low volume, costly treatments. Access to these treatments is often on a cost-per-case basis. This can add to delays in the patient's pathway, and adds to the administrative burden for the service.

Radiotherapy treatments are delivered over differing timeframes ranging from a single dose for palliation to several weeks as part of a fractionated treatment course.

Different cancer types, stages and sites will have different overall radiation dose and fractionation schedules associated with them. The capacity requirements on the treatment delivery units (LINACs - Linear Accelerators) will be affected by a complex relationship between the number of patients, the number of fractions and the complexity of each treatment. There is a trend towards the use of less fractions per treatment, which reduces demand on the accelerators, but there are growing numbers of more complex treatments which increase demand on the accelerators. The capacity available on the radiotherapy treatment units needs to be able to

23 Borras JM, Lievens Y, Barton M. et al (2016) 'How many new cancer patients in Europe will require radiotherapy by 2025? An ESTRO-HERO analysis'.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

accommodate changes to this complex balance between reducing the number of fractions and increasing the complexity of the treatment.

Modern treatments can take many hours or days to plan and require highly trained staff and advanced software packages to fully exploit the potential of modern radiotherapy techniques. Each person will require some level of treatment planning. The increasing complexity of treatment impacts directly on the workload of the treatment planning staff.

Recent advances in radiotherapy have ensured more accurate delivery of treatment thus reducing long-term side effects and improving quality of life. As treatment becomes more advanced, there will be a requirement for ongoing investment. Newer treatments such as stereotactic ablative radiotherapy (SABR) are becoming more routine and their use is likely to be extended to a much wider range of tumour sites in the short to medium term. Currently there is a clear need for a rolling replacement programme for LINACs combined with investment in both software and staff training. Planning ahead for the adoption of novel technologies, such as MR simulation treatment planning in the short term and MR LINAC delivered radiotherapy in the medium term, will be essential to the delivery of world-class treatment.

Radiotherapy is a very data intensive treatment modality. This includes multiple pre-imaging data sets, both for diagnosis and treatment planning purposes, multiple treatment verification image data sets and potentially many follow-up image data sets.

To deliver a safe, quality-assured and outcome-driven radiotherapy service robust and accessible data sets are required in line with other UK countries which enable them to routinely analyse radiotherapy outcomes and to contribute to national and international audits. Commitment to a continual cycle of data review and examination is fundamental in providing learning opportunities which help to reduce cancer relapse, toxicity and improve quality of life.

Action 20. Introduce and implement new radiotherapy techniques and technology in line with national guidance including staffing and associated training.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Systemic Anti-Cancer Treatment

Systemic Anti-Cancer Treatment (SACT) is a collective term which describes all drugs used to treat cancer and includes chemotherapy, immunotherapy and targeted therapies. It can be given intravenously or orally, in hospital or in other settings. As the incidence of cancer increases and survival continues to improve, there is an associated increase in the demand for systemic anti-cancer therapy. SACT may be given on its own or in combination with other treatments and may be given with the aim of curing cancer or of prolonging life.

SACT is currently delivered in both cancer centres and in the three cancer unit hospitals, Antrim Area Hospital, Craigavon Area Hospital and the Ulster Hospital. The cancer unit service depends on visiting oncologists to provide SACT clinics as well as outpatient clinics for new and review patients. Currently, unit-based oncology consultants consist of two consultants in South Eastern HSC Trust and one consultant in the Southern HSC Trust. To prevent professional isolation and provide peer support, these posts link into audit and quality improvement, safety and educational meetings hosted through the Northern Ireland Cancer Centre (NICC). The consultants also provide clinical leadership and care for the Trust Acute Oncology Service and for patients based in the units. Looking to the future, Cancer units and the NICC should explore an expansion in further unit-based posts with associated dedicated funding.

The current service model for non-surgical oncology was established over 20 years ago. Since then there have been major developments in many areas of cancer care including imaging, pathology, genetics, surgery and treatment regimes. For many years, there have been ongoing issues with the sustainability and resilience of the service. The Oncology Services Transformation Programme (OST) reported in 2019 and was followed by the Oncology Haematology Stabilisation Plan in October 2020. OST identified a 6% projected annual growth requirement in SACT services until 2026.



Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Recent data has demonstrated that growth has been very significantly greater than predicted. Data from the Regional Information System for Oncology and Haematology (RISOH) demonstrates a growth of 32% in the number of oncology prescriptions between 2018/19 (when the system was brought into use) and 2021/22. Based on OST projections of 6% growth per annum, we would have expected to see a 19% increase over this period. This data demonstrates that not only is the service seeing more patients but the complexity of the patients and treatment prescribed have increased. The pressure is being felt across the entire multidisciplinary team.

While the increases have not been as dramatic within haematology, they are still well in excess of 6% per annum growth.

The project also determined that the way forward was to develop a sustainable medically-led and supported service as opposed to the current consultant-delivered model. It is essential that these plans are implemented if we are to ensure an efficient, effective and resilient service for the future. Failure to implement will mean that we do not make the most appropriate use of skills within the medical and non-medical workforces. Furthermore, the continued use of a consultant-led service will be at considerably greater cost than other models in the future.

The COVID-19 pandemic has resulted in some positive changes to the delivery of SACT services, including the delivery of certain oral SACT treatments to peoples' homes, the development of near-to-home phlebotomy services and the use of remote assessment, all of which have been well received. Learning from these developments must be used to shape services for the future. Oncology services have been maintained throughout the pandemic, but as referrals have started to recover and more people are offered SACT or radiotherapy as alternatives to surgery, the pressure is increasing on an already very fragile service.

The home delivery of oral SACT developed during the pandemic has reduced footfall in hospitals and provided convenient, safe care for patients. This could be extended to people receiving subcutaneous therapies (given by injection under the skin) who agree to and are competent to self-administer their treatment. A significant number of haematology patients are under active surveillance (watch and wait). This includes people with early stage chronic lymphocytic leukaemia and other pre-malignant conditions. Many of these people are suitable for primary care or nurse-led follow up.

Over recent years, there has been a rapid expansion in the use of oral targeted therapies and immune checkpoint inhibitors in particular. In contrast to the use of intravenous cytotoxic chemotherapy requiring specialist nursing care, many of these new treatments are either oral medications or can be administered as relatively simple intravenous infusions. The use of chemotherapy is likely to continue.

However, as a proportion of the total number of SACT delivered, its use is proportionately likely to fall over the next 10 years. This will afford the

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

opportunity to explore the development of other models of delivery of this treatment in the future, for example delivery of treatments in health and wellbeing centres, or in non-cancer unit hospitals with day care facilities. Failure to provide SACT at home or near to home for those suitable is adding to the footfall in hospitals and is costly in both time and travel for people living with cancer.



Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Pharmacy

The OST programme made specific references to modernising pharmacy services. This includes the need to expand and develop the clinical and aseptic pharmacy workforce. Failure to do so may risk the sustainability of current and future services and will restrict the ability to manage both new and complex treatments and the expansion of precision medicine. There is a need to plan for a more integrated and holistic pharmacy service. This includes pharmacists undertaking clinical verification, medicines optimisation, prescribing, monitoring of patients, patient education and community liaison. Pharmacist involvement in these areas has been shown to be effective in identifying treatment and adherence issues, improving the patient experience, improving patient and carer knowledge, and making cost-effective medicines choices. The outcomes of the current review of aseptic pharmacy will be invaluable in the future development of regional pharmacy services.

Action 21. Implement in full the recommendations of the Oncology Service Transformation Project and the Oncology Haematology stabilisation plan.

Action 22. Ensure timely treatment where services cannot be provided in Northern Ireland due to specialist nature of services, technology constraints or low number of patients. Continue to monitor the viability of providing these services locally including CAR-T.

Action 23. Develop near-to-home phlebotomy services.

Action 24. Review the model of delivery for Systemic Anti-Cancer Treatment services including the delivery of near/close-to-home SACT.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Acute Oncology Services

Acute oncology services have been developed across most of the UK in response to a report in 2008 from the National Confidential Enquiry into Patient Outcome and Death (NCEPOD), which showed serious deficiencies in the care of acutely unwell cancer patients. The services exist in hospitals that have emergency departments or are specialist cancer hospitals. Their role is to address both the needs of people presenting as emergencies prior to diagnosis, as well as dealing with acute consequences of treatments provided to patients. In many cases, people are presenting with life-threatening issues such as neutropenic sepsis. Acute Oncology Services (AOS) were implemented across Northern Ireland in 2016. This represents a major step forward in the safe provision of non-surgical oncology services. To date, they have demonstrated reduced hospital stay, avoidance of admission, have expedited investigative pathways and have also shown that unnecessary investigations can be avoided. There are, however, recognised limitations to the service. Currently the service is provided across all Trusts on a five-day, 9-5 model.

Cancer registry data demonstrates that two thirds of people who would benefit are presenting outside this time frame. A National Peer Review visit in 2018 highlighted a number of serious concerns including insufficient staffing. Given the increasing incidence of cancer and number of people receiving SACT, the current AOS are not sustainable.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Cancer of Unknown Primary (CUP)

Following on from the NCEPOD Report, guidance has been developed by NICE (2010) mandating the provision of a CUP Service. Metastatic CUP is a common and well-recognised syndrome. It represents 3–5% of all malignancies and is the fourth most common cause of cancer-related death. Overall survival at 12 months is around 16%, but only 6% for those who present as an emergency. People diagnosed with CUP are known to have aggressive advanced disease, complex clinical needs, chemotherapy-resistant biology and poor clinical outcomes.

A CUP service is a dedicated specialist team aiming for improved survival-based outcomes and enhanced quality of life and patient experience. A regional CUP service for Northern Ireland should be commissioned to ensure timely diagnosis, improved survival and better outcomes for patients.



Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Metastatic Spinal Cord Compression (MSCC)

Metastatic spinal cord compression (MSCC) occurs when there is pathological vertebral body collapse or direct tumour growth causing compression of the spinal cord. Irreversible neurological damage ensues with resulting permanent paralysis.

The true incidence of MSCC is unknown but post-mortem evidence indicates that it is present in 5–10% of people with advanced cancer. In 2008, NICE[24] issued guidance on MSCC which recommends that patients with suspected, impending or confirmed metastatic spinal cord compression should have their care coordinated and streamlined to ensure appropriate and timely treatment, the benefits of which are earlier diagnosis and importantly improved outcomes for patients including prevention or delay in the onset of paralysis, timely rehabilitation and significantly reduced length of stay in hospital.

Without access to a regional MSCC coordination service, the pathway for these people is fragmented resulting in potentially delayed diagnosis, poorer survival outcomes and sub-optimal quality of care for those with limited life expectancy.

Action 25. Develop a 24/7 metastatic spinal cord compression service with rapid access to imaging and treatment.

Action 26. Extend the acute oncology service across all Trusts to seven-day working.

24 NICE (2008) 'Diagnosis and management of adults at risk of and with metastatic spinal cord compression' http://www.nice.org.uk/CG75.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Precision Medicine

In the last decade, molecular pathology and diagnostics has successfully been implemented in health services, resulting in a dramatic change in the access to new targeted drugs for people with cancer. The expansion from the current molecular pathology structure to a more holistic genomic medicine approach is inevitable in the next few years, and it is supported UK-wide through several white papers and more recently through the transformational activities of the 100,000 genomes project led by NHS England. Northern Ireland is a part of this project via recognition as a Genomic Medicine Centre.

Precision medicine will become increasingly important in determining the most appropriate management plan for people with cancer. Improvements in technology mean that molecular profiling will become available at a relatively low cost and information will be available within clinically-relevant timeframes. The long-term vision for Precision Cancer Medicine in Northern Ireland is for all cancer patients to have access to high- quality, comprehensive and timely molecular characterisation of their tumour to inform therapeutic and clinical management. However, Northern Ireland lags behind other regions of the UK in developing this service.

The systematic application of genomic technologies has the potential to transform lives by:

- Enabling a quicker diagnosis for patients with a rare disease
- Matching people to the most effective medications and interventions, reducing the likelihood of an adverse drug reaction
- Increasing the number of people surviving cancer each year because of more accurate and early diagnosis and more effective use of therapies

Going forward, Molecular Tumour Boards will be established to provide advice to multidisciplinary teams (MDTs) in determining appropriate management options and prognosis. These services should be fully incorporated into all aspects of cancer pathways including diagnosis and screening services, therapeutic decisions, monitoring of response, relapse or recurrence. Embedding genomic testing in routine patient management, including generic consent, would generate an efficient pathway for the implementation of precision cancer medicine.

It is important to ensure that people and their families are well informed of the benefits and consequences of genomic testing, particularly in regard to the risks of pertinent findings (i.e. genetics variants linked to cancer predisposition such as BRCA1/2, MHL1).

Action 27. Deliver genetic and genomic testing in cancer pathways in line with NICE recommendations.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Haematological Cancers

Haematological cancer, otherwise known as blood cancer, is a broad term which refers to cancer which primarily affects the blood or blood-producing organs. These cancers range in complexity and prognosis with some being low-grade chronic conditions to aggressive life-threatening conditions. Treatment also varies significantly from surveillance, outpatient chemotherapy and immunotherapy, to intensive and complex including stem cell transplantation.

Haematology services are provided within all Trusts. Specialist level 3 care is provided at Belfast City Hospital (BCH). Data demonstrates an increase in new referrals to haematology services in Northern Ireland of 42% between 2013 and 2018. The associated day-patient activity has increased by 22.9% over the same time period and inpatient activity has increased by 32%. This regional specialist unit generally runs at 120-130% capacity with outlying patients in the Northern Ireland Cancer Centre.

Currently, the BCH site provides autologous haematopoietic stem cell transplantation (auto-HSCT) and sibling allogeneic transplantation (allo-HSCT). Patients undergoing Matched Unrelated Donor (MUD) transplant receive pre-transplant work-up and post- transplant follow-up in BCH but they must travel to another centre such as St James's Hospital in Dublin or a London-based transplant unit to undergo the procedure. The number of people undergoing auto-HSCT is rising year on year. In 2019, the transplant service was unable to meet the demands and as a result, patients were transferred to King's College Hospital, London for transplantation. In order to meet the ever-increasing demand for haematopoietic stem cell transplantation and avoid travel outside of Northern Ireland, expansion of transplant capabilities at BCH is required.

NICE guidance (NG-47) clearly defines the facilities required to provide level 3 care including single occupancy rooms with individual bathrooms and clean air systems. NG47 also stipulates the need for onsite contiguous access to critical care along with respiratory and cardiology specialities to safely care for patients receiving higher intensity SACT and transplant.

Chimeric Antigen Receptor T cell Therapy (CAR-T) has emerged as a promising new treatment for some blood cancers in both children and adults. Approval in the UK has been given for the treatment of follicular and mantle cell lymphoma with other approvals expected in the short term. The clinical indications for this intervention continue to expand and it is likely that it will rival and possibly replace autologous HSCT in some instances.

Some 30% of patients undergoing CAR-T require ICU admission during their inpatient stay. A multiprofessional approach is required for the safe management of these patients including timely input from critical care, renal, neurology, cardiology and allied healthcare professionals.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

At present this treatment is only available at a small number of highly specialised centres in other jurisdictions. Relatively small numbers of adult patients are referred annually for CAR-T but numbers are expected to rise significantly in the coming years. CAR-T is also licensed for use in the treatment of children and young people.

Travel for people can be challenging given their underlying diagnosis and usually involves at least two to three visits to a GB site before CAR-T takes place. Following the procedure, people spend three to four weeks in hospital before returning home.

New models of care for haematology need to be developed including ambulatory and Out of Hours (OOH) facilities. This would enable a reduction in the numbers of people being delayed from hospital at discharge, the timely management of neutropenic sepsis and other life-threatening complications and people being inappropriately admitted to hospital.

Electronic prescribing of SACT for haematology patients was highlighted as a major concern during the SACT peer review 2019. This limits data collation and comparison of patient outcomes. Standardised electronic prescribing systems have been shown to reduce the risks of SACT-related incidents. An electronic prescribing system must be fully implemented for all haematology patients.

Action 28. Develop ambulatory care haematology units in each of the Trusts and establish near-to-home treatment services for suitable patients.

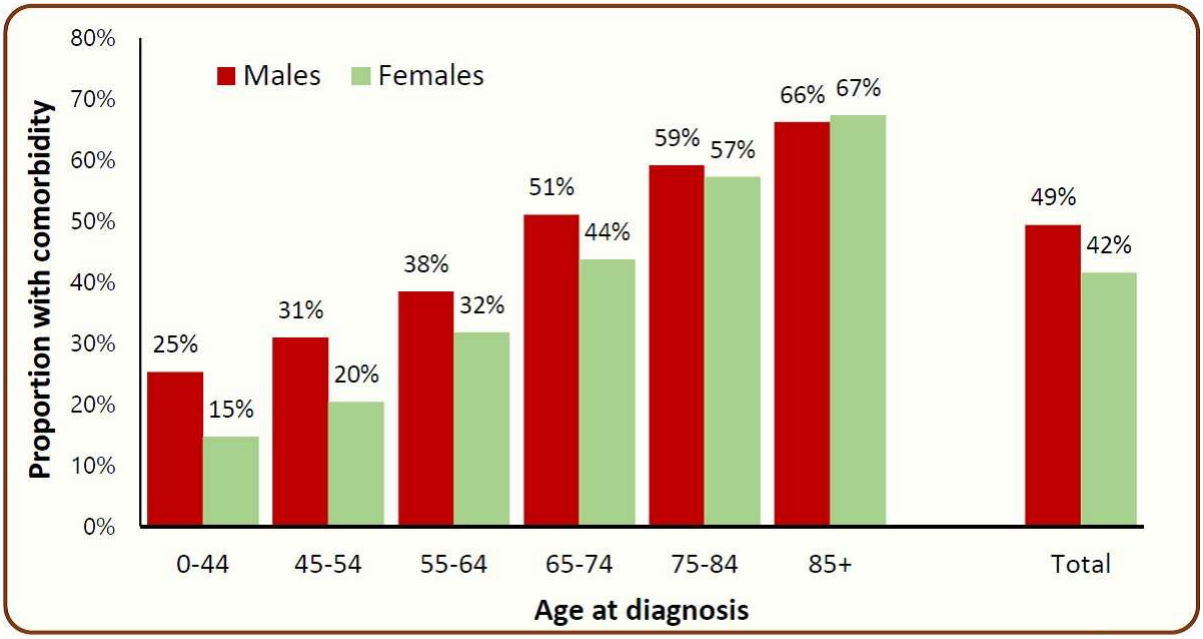
Action 29. Implement a safe and robust electronic prescribing system for all Systemic Anti-Cancer Treatment regimes.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Older People with Cancer

Cancer is a disease related to ageing and increases in incidence in older adults. 2015 figures for the UK show that 36% of people diagnosed with cancer were over 75 years of age. It is estimated that by 2035, this proportion will rise to 45% and will account for 65% of cancer deaths.[25] The Cancer Research UK report 'Advancing Care, Advancing Years: Improving Cancer Treatment and Care for an Ageing Population' notes that age is a proxy measure for complexity as increasing age is associated with increased comorbidities, cognitive issues and complex social care needs. This is illustrated using data from the Northern Ireland Cancer Registry. These issues will require significant consideration in the development of cancer treatment and care plans. Like all other age groups, the needs of people vary. Many older people are active and in good health while others are frail with multiple other long-term conditions.

Figure 6: Age and Co-morbidity. Northern Ireland Cancer Registry



Note: Includes cancers (ex. NMSC) diagnosed in 2016, with comorbidities up to one year before diagnosis.

Source: Northern Ireland Cancer Registry

Research by the National Cancer Intelligence Network in England (2015)[26] has highlighted the fact that older people are more likely to have their cancer diagnosed late and to present as an emergency.

25 Smittenaar CR, et al. (2016) Cancer Incidence and Mortality Projections in the UK Until 2035. Brit J Cancer 115, 1147-1155
26 National Cancer Intelligence Network (2015) 'NCIN, Older People and Cancer (version 3)'.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

There is evidence of age-related inequality in cancer outcomes with reduced cancer-specific survival in older patients and also evidence of discrepancy between outcomes in older people in the UK compared to the best performing nations.[27] [28] [29] There is no reason to believe the position in Northern Ireland differs from that in any other UK nation.

There is evidence that older people are less likely to receive different types of treatment which may be a result of individual choice, because they are too unwell for active treatment or because they choose quality over quantity of life. It may be due, at least in part, to them not being offered treatments due to assumptions made about fitness for treatment based on age. The assessment and care of older people with cancer are complex and have given rise to the specialty of geriatric oncology supported by its own international association, the International Society of Geriatric Oncology (SIOG).

Methods currently used routinely to assess fitness for treatment are, arguably, not fit for purpose and lead to poor assessment of the needs of older people with cancer. There is also a lack of evidence about the benefit of certain cancer treatments in the elderly who are not adequately represented in clinical trials.

Care of the Elderly Services should be better integrated with oncology and haematology. The identification of frailty is largely based on assessment of performance status, is a visual assessment and does not usually rely on more accurate validated frailty screening tools.

In addition to the risk of under-treatment in older people, there is a risk of overtreatment without the use of appropriate geriatric assessment screening tools to identify those older people in need of a more thorough assessment of frailty. Getting the balance right to ensure appropriate treatment, either curative or with palliative intent, is difficult but nonetheless vital.

27 Coleman, M.P. et al. (2011) 'ICBP Module 1 Working Group, Cancer survival in Australia, Canada, Denmark, Norway, Sweden, and the UK, 1995–2007 (the International Cancer Benchmarking Partnership): An analysis of population-based cancer registry data', The Lancet, vol. 377: 127–38.
28 Berrino, F. et al (2007) 'Survival for eight major cancers and all cancers combined for European adults diagnosed 1995–99: results of the Eurocare-4 study'. The Lancet Oncology, 8, 773–83.
29 Woods LM, et al.(2009). 'Large differences in patterns of breast cancer survival between Australia and England: a comparative study using cancer registry data'. International Journal of Cancer, 124, 2391–9.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Adults with Learning Disabilities, Communication Needs and Chronic Mental Health Problems

Outcomes for people with cancer who suffer chronic mental ill health are poorly understood. There is data to suggest that they are more likely to present with advanced stage cancer and, stage for stage, have worse cancer-specific outcomes than the general population.[30] Similar evidence exists for people with learning difficulties.[31] Furthermore, people with mental ill health problems have higher rates of health behaviours linked with cancer mortality including cigarette smoking and excess alcohol use and may experience bias in the consideration of symptoms they complain of.

For those with learning difficulties and other communication issues including dementia, it most often falls to carers, family or other healthcare professionals to notice changes that require investigation. In order to enable early diagnosis, it is important to make these carers and others aware of the signs and symptoms of cancer.

The delivery of cancer treatment for people with learning difficulty or mental ill health is potentially complicated with issues around their capacity to understand and consent to treatment. This may require formal assessment of capacity and careful decision making with the person, supported by their family. There must be better collaborative working between cancer services, learning disability and mental health services to improve outcomes for these groups of people.

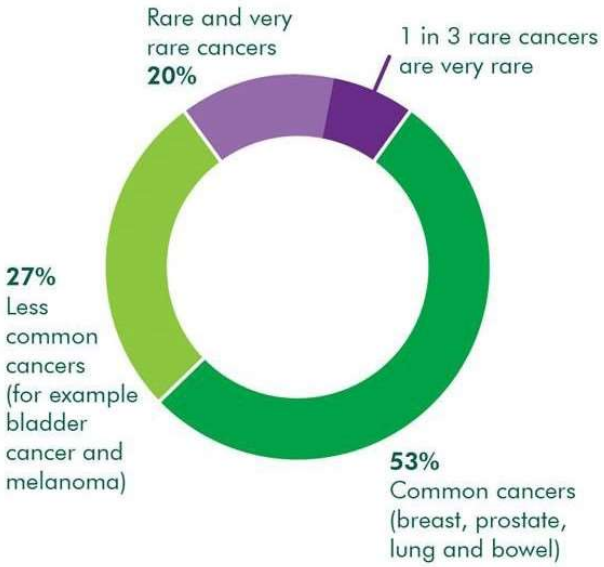
30 Cunningham, R. et al. (2015), 'Cancer survival in the context of mental illness: A national cohort study'. General Hospital Psychiatry 37 (2015) 501–506.
31 Hafeez, S. Singhera, M. and Huddart, R. (2015) Exploration Of The Treatment Challenges In Men With Intellectual Difficulties And Testicular Cancer As Seen In Down Syndrome: Single Centre Experience', BMC Medicine 13:152

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Rare Cancers

Four main cancers: breast, bowel, lung and prostate make up 53% of all cancers. Less common cancers such as melanoma and bladder account for 27% with the remaining 20% accounted for by rare and very rare cancers. A cancer may be rare because of where it is, if it affects a child, teenager or young adult or it may be a subtype of a more common cancer.

Figure 7: Rare cancers – proportions of common, less common, rare and very rare cancers. Macmillan Cancer Support



By their nature, rare cancers can be harder to diagnose. Treatment tends to be complex and services are usually centralised in highly specialised centres. People may have surgery, SACT or radiotherapy provided in specialist centres outside of Northern Ireland. There is a need for comprehensive patient pathways for diagnosis, treatment and follow-up care with a particular emphasis on good multidisciplinary team working.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Metastatic Cancer

Cancer which spreads to another part of the body from its initial site is called metastatic cancer. Treatments are available to either slow the progression of the disease or to improve quality of life by treating the symptoms. The treatment offered will depend on many factors including previous treatment, general health status and personal choice. In common with other stages, treatment offered may include hormonal therapy, chemotherapy, immunotherapy, radiotherapy and surgery. Unfortunately for many, metastatic cancer will ultimately be terminal but a growing number of people, with the appropriate treatment and care, are living for many years.

Currently data is not collected for people with metastatic disease in a systematic way for all cancer types. This must be included as an integral part of the development of mandated data sets for cancer. Accurate data will support the development of evidence-based services for the future.

There is a need to develop regional MDTs for people with metastatic disease to ensure evidence-based optimal treatment and care and to enable access to clinical trials.

Action 30. Develop appropriate pathways and accessible services for older people with cancer, adults with learning disabilities, communication needs and chronic mental health problems, rarer cancers and metastatic cancer.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Children and Young People

Childhood is a time of very rapid development and change. What happens in childhood has a life-long impact and affects life chances and outcomes.

Spending long periods in hospital or at home feeling ill can seriously affect a child or adolescent's development and outcomes. Special care and resources are needed to support ongoing development and education during this time. The social and emotional needs of children, adolescents and their families must be taken account of and supported during cancer treatment.

The guideline for children's cancer services NICE CSG 7: Improving Cancer Services for Children and Young People with Cancer was published in 2005 and reviewed in 2015. This guideline recommends that care across the UK should be coordinated from designated centres.[32] Under the auspices of the Children's Cancer and Leukaemia Group (CCLG) care is delivered through 19 Principle Treatment Centres (PTCs) led by professional experts in childhood cancer shaping a future where all children survive and live happy, healthy and independent lives.



32 'National Institute for Health and Clinical Excellence, 2005, Improving Outcomes in Children and Young People with Cancer -The Manual' pdf. https://www.nice.org.uk/guidance/csg7.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Children diagnosed with cancer up to the age of 16 will have their care coordinated by the PTC at the Royal Belfast Hospital for Sick Children (RBHSC).

A diagnosis after the age of 16 will mean care is provided by the regional Cancer centre in BHSCT and/ or one of the regional adult cancer units depending on the diagnosis and treatment.

"High levels of expertise, but facilities really letting the services down."

Built as an eight-bedded unit, capacity in RBHSC was increased to 10 beds in 2018. A separate day-care unit was designated in 2013 to meet the increased demand, and in 2020, this facility was further developed.

Based on current bed occupancy and predicted need, the new children's hospital, expected to open in 2027, will have 13 inpatient beds for haematology and oncology and an eight-bedded unit.

The PTC offers a range of Systemic Anti-Cancer Therapies (SACT) including chemotherapy, radiotherapy, immunotherapy, and Autologous Haemopoietic Stem Cell Transplant.

The centre also offers a portfolio of clinical trials for a range of haematological and oncological conditions. A nurse-led telephone triage trial service is key to this acute service, with SACT-trained nurses assessing the need for telephone advice or direct access to the centre for those requiring face-to-face assessment or admission.

However, it does mean that families from outside Belfast must travel to RBHSC for all treatment and care – possibly passing other hospitals with children's wards and services on the way. There is a need to explore options for the development of shared-care services for procedures such as blood tests and oral chemotherapy outside of Belfast.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry



The provision of highly specialist treatments such as allogenic haemopoietic stem cell transplant, proton beam therapy, specialist surgery or early-phase clinical trials is provided in specialist centres outside of Northern Ireland.

Children will follow an initial treatment plan in Belfast and on return will have step-down care and any further treatment. It is essential that appropriate support is provided for both children and parents when receiving care outside of Northern Ireland. Many parents have highlighted the challenges of being away from home with a seriously ill child for months at a time, in particular the separation from their other children and wider family support. In addition, many families struggle financially as one parent often has to leave work to care for the ill child or young person.

There is a desire to explore the possibility of developing an all-island service for paediatric oncology to improve outcomes for children, young people and their families.

The treatment and care provided by the health and social care team in RBHSC is supplemented by services provided by a range of charities. These include the funding of core specialist posts and the provision of many therapeutic services for both children, young people and their families.

Play specialists organise a wide range of activities but many of the activities are primarily aimed at pre-school-aged children who tend to be the biggest group of children on the ward at any one time. It can be very isolating for older children and young people when they are in hospital for long periods.

Many former patients and parents highlighted a lack of age-appropriate activities and environment for older children on the ward.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Action 31. **Every child, young person and adult diagnosed with cancer, and their carers, will have access to staff with the specialist knowledge and skills to provide developmentally appropriate, person-centred care.**

Action 32. **Increase collaboration between Northern Ireland, Great Britain and the Republic of Ireland in the provision of children's oncology services.**

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Teenagers and Young Adults (TYA)

The most common cancers in this age group are leukaemia, lymphoma, thyroid cancers, brain and spinal cord tumours, testicular and ovarian cancers and sarcoma. Treatment is currently delivered in all Trusts with specialist and complex services provided in the Northern Ireland Cancer Centre, Belfast Trust.

Due to the specific age-appropriate needs of teenagers and young adults, TYA cancer care is a distinct speciality. Cancer is a rare disease in this age group and therefore the young people become a rarity amongst their peers. Their specific needs are both psychosocial and physical. TYA with cancer interact with many services including haematology, oncology, medical and surgical specialities, psychology, psychiatry, palliative care, social work, youth work and education. Their care also transcends professional, organisational and geographical boundaries.

It is acknowledged that, in some parts of the UK and Ireland, age criteria may vary and there may be some flexibility in age boundaries of services to ensure that individual patients can access the optimum disease and age-appropriate services.

TYA cancer patients fall within both paediatric and adult cancer services. Evidence indicates the care needs of this group of people as being separate from children and adults, requiring a multidisciplinary approach incorporating both disease- specific and age-specific expertise.

Charitable funding has enabled the provision of TYA Clinical Nurse Specialists (CNS) in each Trust, who, as part of the multidisciplinary team, ensure young people are supported throughout the treatment pathway. This includes coordinating investigations, fertility preservation prior to treatment and referral on to other services. Funding for other key posts and services is provided by a range of cancer charities. There is no regional TYA MDT in Northern Ireland, and very few named clinicians with responsibility for TYA.



Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

The European Society for Medical Oncology have highlighted a range of issues for TYA patients including the lack of equitable access to specialised, age-appropriate centres with age-appropriate multidisciplinary care and the lack of available clinical trials with novel treatments. It states that survival gains have improved only modestly compared with older adults and children with cancer. Other findings from ESMO highlight deficiencies in access to both specialist facilities and to support from a wide range of healthcare professionals including specialist nurses, AHPs, social workers and psychologists. They go on to advocate a strengthened multidisciplinary approach with greater involvement of both paediatric and adult oncologists and haematologists with expertise in treating adolescents and young adults.

The ESMO working group who have developed this paper specify minimum essential criteria for adolescent and young adult cancer services, which, in addition to effective multidisciplinary team working and access to clinical trials, include fertility preservation, age-appropriate psychosocial support, age-specific environments, access to siblings and peers, age-specific palliative care, late-effects services, provision of social activities and education.

Services in Northern Ireland fall short of these recommendations.



Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Transition

Cancer services for teenagers and young people are becoming much more aware of the importance of patient choice while they navigate multifaceted care and treatment pathways.

Transition can be a stressful and anxious time for young people and their parents or carers. They may be unsure about what to expect, proposed treatment plans and what help may be available to them in order to plan for their future.

The arrangements for the transition of TYA vary given the complexity of this age group. Transition may be from the Royal Belfast Hospital for Sick Children (RBHSC) paediatric services to adult services, from a regional hospital to the Northern Ireland Cancer Centre (NICC), from NICC back to a regional hospital. For significant numbers, it also involves moving to hospitals outside of Northern Ireland for specialist treatment and then back again.[33]

In addition to the multiple transitions through health and social care, consideration should also be given to the 'normal' transitions of childhood and adolescence such as education, further education and employment. Cognitive impairment due to treatment may be a significant factor for some children and young people with brain tumours. In order for all children and young people living with cancer to realise their potential, better integration between services is required.

Well-established transition models, which are largely nurse-led exist elsewhere in the UK and Ireland and learning from these will be beneficial in developing an appropriate service in Northern Ireland.

Action 33. Review the provision of services for teenage and young adults in Northern Ireland including transition arrangements, age-appropriate environments, psychological support and long-term follow up.

33 (GOSH 2011). The Adolescents and Young Adults with Cancer.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Multi-disciplinary Teams (MDTs)

Multi-disciplinary Teams (MDTs) working through Multi-disciplinary Meetings (MDM) bring continuity of care and reduce variation in access to treatment – and ultimately improve outcomes for patients. They have been in place in Northern Ireland for the last 20 years. The membership of MDTs is in keeping with NICE Improving Outcomes guidance. Cancer MDTs have been subject to an ongoing process of MDT Peer Review since 2013 which has been funded by Macmillan Cancer Support.

Teams, which include medical specialities, nursing and AHPs, are under increasing pressure due to the growing number of cancer diagnoses, the increased number of treatment options and greater need for a co-ordinated approach to cancer management between specialties. Reform of the current MDT system is required to ensure they remain effective and efficient and that adequate time is available for the discussion of complex cases. Time for MDT meetings requires adequate recognition in the job plans of all MDT members and, where required, preparation time for these meetings.

There has been work to develop referral proforma for MDMs and management protocols; however, these have not been universally adopted. All discussions at MDMs are captured on the Cancer Patient Pathway System (CaPPS) and outcomes are generally communicated to GPs within 24 hours of the MDT occurring, although this is not always the case.

Whilst it is expected that all people newly diagnosed with cancer will be discussed at an MDT meeting, there is no formal requirement to discuss people with relapsed or progressing cancer. This could lead to variations in access to treatment and a lack of consideration of all treatment options available. A programme of audit of management decisions for MDTs should be introduced and consideration should be given to the introduction of MDT morbidity and mortality meetings which have been established in England.

Action 34. An effective Multi-disciplinary Team meeting will be held for all people diagnosed with cancer including cancer of unknown primary and metastatic disease.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Theme 3: Supporting People to Live Well and Die Well

Supporting People

People affected by cancer include patients, family members, carers and staff, all of whom will require support at different times, in differing formats and at varying levels. People diagnosed with cancer will require care and support at all stages of their cancer journey from diagnosis, through treatment, living with and beyond cancer and, for some, into palliative and end-of-life care.

The HSC is committed to a person-centred approach which aims to put the public, patients, their carers and staff at the heart of cancer services and empower managers and healthcare professionals to commission, plan, monitor and deliver effective and efficient services of the highest quality. No two people are the same, either in their cancer or their health and care needs. When care is truly person-centred, people are treated as individuals, with compassion, dignity and respect. The impact of cancer extends beyond the physical effects of the disease to include psychological, social, economic and spiritual consequences for people living with cancer and their carers.

There needs to be a sustained focus on enabling, supporting and empowering people to make informed decisions about their treatment and care and supporting them to self-manage in the longer term.



'Person centeredness is an approach to practice through the formation and fostering of healthful relationships between all care providers, service users and others significant to them intheir lives. It is underpinned by values of

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

respect for persons (personhood), individual right to self-determination, mutual respect and understanding.[34]

The approach of focusing on integrated personalised care for people with cancer across health settings has been adopted by Macmillan through the Recovery Package. People with cancer, and particularly those who are also managing other long-term conditions, will interact with other services. Research has shown that one of the strongest predictors of good patient experience is overall coordination of care. In the most recent Northern Ireland Cancer Patient Experience Survey (2018), only 72% of participants felt that all those involved in their care worked well together to deliver their care.[35]



The Recovery Package is a series of key interventions which, when delivered together, greatly improves outcomes for people living with and beyond cancer. The components of the Recovery Package are outlined in the table below and contain: Holistic Needs Assessment (HNA) and Care Planning, Treatment Summary Records (TSR), Cancer Care Review (CCR), Health & Wellbeing interventions and Risk Stratification. This has been implemented at varying levels across the four nations of the UK and continues to evolve as more data is generated. Implementation of the Recovery Package is a core part of both the English Cancer Strategy (2015) and Long-Term Plan (2019). The subsequent Comprehensive Model and

34 McCormack, B. and McCance, T. (2017) Person-Centred Practice in Nursing and Health Care: Theory and Practice. Oxford: Wiley Blackwell.
35 Public Health Board HSCNI (2019)'Northern Ireland Cancer Patient Experience Survey 2018 All Trusts Report - Draft v0.3' https://www.publichealth.hscni.net/sites/default/files/2019-01/Northern%20Ireland%20Cancer%20Patient%20Experience%20Survey%202018%20All%20Trusts%20Report.pdf.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Personalised Care (2019) looks at how person-centred care can be integrated and delivered across four domains: acute, primary, community and digital.



An Integrated Assessment Map (IAM Portal [36]) developed by Teenage Cancer Trust is an age-specific, multi-domain framework which provides a structure to support professionals, teenagers and young adults in holistically assessing needs for information and support at any point in their cancer journey. It is designed to look at the impact of and adjustment to their cancer and its treatment within a bio-psycho-social-educational-vocational framework – i.e. what does having this cancer and its treatment mean for this young person and their support network at this point in time. Teenage Cancer Trust is implementing the IAM Portal across the UK and this should be implemented in Northern Ireland.

Macmillan Recovery Package	
Holistic Needs Assessment (eHNA) and CarePlanning	A supported conversation using a structured electronic questionnaire to identify needs, facilitate discussion and agree the best way to meet them from the person's perspective. It ensures that physical, practical, emotional,spiritual and social needs are identified in a timely and appropriate way, and that resources are targeted at those who need them most.
Treatment Summary Records (TSR)	A pro forma document which records clear information about a person's treatment, any immediate to longer-term consequences of treatment that they need to be aware of, on-going clinical management, any actions they need to take and who to contact with any questions or concerns. It is completed after a significant phase of a person's cancer treatment. A copy is provided to the person living with cancer and their GP.
Cancer Care Review (CCR)	CCRs involve a person with cancer having a holistic conversation with a primary care healthcare professional

36 Teenage Cancer Trust (2022) https://www.iamportal.co.uk.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

	in order to discuss issues relating to their cancer or treatment.
Health & Wellbeing interventions(H&WB)	The aims of Health and Wellbeing (H&WB) interventions are to educate people with cancer on how to live well, inform people with cancer about where they can access the support they need, help people with cancer to cope with difficulties (e.g. stress/anxiety, diet, consequences of treatment/late effects), provide targeted information to people with cancer, and provide opportunities for people with cancer and their carers to access peer support.
Risk Stratification	An approach to profiling people following treatment for cancer that is based on their clinical and individual needs. Itis appropriate for all people whether they have been treated with curative or palliative intent.

Ultimately, the Recovery Package seeks to provide the support that people living with cancer need to lead their best possible lives. Full implementation of the Recovery Package can ensure that, from diagnosis or soon after, people's needs are identified and addressed.

Data from electronic Holistic Needs Assessment (eHNA) will be a key resource in the development and improvement of cancer services for the future and will enable benchmarking between services, across cancer types, Trusts and the four nations of the UK. There are benefits to eHNA being embedded in the ongoing development of Encompass.

With increasing numbers of people surviving their cancer diagnosis, cancer follow-up in primary care is likely to resemble that of other chronic diseases. Healthcare professionals must be encouraged to provide a TSR and CCR to everyone who has been diagnosed with cancer.

Health and wellbeing events should continue to provide a forum by which attendees can receive information on how to self-manage their condition. These events must be offered for all cancer types.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry



Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Risk-stratified Follow Up

The traditional model of oncology follow-up clinics is being challenged like never before. Demand for outpatient appointments is increasing as more people are living with a cancer diagnosis; however, many follow-up appointments would appear to offer little value to the patient. This is due, in part, to traditional oncology follow-up clinics having focused mainly on detection of cancer recurrence and less so on the comprehensive range of health-related quality-of-life (QOL) issues.[37] Many cancer survivors attending these clinics report ongoing, unidentified and unmet needs.

In addition, recent studies have highlighted a feeling of abandonment from patients during the transition period from cancer patient to survivor.[38] Needs inevitably change as people move along the pathway demanding a more tailored approach to care. Self- management is in place for many breast cancer patients and this should be extended to other cancers where clinically appropriate. This would reduce the need for hospital appointments and would enable resources to be redistributed to diagnosing more new patients and supporting those with metastatic and complex disease.

Appropriate follow up is essential to ensure monitoring of a person's clinical condition and timely investigation of possible disease relapse or progression. A stratification of risk allows the clinical team, and the person living with and beyond cancer, to make a decision about the best form of aftercare. This is based on knowledge of the disease (the type of cancer and what is likely to happen next), the treatment (what the effects or consequences may be both in the short and long term) and personal clinical circumstances (whether they have pre-existing illnesses or conditions, and how much support they feel they need).

Models of aftercare include:

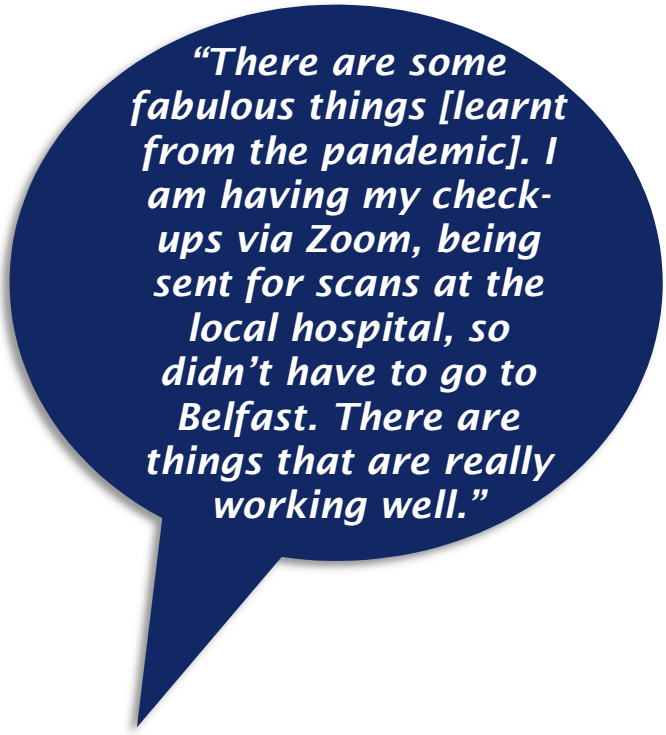
- Supported self-management – Individuals are given information about:
    - Self-management support programmes or other types of available support
    - Clinical signs and symptoms to look out for
    - Who to contact if they notice anything of concern
    - Scheduled tests they may need (such as annual mammograms)
    - How to contact relevant professionals if they have any concerns

- Shared care – people continue to have face-to-face, phone or

37 Jefford, M., Rowland, J., Grunfeld, E. et al. (2013) 'Implementing improved post- treatment care for cancer survivors in England, with reflections from Australia, Canada and the USA', British Journal of Cancer, 108, 1: 14–20.
38 Davies, N., Batehup, L. (2011) 'Towards a personalized approach to aftercare: A review of follow-up in the UK', Journal of Cancer Survivorship, 5, 2: 142–151.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

email contact with professionals as part of continuing follow up. Nurse-led follow up is a shared care approach recognising the extended role of the nurse. A systematic review[39] concluded that nurse-led care can be more beneficial than doctor-led care in terms of physical outcomes, psychosocial aspects of care and patient satisfaction, whilst not impairing the long-term survival of patients with cancer. Local evaluations have demonstrated effective nurse-led follow-up.[40]



- Hospital-based care – people with more complex conditions and needs who remain under the care of the consultant.

- Emerging models which involve new joint multi-professional clinics, such as post radiotherapy for people recovering from head and neck cancer led by a Clinical Site Specialist Radiographer and CNSs. There is potential to further develop these models to include the management of late effects and consequences of treatment.

Prior to the COVID-19 pandemic, some follow-up monitoring was being undertaken by CNSs via telephone. As a direct consequence of the pandemic, the use of technology in follow-up care has increased significantly. Further work needs to be carried out to establish which modality is best, for which patients and to understand which member of the team is best suited to carry out the review. Training for staff, the development of protocols and agreement on the appropriate technology will be required to develop this further to ensure the optimum experience for both people living with cancer and staff.

---

39 Caird, J., Rees, R., Kavanagh, J. et al. (2010) The Socioeconomic Value of Nursing and Midwifery: A Rapid Systematic Review of Reviews, EPPI Centre, Social Science Research Unit, Institute of Education, University of London.
40 Semple, C.J. & Lynas, C. (2018) 'Development, integration and evaluation of nurse- led follow-up across five tumour sites at a cancer unit in Northern Ireland', Cancer Nursing Practice, doi: 10.7748/cnp.2018.e1460.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Action 35. **Develop a person-centred model of care that builds on learning from COVID-19 with increasing use of telehealth and technology.**

Action 36. **Offer all people a holistic needs assessment, an appropriate care plan and provide signposts to relevant sources of help and support.**

Action 37. **Develop a comprehensive treatment summary record for all people diagnosed with cancer.**

Action 38. **All people who have completed cancer treatment will be assessed and risk stratified to appropriate follow-up pathways.**

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Support from Clinical Nurse Specialists

Cancer Clinical Nurse Specialists (CNSs) play an important role in the management of individual patients as their key worker.[41] They are a core member of the multidisciplinary team (MDT), and as such, each MDT is required to have a Clinical Nurse Specialist in order to meet accepted MDT peer review standards. Data from the Northern Ireland Cancer Patient Experience Study (2018) clearly demonstrates that the support of a CNS is the single most important factor in a patient's experience of care. However, not all patients have access to a CNS and for many, the support is limited to the diagnostic and surgical part of the service.

CNSs should be available across the cancer pathway, through diagnosis, treatment for primary and metastatic disease and throughout follow up. This applies to all children diagnosed with cancer and their parents and includes a dedicated TYA CNS service to support teenagers and young adults throughout their care. CNSs have a key role in: ensuring that all people with cancer have their holistic needs assessed, the development of personalised care plans and facilitating self-management and appropriate longer-term follow up.

Action 39. All patients, including children and young people, diagnosed with cancer will have access to a Clinical Nurse Specialist throughout the entire care pathway.

41 NHS (2011) 'Quality in Nursing Excellence in Cancer Care: The Contribution of the Clinical Nurse Specialist', https://www.england.nhs.uk/improvement-hub/wp-content/uploads/sites/44/2017/11/Clinical-Nurse-Specialists-in-Cancer-Care_Census-of-the-Nurse-Workforce_Eng-2011.pdf

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Mental Health and Wellbeing Support

Stress and distress are a common response to a diagnosis of cancer, not only for the patient, but also for the families.

Research carried out by Macmillan indicates that 21% of people living with cancer experience problems with poor mental health and that 73% of people living with cancer report some type of emotional concern, most commonly worry, fear and anxiety, sadness, depression or loss of confidence. Data shows that circa 70% of people diagnosed with cancer have other long-term conditions to manage alongside their cancer.[42]

Mental ill health cross cuts the entire cancer pathway. Some services are offered by the voluntary sector but outside of this provision, formalised pathways do not exist for cancer patients. A mental health Strategy has been developed to address existing inequalities; however, we know that services in each of the Trusts are overwhelmed, no clear pathways from cancer services exist and this has a significant impact on primary care workload. Promoting good mental health and preventing mental ill health from developing amongst those living with cancer, as well as ensuring adequate management of conditions should they occur are important in the provision of holistic cancer care. The number of people needing help with their mental health is likely to grow as more people are living longer following a cancer diagnosis. There are significant gains to be realised both in patient quality of life and savings in health -care costs.

A cancer diagnosis often brings a significant change to family dynamics and research shows that family members can often display higher levels of anxiety and depression than patients themselves.[43]

Referrals to psycho-oncology services have risen sharply in recent years with disparity in provision between Trusts and long waiting lists in several areas. In addition to an increase in referral rates, there may be need to prioritise certain groups of people diagnosed with cancer, due to an increase in risk factors:

- Teenage and Young Adults (TYAs)
- Pregnant women and new mothers
- People awaiting assessment in advance of prophylactic breast surgery in line with NICE guidelines (CG164). People awaiting risk-reducing surgery must be seen within a reasonable timeframe to avoid delays in completing surgery and possiblecancer diagnosis in the interim period.

42 Macmillan Cancer Support (2020) 'Prevalence - People living with cancer '. https://www.macmillan.org.uk/_images/cancer-statistics-factsheet_tcm9-260514.pdf.
43 Mullen, L. & Hanan, T. (2019) National Cancer Survivorship Needs Assessment: Living with and beyond cancer in Ireland, Dublin: National Cancer Control Programme, https://www.hse.ie/eng/services/list/5/cancer/profinfo/ survivorship-programme/living%20with%20and%20 beyond%20cancer%20in%20 ireland.pdf.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

- People receiving palliative care and those at end of life (NICE 2004; 2008). It is essential that people who are receiving palliative care are seen before they become too fatigued or unwell,to be able to engage in psychological assessment or therapy.

Pathways will be developed for the screening, assessment and management of mental ill health.

Services to support mental health and wellbeing will typically receive patient referrals following diagnosis on completion of treatment, at diagnosis of cancer recurrence/relapse and for people receiving palliative and end of life care. NICE (2004) also describes the need for care and support of the diagnosed patient's family and carers, and this is especially true in the case of children and young adults diagnosed with cancer (NICE, 2005).

Counselling supports people dealing with the emotional impacts of cancer. A range of cancer charities across Northern Ireland provide counselling, both in hospitals and in the community, specifically to people with cancer and their families.

Alternative therapies can also provide help and support. For example, creative arts therapies comprise music therapists, art therapists and drama therapists who are skilled clinical healthcare professionals. They can help reduce anxiety, pain, tiredness and increase wellbeing and often provide the opportunity for people and their families to express feelings and emotions which are often impossible to express verbally. Such therapies may therefore provide support to promote good mental health and may provide alternatives to traditional services.

Whilst there is an array of services available across health and social care and in the community, awareness and access to services remain a challenge for many. Services provided by the voluntary sector are largely self-funded through fundraising activities. In addition, the reduction in counselling provision during the COVID-19 pandemic has negatively impacted on the waiting times for clients and has further added to their emotional distress.

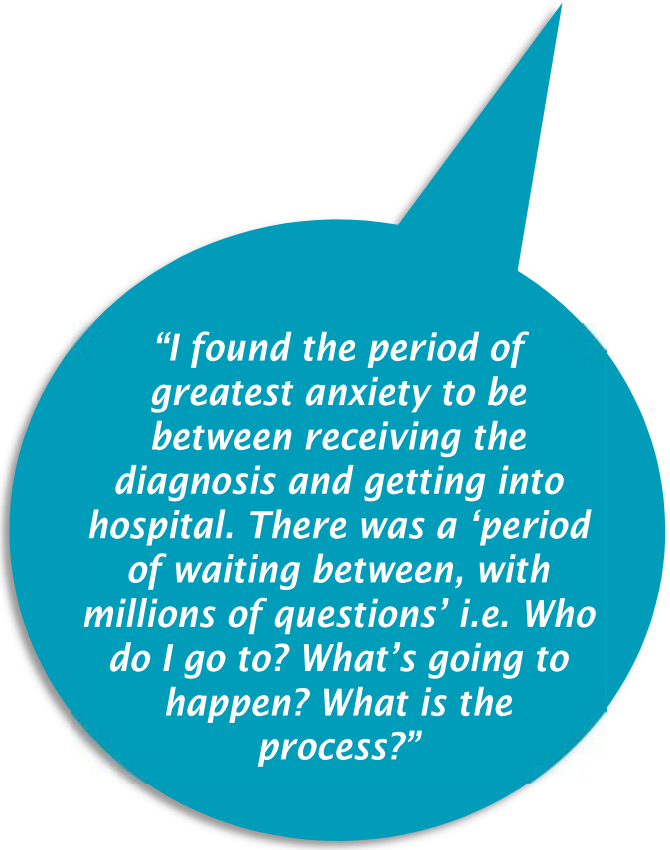
It is essential that all people affected by cancer are able to access different types of support, provided by the appropriate person, dependent on their level of need in a timely manner.

Action 40. In alignment with the mental health strategy develop a model to promote good mental health and wellbeing for people affected by cancer and develop pathways to ensure that all people with cancer have access to mental health support in line with their needs.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Information and Therapeutic Support

Staff from all sectors who interact with people and their families play a key role in the provision of information and support. All Trusts have designated specialist services which lead on the provision of high-quality information and support. In addition, both local and national cancer charities have a focus on the provision of information and support services, many providing information via helplines, online fora and via social media channels which HSC is not resourced to do. Collaborative working to maximise resources is essential to ensure all those who need information get it when and where required.



An independent evaluation of Trust Information and Support Services was undertaken in 2019 and the report makes a series of recommendations to ensure that all people are routinely referred to information and support services.[44] These include the increased use of digital applications, integration of social prescribing, improved provision for carers and enhanced partnership working with the community and voluntary sector.



Many people will seek information from pre-diagnosis particularly when they are referred by their GP for further investigations. Specific information resources must be developed and provided to all

44 Macmillan Cancer Support (2020) Evaluation of Macmillan Information and Support Services in Northern Ireland, Rocket Science.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

patients at this early stage, specifically for those people who are referred via the 'red flag' route.

Information for people living with cancer goes far beyond the physical implications of cancer. Provision must be holistic in nature and encompass financial and benefits advice, employment issues and support for carers.

It is imperative that there is equitable provision of information and support for all sections of society including those who do not have English as their first language, people with a learning or sensory disability and age appropriate information for children, teenagers and young adults. We must also ensure that all people diagnosed and treated in the independent sector have access to the full range of information and support services.

Currently over a third of those living with cancer in Northern Ireland are of working age. Cancer can have a major impact on a person's ability to work and while most wish to stay in or return to work, many do not receive the information, advice or rehabilitation support they need to help them do so. This results in people falling out of work, having a major impact on individuals, families and employers. Significantly, there is strong evidence to suggest that remaining or returning to work can promote recovery and lead to better clinical and psychosocial outcomes.[45]

Spending long periods in hospital or at home can seriously impact on children and young people's developmental and educational outcomes. Special care and resources are needed to support ongoing development and education during this time. Currently, support for education is variable and there are particular challenges for young people aged 16–18.

The social and emotional needs of children and their families must be taken account of and supported during cancer treatment. The need to invest in and strengthen social and emotional support for children, young people and their families was one of the strongest messages coming from our engagement with people with lived experience.

Benefits advice services, hardship grants to patients and financial guidance are a vital means of supporting people facing the financial hardships caused by cancer. Services are currently available in all Trusts but are provided and predominantly funded on an annual basis by voluntary sector organisations with no agreed recurrent funding streams.

Therapeutic services is an umbrella term which represents a wide range of support services. This includes complementary therapies, self-management programmes and support groups, practical support, creative therapies, pain and symptom control, lifestyle change supports, chaplaincy services and helplines. Specific services for children and young people include short breaks, peer mentoring and educational events. The vast majority of these

45 Waddell, G., Burton, A.K. (2006) Is work good for your health and well-being? London: The Stationery Office

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

services are provided in the community by the voluntary sector. Post pandemic, many of these services are at risk due to the impact on fundraising for almost all charitable organisations. Better integration and collaboration will be essential to ensure the sustainability of many therapeutic services for the future.

Action 41. All people with a cancer diagnosis will be referred to a Cancer Information and Support Service at diagnosis.

Action 42. Timely and appropriate access to therapeutic and practical support services for people affected by cancer targeting emotional, physical, spiritual and social needs will be provided.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Carers

Support and care provided by families and informal carers is vital to the wellbeing of patients given their assistance in managing medications, treatment regimes, symptom management, personal care, social and psychological support. Providing informal care is challenging for many and can have a negative impact on both physical and mental health. Evidence has shown that there is a need to deliver improved services for informal carers of patients with cancer in Northern Ireland.[46] [47] [48] [49] Healthcare professionals have a responsibility to ensure that carers' needs are assessed and that they can obtain information easily across the illness trajectory with adequate signposting to additional support. Cancer Caring Coping[50] is a co-designed, one-stop, online, multi-medium resource (www.cancercaringcoping.com) tailored to support carers of adults in Northern Ireland from diagnosis to possible bereavement. This resource should be made available to all carers. In addition to support from social work teams, a wide range of support is provided by cancer charities for parents and carers of children and young people.

In addition, people providing unpaid care for loved ones with non-curative cancer and at end of life should have access to support services to meet their own health and wellbeing needs. This includes regular breaks from caring and reliable respite care.[54]

Whilst carers in all situations face challenges, there is a particular need to ensure appropriate support for parents of children and young people with cancer. Services and facilities including overnight accommodation are predominantly funded and provided by charities. There is a clear need for much better partnership working and integration with statutory services to ensure that all families get the support they need across the entire pathway

Support for staff working in cancer services must also be considered. Research has shown that good staff experience contributes to better patient care. Emphasis should be placed on readily accessible up-to-date information, support and advice.[51]

---

46 Santin, O., Murray, L., Prue, G., Gavin, A., Gormley, G., Donnelly, M. (2015) 'Self- reported psychosocial needs and health-related quality of life of colorectal cancer survivors', European Journal of Oncology Nursing, 24: 121–129.
47 Santin, O., Mills, M., Treanor, C., Donnelly, M. (2012) 'A comparative analysis of the health and wellbeing of cancer survivors to the general population', Journal of Supportive Cancer Care, 20,10: 2545–2552.
48 Treanor, C., Santin, O., Mills, M., Donnelly, M. (2012) 'Cancer survivors with self-reported late effects: Their health status, care needs and service utilisation', Psycho-oncology, 22: 2428–35.
49 Santin, O., Treanor, C., Mills, M., Donnelly, M. (2014) 'The health status and health service needs of primary caregivers of cancer survivors: A mixed methods approach', European Journal Cancer, Volume 23, Issue 3: 333–339.
50 Santin, O., McShane, T., Hudson, P., Prue, G. (2018) 'Using a six-step co-design model to develop and test a peer-led web-based resource (PLWR) to support informal carers of cancer patients', Psycho-oncology https://doi. org/10.1002/pon.4969
51 Marie Curie (2018) 'Lost retirement: The impact on older people of caring for someone with a terminal illness' https://www.mariecurie.org.uk/globalassets/media/documents/policy/policy-

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Supporting People to Live Well

Whilst more people than ever are surviving after a cancer diagnosis, not everyone who has survived is living well. Over half of those diagnosed with cancer today will live for at least 10 years and for some types of cancer, the figure is much higher. Contributions from people living with cancer to the development of this Strategy have consistently demonstrated that surviving is very different from living well. Research carried out by Macmillan in 2013 found that at least one in four people living with cancer faces poor health or disability following treatment for cancer. Many people will make a good recovery following treatment but a significant proportion will continue to live with a wide range of problems. People who have had curative treatment can be left with disabling, chronic long-term conditions as a result. As there are no agreed pathways in place, their treatment and care are often poorly managed, disjointed and uncoordinated.





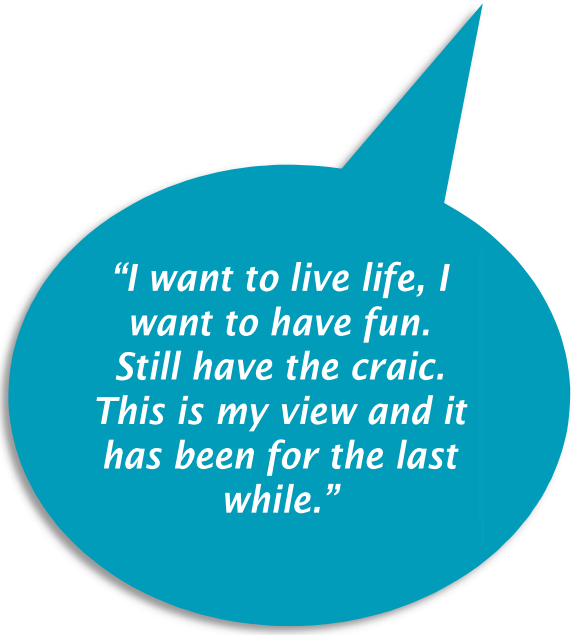
A significant proportion also live with the increased risk of developing cardiac, bone and bowel problems as a direct consequence of their treatment, some of which will not become apparent until many years later. Up to 75% of children and young people who have been treated for cancer will have long-term consequences of cancer including a greatly increased risk of developing a second cancer. Survivors of childhood cancer are three times more likely to die 35 years after diagnosis than peers without a cancer diagnosis.[52]

publications/lost-retirement-the-impact-on-older-people-of-caring-for-someone-with-a-terminal-illness.pdf.

52 Ruelen, R.C., Winter, D.L., Frobisher C. et al. (2010) 'British Childhood Cancer Survivor Study Steering Group. Long-term cause-specific mortality among survivors of childhood cancer', JAMA, 304(2): 172–9.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

There are many treatments used to manage a diagnosis of cancer including surgery, radiotherapy, chemotherapy, immunotherapy and hormonal therapy. These can be used alone or in combination, often over a prolonged period of time. Side effects are part of any treatment regime but for the purposes of this section, the focus is on the longer-term, chronic effects of treatment.



There is a gap in the knowledge and understanding of late effects and consequences of treatment, particularly in light of an ageing population. Many people live with their problems, often struggling to get the right treatment and support, and many are unaware that help is available, assuming that the symptoms are the cost of a cure. As more people survive cancer, the problems associated with late effects, consequences of treatment and long-term follow up will grow. This comes at a high cost to both the individual and to health and social care. Not only is this an issue for the quality of life of those affected, it is also a major challenge for the timely provision of long-term, tailored care and support. Currently services either do not exist or are not resourced to meet the growing demand. This is compounded by a lack of available data to quantify the numbers of people affected.

Cardiovascular

The European Society of Medical Oncology (ESMO) consensus paper of 2020[53] states 'with increasing numbers of cancer survivors living longer, oncologists and other health care providers are faced with challenges in managing long-term and late toxicities of therapy, recognizing that cardiovascular issues are significant causes of morbidity and mortality in this population.'

There is robust, compelling international evidence about the growing impact of cancer treatments on cardiovascular health. Next to cancer recurrence, progression and second malignancies, the leading cause of death in cancer survivors is cardiovascular diseases (CVDs) due to the intense oncological treatment which many people receive. A significant number of anti-cancer therapies are associated with some level of cardiovascular toxicity, ranging

53 ESMO (2020) 'ESMO Consensus Guidelines 2020 Management of cardiac disease in cancer patients throughout oncological treatment: ESMO consensus recommendations – ScienceDirect' https://www.annalsofoncology.org/article/S0923-7534(19)36080-6/fulltext.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

from asymptomatic and transient to long-term permanent life-threatening problems.

In a recent report, the American Society of Cardiology[54] states that 'the management of cancer can no longer be limited solely to the active treatment of malignancy, we must invest in additional research and foster multidisciplinary collaboration to tackle gaps in our knowledge and ultimately improve both cancer and cardiovascular-related health outcomes in this growing population.'

Children and young people, in particular, are at serious risk of premature death in later life from cardiovascular and respiratory failure as a consequence of treatment[55] Some pathways are currently in place for this group of patients but this is not a commissioned service. Cardiovascular oncology is an emerging specialism with dedicated services developing in other parts of the UK.

In Northern Ireland, increasing numbers of people living with cancer who are at risk of developing cardiovascular disease due to treatment are being referred to cardiology services, which is having a major impact on waiting lists and access to services such as echocardiograms. It is estimated that circa 3000 echocardiograms are done for oncology patients per annum.

Bone Health

Hormonal therapy is a main stay of treatment for both breast and prostate cancers, often resulting in inevitable osteoporosis. This is also the case for people who have prolonged treatment with steroids. Pathways are in place for monitoring bone density for people living with breast cancer but there are no existing pathways for men living with prostate cancer or others at high risk.

Significant numbers of people develop metastatic bone disease which, for many, can be managed over a period of years. Over successive years, there has been a steady increase in referrals to orthopaedic services combined with a significant workload managing long bone fractures and spinal cord compression. Access to appropriate palliative care can be an issue for people with long bone fractures who are initially managed in acute orthopaedic wards. There is no commissioned service in place for the management of metastatic spinal cord compression.

54 Tan, C MD & Denlinger C. MD (2018) American College of Cardiology Cardiovascular Toxicity in Cancer Survivors: Current Guidelines and Future Directions https://www.acc.org/latest-in-cardiology/articles/2018/06/29/12/57/cv-toxicity-in-cancer-survivors.
55 Mulrooney, D.A. et al. (2009) 'Cardiac Outcomes in a cohort of adult survivors of childhood and adolescent cancer: Retrospective analysis of the Childhood Cancer Survivor Study cohort', BMJ 339: b4606.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

GI Consequences of Pelvic Radiotherapy

Although more people are surviving cancer, problems associated with pelvic radiotherapy are presenting many years (up to 5-10 years) post treatment which has obvious consequences for individuals who have had treatment and for service provision. Many people report severe and distressing symptoms such as faecal incontinence, urgency, bleeding, flatulence and pain. Given the time from initial treatment, often neither the person nor primary care teams are aware that this is a likely late effect of radiotherapy treatment.

A regional task and finish group was established to develop guidelines and pathways for the management of the consequences of pelvic radiotherapy. The NICaN GI Consequences of Pelvic Radiotherapy Task and Finish Group Report was published in 2017 but, to date, has not been implemented in all Trust areas.

Elsewhere in the UK, Centres of Excellence for the management of pelvic radiation disease are being established to manage the most complex cases. In addition to the establishment of Trust pathways, consideration should be given to the development of a regional service for those with complex problems.

Sexual Health and Fertility

Cancer treatment can have devastating physical and psychological consequences on sexuality and fertility for many people. There may be a wide range of issues including erectile dysfunction, early menopause, body image issues due to disfiguring surgery, loss of libido, reduced fertility and, for some, infertility.[56]



No formal, coordinated services or pathways exist and undoubtedly the impact of cancer treatment on sexual health is unreported.

There are particular issues for children and young people diagnosed with cancer. Established pathways to the regional facility centre are in place which are very responsive when time is of the essence to start cancer treatment. For pre-pubescent children, research-based interventions are becoming available in Oxford and Edinburgh. Consideration should be given as to how

56 Belfast Health and Social Care Trust (2017) 'Has Cancer affected your sexuality, sex life and relationships', Belfast: Belfast Health and Social Care Trust; Katz, A. (2005) 'The Sounds of Salience: Sexuality Information for Cancer Patients', Journal of Clinical Oncology, 23(1): 238-241.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

children in Northern Ireland can avail of these in a timely manner. Every young person commencing treatment should be offered the opportunity to talk about their fertility options and how their prognosis may or may not affect that.

At present, as for all cases, people who are infertile because of their cancer are entitled to one cycle of IVF. The recent commitment within New Decade, New Approach to fund three cycles of IVF treatment will have a positive impact in this area.

Diabetes

The relationship between diabetes and cancer is complex. Observational studies suggest that cancer outcomes are poorer in patients with diabetes. It is suggested that improving glycaemic control may improve cancer treatment outcomes.[57]

Approximately 22% of patients undergoing cancer treatment have a pre-existing diagnosis of diabetes.[58] Approximately 10% of patients not known to have diabetes will develop it during their cancer treatment.[59] [60] This may be as a direct effect of the cancer or as a consequence of the treatment (such as after surgical resection of the pancreas or as side effects of the SACT regimen). Glucocorticoid medications (steroids) are a significant contributor to hyperglycaemia in SACT.

Recently guidance specific to patients with cancer has been published jointly by the UK Chemotherapy Board and the Joint British Diabetes Societies for Inpatient Care.[61] This document recommends three steps to manage patients undergoing SACT:

- Screening to identify patients at high risk of developing complications
- Providing a glucometer and educating high-risk patients in its use
- Management of hyperglycaemia

At present, there is no resource within cancer services to provide this care. It is currently done as an emergency referral to diabetes services. As screening is not taking place routinely, we suspect that there are large numbers of

57 Jacob, P., Chowdhury, T.A. (2015) 'Management of Diabetes in Patients with Cancer', Q J Med. 108: 443–448.
58 Habib, S.L., Roina, M. (2013) 'Diabetes and risk of cancer', ISRN Oncology 583786
59 Pilkey, J., Streeter, L., Beel, A., Hiebert, T., Li, X. (2012) 'Corticosteroid-induced diabetes palliative care', J Palliat Med. 15(6): 681–9.
60 Gannon, C., Dando, N. (2010) 'Dose-sensitive steroid-induced hyperglycaemia', Palliat Med., 24(7): 737–9.
61 Joint British Diabetes Societies for Inpatient Care Guidelines Group and UK Chemotherapy Board (2021) The management of glycaemic control in patients with cancer, London: Joint British Diabetes Societies for Inpatient Care.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

patients who progress through their oncology treatment with hyperglycaemia without being identified. A pilot scheme is in place at the Northern Ireland Cancer Centre and clinics are having a significant positive impact on patient care but are currently unfunded. In addition, all Trusts are reporting significant increases in referrals to community Diabetic Specialist Nurse Services. Funding will be required to implement these services in both secondary and primary care province-wide.

Lymphoedema

Lymphoedema can develop when lymph nodes or lymph vessels are removed or damaged. It is a permanent, often disabling condition and cannot be cured. With appropriate support, many people are able to manage their condition with a regimen of meticulous skin care, exercise and wearing compression garments. It is commonly associated with breast, head and neck, and gynaecological cancers. There has been a commissioned lymphoedema service in place since 2008 with services provided in all Trusts for both malignant and benign conditions. Referral numbers have increased year on year resulting in long waiting lists and funding has not kept pace with the growing demand. Evidence from the National Cancer Action Team in England shows that investment in lymphoedema services is extremely cost effective and significantly reduces the number of hospital admissions.[62]

Neuropathy

Surgery and radiotherapy for cancer can damage nerve tissue in the targeted treatment areas, and chemotherapy may affect systems throughout the whole body. Nerve damage may be central – with brain effects of loss of cognition and memory, reduced hearing, vision, taste and smell; and/or autonomic – with changes in heart and blood pressure regulation, poor gut function: and/or peripheral – with reduction of normal sensation and motor function of the limbs, increased abnormal sensation and pain, and increased fatigue from loss of function or difficulties in coping with the burden of altered sensation. Some will reverse or decrease over time but many are permanent, causing significant disability. Nerve damage from cancer treatment is enhanced by pre-existing nerve dysfunction due to stroke, injury, diabetes and other conditions.

Studies show that following chemotherapy, 60% of people experience peripheral neuropathic pain three months after treatment, and that it

62 National Cancer Action Team (2013) 'Cancer Rehabilitation, Making Excellent Cancer Care Possible'.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

persists for 30% at six months. Overall, between 33% and 40% of cancer survivors suffer from chronic pain.[63] [64]

Specialist palliative care clinicians and AHPs have an invaluable role to play in the management of cancer pain, not limited to end-of-life care. There is a need for better integration and collaboration between palliative care, oncology, haematology and pain management teams.

The Faculty of Pain Medicine of the Royal College of Anaesthetists published 'A Framework for Provision of Pain Services for Adults Across the UK with Cancer or Life- limiting Disease' in 2019. This presents a framework and operational guidance for improving pain services for adults across the UK with cancer or life-limiting disease and should be used to develop services across Northern Ireland.[65]

Respiratory

Breathlessness can have many causes including damage to the lung by cancer treatments (radiation pneumonitis, chemotherapy fibrosis and surgical scarring), loss of physical fitness/de-conditioning, disease progression, end-of-life symptoms and other co-morbidities. There are no formal pathways for treating breathlessness as a consequence of cancer treatment or disease progression. Traditionally, referrals are made later in the patient journey when patients are short of breath at rest. Earlier referrals would improve quality of life and maintain independence for many.

Chronic Fatigue

Cancer-related fatigue (CRF) is the most commonly reported symptom affecting quality of life and ability to function. Fatigue affects large numbers of people after cancer treatment but for some it persists as a chronic long-term condition. Due to difficulties with identification, problems can often go unreported and as a result, unaddressed.

No formal commissioned services exist; where support exists it is often an add-on to other services, tumour-dependent or provided by charities. Simple interventions such as physical activity have been shown to significantly reduce levels of fatigue.

---

63 Paice, J.A. (2011) 'Chronic treatment-related pain in cancer survivors', Pain, 152(Supplement): S84–S89.
64 Seretny, M., Currie, G.L., Sena, E.S., Ramnarine, S., Grant, R., MacLeod, M.R., Colvin, L., Fallon, M. (2014) 'Incidence, prevalence, and predictors of chemotherapy-induced peripheral neuropathy: A systematic review and meta-analysis', Pain, 155(12): 2461–2470.
65 Faculty of pain medicine of the Royal College of Anaesthetists (2019) 'Framework for pain services cancer and life limiting disease 2019.pdf', https://fpm.ac.uk/sites/fpm/files/documents/2019-07/Framework%20for%20pain%20services%20cancer%20and%20life%20limiting%20disease%202019.pdf

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Continence

Surgery, radiotherapy or disease progression can result in bladder and bowel incontinence, affecting both males and females, and can be seriously life changing. Conservative services (e.g. lifestyle advice, pads etc.) are available but do not actively treat the condition. BHSCT successfully piloted the physiotherapy management of continence due to prostate cancer, and is now an award-winning service. Similar charity-sponsored pilots are ongoing for the therapeutic management of incontinence related to colorectal and gynaecological causes; these are not yet commissioned.

Action 43. All people starting cancer treatment will have their health status assessed and recorded and a plan developed to mitigate potential late effects and consequences of their treatment.

Action 44. Develop a regional, multidisciplinary approach to the identification and management of all people at risk of late effects and consequences of their cancer treatment.

Action 45. Identify people deemed to be at highest risk for late cardiovascular effects and enrol them in a follow-up programme.

Action 46. Screen children to detect early, subtle cardiac abnormalities that might be treated, or may be reversible. In addition, where children are treated with anthracyclines or cardiac radiation they will have lifelong screening.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Caring When Cancer Can't be Cured

Cancer is the largest cause of death in Northern Ireland. The most up-to-date figures are circa 4,500 deaths per year with slightly more men than women dying from cancer.

Findings from the Northern Ireland Health Inequalities report for the period 2017–2019 show that among people aged under 75, the death rate from cancer in the most deprived areas was greater than the least deprived areas by a factor of 1.7.

Numbers of children and young people are small, with on average nine children and seven young adults dying annually.

Average Number of Cancer Deaths in Children & Young Adults Recorded in Northern Ireland by Age Band for the Period: 2014–2018			
	Age Band 0-15	16-24	Total
Average number of cases per year	9	7	16
Total	43	33	76

The Department's vision for palliative care is that any person with an advanced non-curative condition lives well and dies well irrespective of their condition or care setting.



This requires a philosophy of palliative and end-of-life care that is person- centred and which takes a holistic approach to planning, co-ordinating and delivering high-quality reliable care, enabling people to retain control, dignity and, crucially, choice in how and where their care is delivered to the end of their life.

It means being sensitive to the personal beliefs, cultures and practices of individuals and their families and carers and recognising the contribution good palliative and end-of-life care can make to the quality of their lives.

Additionally, it means that where the person's preference is to receive care, and where possible to die at home, the infrastructure and opportunities are in place to make such a choice real and viable. Palliative care is defined as: 'the active, holistic care of patients with advanced progressive illness'. Management of pain and other symptoms and the provision of psychological, social and spiritual support is paramount. Many aspects of

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

palliative care are also applicable earlier in the course of the illness in conjunction with other treatments. More recently the importance of 'early identification and impeccable assessment' has been added to this definition as it is thought that problems at the end of life can have their origins at an earlier time in the progression of the illness and should therefore be recognised and dealt with sooner.

Palliative care can, in some cases, mean a shift from a curative focus towards an approach which seeks to alleviate and prevent the escalation of symptoms. The transition between curative and palliative care is often blurred, which emphasises the importance of communication between the individual and the healthcare professional with regard to the intention of treatment. Identifying this transition informs thoughtful decision-making about the appropriateness of proposed treatment options and explores the provision of further social and spiritual support to address emotional, psychological and practical needs, invaluable to the individual, their family and carers in managing the condition.

End of life is described as the period of time during which an individual's condition deteriorates to the point where death is either probable or would not be an unexpected event within the ensuing 12 months; however, a specific timescale cannot always be applied. This point will be different for each individual and will often depend on an assessment of an individual's condition by health and social care professionals, carers and/or the patient themselves. Identifying the point at which illness becomes advanced or reaches the end-of-life phase allows health and social care providers to plan best care with people in order to meet their needs and those of their families and carers throughout the last phase of life and the experience of bereavement. As with palliative care, end-of-life care also includes physical care, management of pain and other symptoms and provision of psychological, social, spiritual and practical support.

Palliative and end-of-life care is provided in many settings: at home, in hospitals, in care homes and hospices. Whilst much of the formalised care is provided by multidisciplinary teams of health and social care professionals, families, carers and volunteers continue to be the crucial cornerstone of this care. The majority of children and young people die either at home or in hospital.

Number of Cancer Deaths in Children & Young Adults Recorded in Northern Ireland by Place of Death for the Period: 2014-2018			
	Age Band		
	0-15	16-24	Total
Home	19	12	31
Hospital	19	15	34
Hospice	5	6	11
Total	43	33	76

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Within this Strategy, we refer to people with ‘non-curative cancer’. By this we do not mean every patient whose cancer cannot be fully treated, but those with a non- curative diagnosis who have been identified as potentially benefiting from a palliative care approach. Increasingly people are living with non-curative cancer for prolonged periods of time. This has been termed ‘treatable but not curable cancer’ and includes many blood cancers, metastatic cancers including breast, bowel and prostate cancer. Growing numbers of people will receive life-prolonging treatment over many years and may require palliative care input on an episodic basis over a more prolonged period of time. Support from many professionals, including a wide range of AHPs, is critical in the management of symptoms and maintenance of a good quality of life. It is essential that referrals are made in a timely manner to ensure that appropriate support and care are provided.

Existing pathways and criteria are not always flexible enough to ensure people can access palliative care services when and where they need them. If alternative services were available this could avoid unnecessary attendance at hospital and admission for some people.

COVID-19 has significantly disrupted key cancer services which is resulting in more people presenting with advanced disease. This raises challenges for the provision of palliative care service delivery in the short to medium term.



Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Identification of Palliative Care Needs

There are a number of benefits from the early introduction of palliative care for people living with cancer, including integration alongside active treatment. Timely access to palliative cancer care can result in better quality of life, lower rates of depression, longer survival and higher satisfaction with care among patients. Access to palliative care is, however, dependent on both clinicians and patients and carers recognising and accepting that they could benefit from this approach. It also requires close, integrated working between key HSC disciplines, for example oncology and palliative medicine.

In practice, it would appear that both cultural and structural barriers are stopping this from happening for some patients, namely:

- The emphasis of many clinicians may be on treatment or survivorship, with a reluctance to refer to palliative care or acknowledge the severity of a patient's prognosis, as this would represent 'giving up'. This may foster an attitude where palliative services are only considered once all active treatment options have been exhausted. Misconceptions about palliative care also exist among patients and their loved ones.
- Late identification of palliative care needs often means those people, who are still deemed as curative, no matter how small the likelihood, may miss out on receiving palliative care and support services. As a result, some people and those important to them are often shocked by rapid deteriorations and feel unprepared for the end of life.
- Late identification also decreases opportunities for advance care planning and steps to facilitate the person's preferred place of care, as well as leading to complex grief in those left behind.

Recent retrospective audits (2019, pre-COVID-19) of people presenting to emergency departments have found 20–30% of people being admitted to hospital following an attendance at ED have unidentified or unmet palliative care needs. Of those admitted, on average, 40% had advanced cancer.

Action 47. Deliver integrated, coordinated and personalised palliative and end-of-life care to people with non-curative cancer when and where they need it.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Access to Palliative Care Key Workers

People are likely to receive care and support from a range of professionals including district nurses, GPs, AHPs, social care workers, their community pharmacy and specialist palliative care professionals. Care may also be provided by a range of organisations including hospices and charities. Patients and families report that it is often confusing having so many different people involved and that communication between services can be fragmented. Living Matters Dying Matters recommended that palliative care patients should be allocated a key worker to co-ordinate care, support and information. To date this has not been implemented uniformly across all Trusts and for all patients.

Action 48. All people with non-curative cancer will have access to a palliative care key worker.



Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Access to Generalist and Specialist Palliative Care Services

Statistics for 2019 show that 47% of all deaths in Northern Ireland occur in hospitals, 19% in care homes and 34% in all other places. The'all other places' for 2019 isn't broken down in the official statistics but we know from previous analysis that around 3% of those deaths will have been in hospice and circa 27% in the person's own home.

Socioeconomic factors may have a particular impact on the end-of-life experience of people in their own homes. Marie Curie's research has shown that people with terminal conditions – including cancer – may be more likely to live in fuel poverty and suffer the damaging consequences of living in cold housing.[66] Elsewhere, wider UK studies have found that people in the most deprived areas are more likely to die in hospital than those in the least deprived.[67] [68]



The delivery of high-quality palliative and end-of-life care requires multidisciplinary input. Specialist palliative care professionals will play an important role, but much of the care that people will receive, including at the end of life, will also be provided by wider 'generalists' – including GPs, district nurses, AHPs and social care workers.

Specialist Palliative Care AHP teams have a significant role in supporting people with complex palliative care needs to remain in their preferred place of care by offering palliative rehabilitation, symptom management and education for the patient, carers and health and social care professionals. Not all Trusts have community specialist AHP teams with referrals being made to generalist teams.

The need for education and training for staff, from basic understanding of what palliative care is and when it is appropriate, identifying need, advance care planning, local referral processes and integration with oncology services through to care in the last days of life and bereavement is vital if care and co-ordination are to be improved.

66 Marie Curie (2020) 'The vicious cycle of fuel poverty and terminal illness'. pdf https://www.mariecurie.org.uk/globalassets/media/documents/policy/policy-publications/2020/fuel-poverty-and-terminal-illness.pdf
67 National End of Life Care Intelligence Network (2012) 'Deprivation and death: Variation in place and cause of death'. https://www.scie-socialcareonline.org.uk/deprivation-and-death-variation-in-place-and-cause-of-death/r/a11G00000017z9GIAQ
68 Macfarlane, M. and Carduff, E. (2018) 'Does place of death vary by deprivation for patients known to specialist palliative care services?' BMJ Support Palliat Care, 8 (4).

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Out-of-hours (OOH) advice and support from specialist palliative care professionals and a palliative care pharmacy is not routinely available to all health and social care teams in all locations across Northern Ireland. Where advice is available, this is usually done on an ad hoc, historical or good will basis. Specialist palliative care provision is currently only available on a Monday–Friday 9–5pm basis with no formalised out-of-hours provision.

In addition, there are challenges in ensuring equitable access for all sections of the population, particularly seldom-heard and underrepresented sectors, e.g. LGBTQ+ people, those from ethnically diverse backgrounds, people with cognitive impairment such as those with dementia, those experiencing homelessness, people in long-term institutional care including prison care, the ageing and frail population, and those living in rural and remote areas.

Action 49. Extend palliative and end-of-life support and continuity of care to seven-day working for all people with non-curative cancer.



Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Advance Care Planning (ACP)

In Northern Ireland, there remains a significant taboo around discussing death and dying. This inevitably can result in conversations about palliative care being put off until the advanced stages of a person's condition, because of the association with the end-of-life stage. This can foster an attitude where palliative services are only considered once all active treatment options have been exhausted.

Advance Care Planning is an umbrella term covering personal, legal, clinical and financial planning. It enables a person to think about what is important to them and plan for their future. It is a voluntary process and helps a person to make known what their wishes, feelings, beliefs and values are, and to make choices that reflect these. A person's Advance Care Planning conversations, any recommendations and/or decisions will be used in the future should a person become unable to make the relevant decisions for themselves. Advance Care Planning is important for every adult at any stage of life and ideally should happen before any crisis, such as the diagnosis of a serious illness. It plays an important role in ensuring that a person is given the opportunity to be involved in shared decision making and to state preferences and wishes which can be recorded and communicated to these involved in their care. People with communication difficulties may need additional support to make informed decisions or communicate their wishes.

The Department of Health Advance Care Planning policy provides a framework for Advance Care Planning for adults (aged 18 years and over), focusing on the health and social care aspects. The policy aims to support a person to have greater choice and control over decisions, including plans for their future care and treatment. Provisions for children and young people with palliative needs are outlined in the Department of Health's strategy: Providing High Quality Palliative Care for Our Children.

Education and training should equip health and social care staff to have regular, meaningful, timely, realistic and practical conversations with people about their diagnosis, prognosis, treatment options and planning for the future. It is particularly important that communication with patients and loved ones is carried out in a sensitive and compassionate manner.

Action 50. Increase awareness and uptake of advance care planning for all people with non-curative cancer.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Pre-bereavement and Bereavement Support

Most bereavement services in Northern Ireland are provided by the community and voluntary sector. Capacity is an issue, with long waiting lists in many areas. Capacity issues are also preventing Trust social work teams from offering greater levels of bereavement support, including follow-up services with carers and loved ones. Patients and their loved ones may have access to chaplaincy support in the hospital setting, but these services will normally cease after discharge, so continuity of care does not continue into the community. Day-to-day support is likely to have been provided via the services delivered to their loved one but these are withdrawn after death. The loss of this support network can compound feelings of loneliness and isolation among recently bereaved carers.

Access to pre-bereavement and bereavement support is crucial to meet the holistic needs of carers and loved ones. It is vital that we adopt a wider approach and ensure that those important to the person living with cancer, including children, are not forgotten. This type of early intervention and support can be helpful in preventing mental health issues connected to early/traumatic loss and complex grief reactions.

Action 51. All people living with non-curative cancer, and those important to them will have access to the bereavement, psychosocial and counselling support appropriate to their needs and preferences before and after death.

The actions outlined for palliative and end-of-life care align closely with the regional priorities of the Palliative Care in Partnership (PCiP) programme and many are already included in the regional palliative care work plan. The PCiP programme is well established and would be well placed to oversee the implementation and delivery of these actions. The recently re-established bereavement group will be taking forward the development of bereavement services for Northern Ireland and our expectation is that this will include services for cancer.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Theme 4: Implementing the Strategy

Workforce and Training

Cancer services are struggling to deliver in a timely manner, with escalating waiting lists in many areas including diagnostics and surgery. The immense pressures the HSC, including all those involved in cancer services, have been put under over the past two years as a result of COVID-19 is fully recognised, which has served to increase pressure on an already stretched workforce. Creating a sustainable workforce to care for those with a cancer diagnosis must be an integral part of the Cancer Strategy.

Oncology and haematology services were fragile pre-COVID-19 with services often dependent on small teams and, in some instances, single-handed consultant practice. Multidisciplinary team work is an essential component of cancer care involving a wide range of health and social care professionals across both primary and secondary care. There is, however, unequal provision across cancer sites and across Trusts.

Diagnostic services are the first step in confirming a cancer diagnosis. There is currently a UK-wide shortage of radiologists which has an impact on the timeliness of investigations and results. Endoscopy services are under extreme pressure across all Trusts and are struggling to meet the growing demand. Likewise pathology services continue to struggle with increasing demand which has been compounded by the COVID-19 pandemic. There is particular concern regarding Medical Physics Expert provision which will have implications for the delivery of diagnostic services, radiotherapy, clinical trials and nuclear medicine in the near future. Our ambition to improve diagnostic services and to diagnose more cancers earlier cannot happen without significant investment to modernise and develop the diagnostic workforce.

Oncology services workforce planning and modelling was undertaken as part of the Oncology Services Transformation work in 2019. A blueprint was developed for a range of roles including nursing, pharmacy, therapy radiographers and doctors. The implementation of this plan is not progressing as planned due to funding constraints and, as a priority, must be implemented in full. If we are to ensure sustainability of services for the future a similar workforce plan must be developed for haematology as a matter of urgency.

Looking forward, the role of genomic medicine will have a significant impact on how we deliver cancer care. This will require a substantial increase in clinical scientist expertise.

Allied Health Professionals (AHPs) are the third largest professional workforce in the HSC, with 13 distinct and unique disciplines. AHPs are

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

integral to the delivery of cancer care across the entire pathway.[69] They are essential in diagnosing cancer, in the delivery of cancer treatment, supporting people through treatment, leading the delivery of prehabilitation and rehabilitation services, managing the long-term effects of treatment and providing palliative and end-of-life care.

Across Northern Ireland, there is inequity of provision across Trusts. Service provision lacks consistency, has been developed in an ad hoc manner and is not sustainable in the longer term. As the number of people being diagnosed and living with cancer increases there is an inevitable knock-on impact on the workloads of AHPs which needs to be addressed as part of future workforce planning to meet the growing demand.

The challenge that lies ahead cannot be underestimated. While workforce planning has been undertaken or is underway in some specialties or professional groups, there is a compelling need to review the multidisciplinary cancer workforce as a matter of urgency. The workforce has grown in recent years but growth has not kept pace with the exponential rise in demand for diagnosis, treatment and ongoing care.

Over the past decade, there have been many major new developments in diagnosing and treating cancer including PET scanning, cytosponge, proton beam radiotherapy, immunotherapy and robotic surgery. Changes in the provision of care, type of treatments and procedures all have an impact on the workforce required to deliver the service.

In addition to an anticipated increase in numbers of staff required, we must address the appropriate skill mix, career pathways, training and retention of staff across the wide range of professions essential for the delivery of cancer services. The current service model for oncology is largely delivered by medical consultants supported by a wide range of other health professionals. The Oncology Services Transformation Plan (2019) clearly demonstrated the need to move towards a consultant-led service, with more services delivered by advanced nurse and AHP practitioners, in line with best practice internationally.

As we move towards the new model, we need to be mindful of the lead-in time required to train and develop staff. It should also be noted that increasing the numbers of non-medical prescribers and advanced nurse and AHP practitioners is associated with a knock-on effect on medical consultants who will be tasked with providing training, mentorship and supervision.

With advances in treatment, many cancers are becoming long-term, chronic conditions; consequently, there is a growing need for the provision of more specialist care in a primary-care setting, closer to home, for suitable patients. New roles such as primary care oncology nurse specialists, specialist AHP

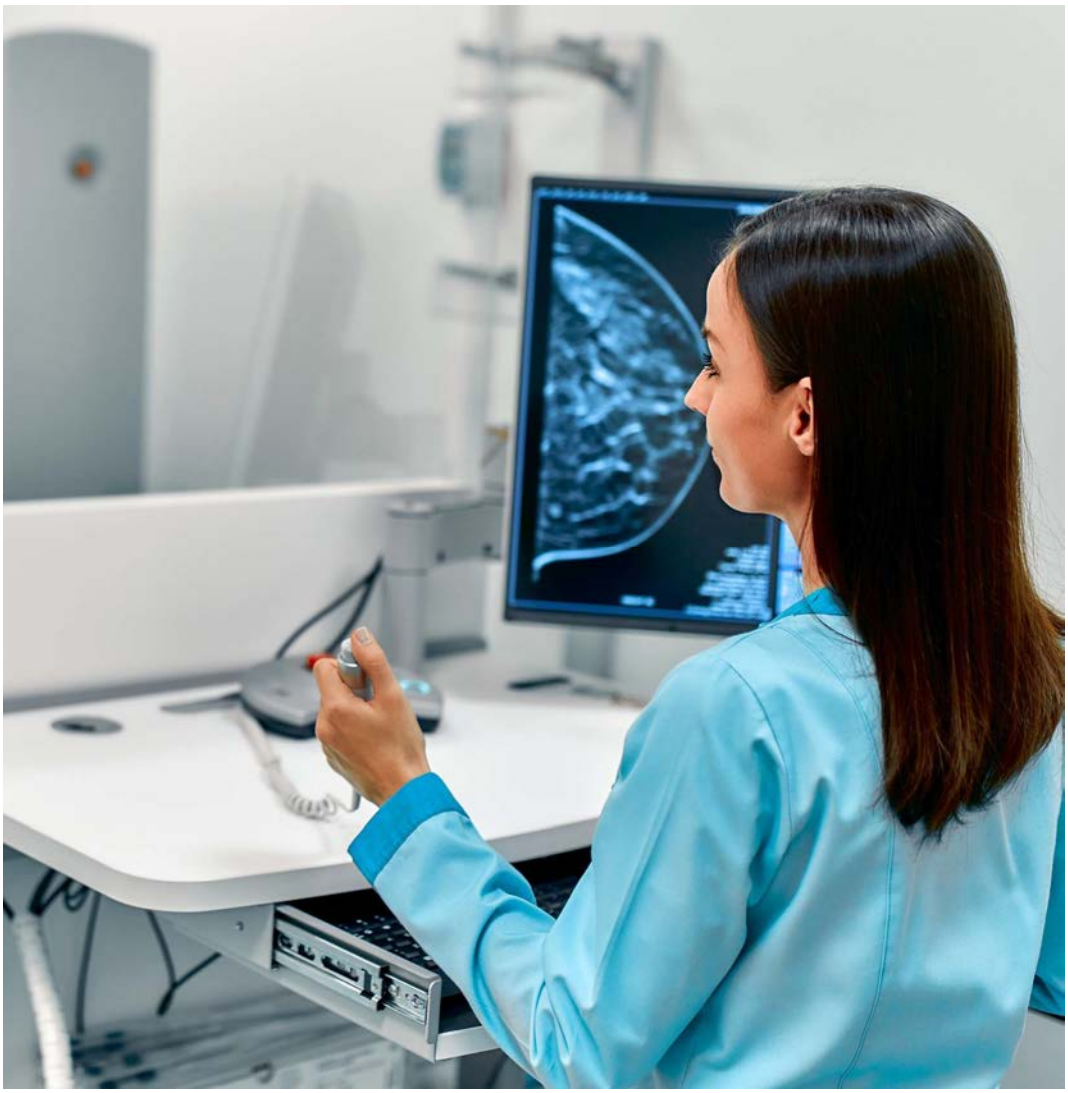
69 NHS England (2018) 'Quick Guide: The role of allied health professionals in supporting people to live well with and beyond cancer. Transforming health, care and wellbeing with allied health professionals', London:Allied Health Professions team, https://www.england.nhs.uk/wp-content/uploads/2018/10/ quick-guide-ahp-cancer.pdf

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

practitioners and advanced nurse practitioners should be developed to work in the GP Federations.

Multi-professional education and training for staff at all levels and in all settings will be an essential enabler for the successful delivery of this plan. A comprehensive training programme must be developed and aligned with the new workforce plan adopting a regional approach to training. Our expectation is that multi-professional training should be the norm going forward.

Action 52. Develop a regional, multi-professional cancer workforce strategy and implementation plan. This will be underpinned by a training plan to ensure there are appropriately skilled staff to deliver services for the future.



Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Communicating with People Affected by Cancer

Communication lies at the heart of healthcare delivery. What people value most highly are good patient-professional interactions and being treated as a person. There is little doubt that communication between cancer patients and staff could be improved.

Breaking Bad News Regional Guidance For Northern Ireland was published in 2003.[70] This guidance outlines a pathway for medical and other professional staff to deliver bad news to patients, clients, their families and carers. Studies have consistently shown that the way a doctor or other health or social care professional delivers bad news places an indelible mark on the doctor/professional-patient relationship.

There is a specific challenge for parents who have been diagnosed with cancer in how best to communicate their diagnosis to dependent children,[71] with evidence highlighting a lack of support and guidance from healthcare professionals (HCPs). Most health care professionals (90%) have had no training in initiating and facilitating this parent-child communication.[72] This is also an issue for parents of children who have been diagnosed with cancer in how to communicate the information to siblings.

Action 53. All healthcare professionals who are expected to carry out sensitive communication must complete an advanced communication skills training programme.

70 DHSSPSNI (2003) 'Breaking Bad News Guidelines. DHSSPSNI', breaking_ bad_news.pdf (headandnecktrauma.org).
71 Semple, C.J. & McCance, T. (2010) 'Parents' experience with cancer who have young children: A literature review', Cancer Nursing 33 (2) 110-118.
72 Semple, C.J., McCaughan, E. & Smith, R. (2017) 'How education on managing parental cancer can improve family communication', Cancer Nursing Practice 16, 34-40.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Research

Within the health and social care sector, the provision of high-quality cancer care is a priority. Among all providers, there is a clear focus on the provision of person-centred services and on improving the experience of care. We know that participation in cancer research improves outcomes for people across all parts of the patient pathway. Research is not an add-on to the delivery of normal care, but it is foundational in the delivery of excellence.

Northern Ireland has a rich heritage in cancer research. Cancer research is conducted across a wide range of organisations including the Northern Ireland Cancer Registry, HSC Trusts, universities, cancer charities, the private sector, and not-for-profit organisations. It is funded from a variety of sources, but there is potential for better co-ordination across organisations and an opportunity to influence research priorities for the future.

The All Ireland Cancer Consortium (AICC) was set up in 1999 with the core aim of reducing cancer incidence and mortality on the island of Ireland through cross-border and transatlantic collaborations in cancer research and education. The AICC has a crucial role to play in the development and implementation of evidence-based outcomes for people affected by cancer in Northern Ireland and beyond.

It is inevitable that there will be many significant advances in technology and new treatments over the life of this strategy. The pace of change in all aspects of cancer means that we must have more agile systems in place to adopt new innovations in a timely manner.

For the successful delivery of this strategy, we must embed a culture in which data, research and intelligence are seen as core components for increasing public awareness, an improved uptake in screening, more efficient and timely diagnostic services, better treatment and care, and ultimately better outcomes for people living with cancer. It is paramount that we optimise the involvement of people affected by cancer in formulating and developing research proposals.

Clinical Trials / Clinical Research

Over the past decade, many successes can be celebrated when looking at the delivery of cancer clinical trials across Northern Ireland, yet the number of patients being offered and participating in cancer clinical trials remains well below that reported in other jurisdictions. It is widely accepted that cancer clinical trials are essential, not only to allow patients to access to new or novel treatments, but more importantly to attract and develop a world-class workforce.

Participation in clinical research ensures that patients have access to novel therapeutic agents or techniques, which may otherwise not be accessible to

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

them. It has been demonstrated that people treated in centres with a strong culture of participation in clinical research have improved outcomes, attributable to care from a highly-motivated team, delivering high-quality protocol-driven care.[73] [74] [75]

Research also benefits individual clinicians, in terms of developing their professional knowledge and skills, and delivers organisational benefits for healthcare providers, both in terms of reputation and in revenue generation from commercial studies. In addition, participation in clinical and transitional research will ensure that cancer care will be improved for future generations of patients.

Data from the 2018 Cancer Patient Experience Survey[76] demonstrated a concerning differential between Northern Ireland and England with only 15% of Northern Ireland patients reporting that they had been asked about taking part in cancer research/clinical trials compared to 31% for England.

The Northern Ireland Cancer Trials Network (NICTN) exists to promote high-quality cancer care by supporting the delivery of clinical research across the Trusts. The NICTN delivers both large, late-phase clinical trials and early-phase studies, as well as supporting the development and delivery of investigator-initiated studies through its Research Management Service. In addition, NICTN provides support for the Belfast Experimental Cancer Medicine Centre (Belfast ECMC) in the delivery of early-phase and biomarker-driven clinical trials. Currently the vast majority of clinical trial activity occurs within the Northern Ireland Cancer Centre in Belfast HSC Trust.

Participation in clinical trials is considered to be an important factor in the higher survival rates seen in childhood cancers, where around two-thirds of children are recruited onto trials. NICTN supports Teenager and Young Adults (TYA) trial activity when available, but activity in this area is extremely low. TYA trials either sit within paediatric or adult services with few straddling both. Going forward, it is important to ensure that trials for TYA are set-up locally in such a way that they can be supported through the transition between paediatric and adult services. In addition, stronger links should be developed with trial sites elsewhere in the UK and the Republic of Ireland.

The complex multidisciplinary nature of clinical trial delivery requires buy-in across Trusts with enhanced access to radiology, pathology and pharmacy services. The opening of trials continues to be challenged due to workforce

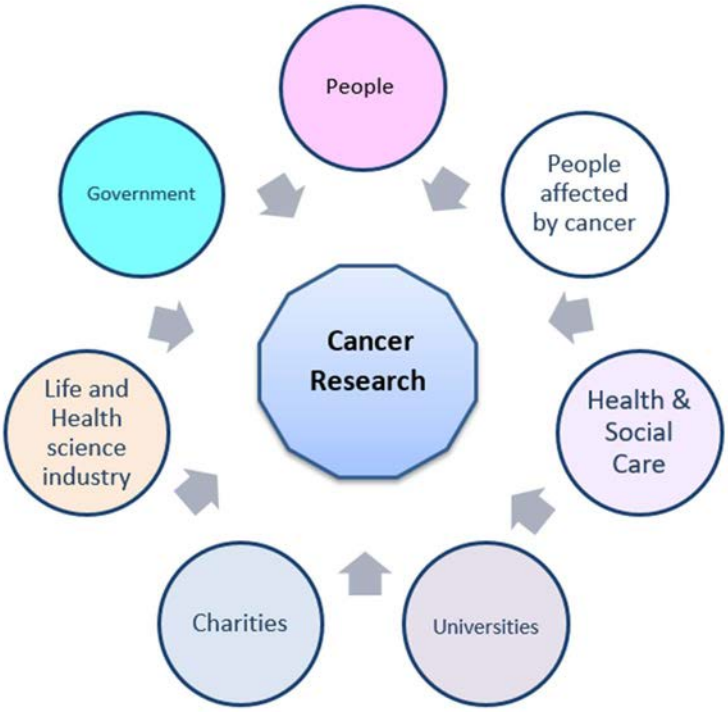
---

73 Majumdar, S.R., Roe, M.T., Peterson, E.D., Chen, A.Y., Gibler, W.B., Armstrong, P.W. (2008) 'Better outcomes for patients treated at hospitals that participate in clinical trials', Arch Intern Med. 168(6): 657–62.
74 Karjalainen, S., Palva, I. (1989) 'Do treatment protocols improve end results? A study of survival of patients with multiple myeloma in Finland', BMJ, 299(6707): 1069–72.
75 Downing, A. et al. (2017) 'High hospital research participation and improved colorectal cancer survival outcomes: A population-based study', Gut, 66(1): 89–96
76 HSC Public Health Agency (2018) 'Northern Ireland Cancer Patient Experience Survey 2018'| https://www.publichealth.hscni.net/publications/northern-ireland-cancer-patient-experience-survey-2018

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

constraints including in terms of research nurses and medical physics experts. In addition, there is a need to ensure reliable funding streams and protected time within job plans to support clinical research across the region.

Figure 8: People with an interest in cancer research.



Per capita research spend in Northern Ireland is considerably lower than in the other UK nations.[77] [78] [79] [80]Numerous charitable organisations provide funding for NICTN activity but in the financial climate 'post-COVID' there is little doubt that this funding will reduce over the short to medium term. Sustainable funding on a par with the rest of the UK must be a key consideration in the ambition to provide better outcomes in the future.

77 National Institute for Health Research (2019) Annual Report 2019/2020 https://www.nihr.ac.uk/about-us/our-contribution-to-research/research-performance/12228_NIHR_Annual_Report_18_19.pdf
78 Welsh Government (2020) 'Explore the Welsh Government's Final Budget 2020-2021' https://research.senedd.wales/research-articles/explore-the-welsh-government-s-final-budget-2020-21/.
79 Scottish Government, Chief Scientist Office (2018) 'Health Research Board Annual Report' https://www.cso.scot.nhs.uk/wp-content/uploads/CSO1819OTsummary.pdf
39.https://www.hrb.ie/fileadmin/2._Plugin_related_files/Publications/2019_Publication_files/Health_Research_Board_Annual_Report_2018.pdf.
80 Health Research Board, 'Annual Report' https://www.hrb.ie/fileadmin/2._Plugin_related_files/Publications/2019_Publication_files/Health_Research_ Board_Annual_Report_2018.pdf.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Understanding the Experience of People Living with Cancer

The ambition for cancer services must be to put people's experience and quality of life on a par with other clinical outcomes such as survival.

Ongoing information and research from patient groups, third-sector organisations and data from service user feedback systems such as Care Opinion and 10,000 Voices is invaluable in highlighting the experience of people living with cancer. There is, however, a recognised lack of information on the impact of treatment and long-term effects on people's lives. This reflects the lack of simple mechanisms by which patient-related outcomes and experience measures can be digitally gleaned and added to clinical records. Reliance on questionnaires, delivered separately or not directly linked to care delivery is inadequate.

At a population level in Northern Ireland, the only tool currently used to measure patient experience is the Cancer Patient Experience Survey (CPES). This has been carried out twice over recent years and both surveys have reported high levels of satisfaction with over 90% of people reporting their care as excellent or very good. CPES provides insight into the experience of people living with cancer locally and can be benchmarked with similar studies elsewhere in the UK.

The methodology is reliant on participants being willing and able to take part, and as a result, people with less survivable cancers, and those from more marginalised communities tend to be poorly represented. To date, the inclusion criteria is for those over 18 years of age. Consideration must therefore be given to how the experience of younger people can be measured. Recently, NHS England have worked with the Picker Institute to carry out the first CPES for under 16s. Learning from this work will be invaluable in shaping how the experience of children and young people in Northern Ireland is measured.

Patient Reported Outcome Measures (PROMs) represent a more person-centred approach to capture and address unmet supportive care needs. While interest exists in PROMS within clinical practice, there is no consistency in the tools or approach taken. The Scottish Cancer Recovery Plan (2020) has committed to provide national support to assessing the potential and value of digital PROMs. Learning from this will be invaluable going forward. In addition, NHS England has committed to the introduction of an innovative quality-of-life metric to track and respond to the long-term impact of cancer. When available, consideration should be given to adopting this for use in Northern Ireland.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Action 54. **Measure the experience of all people with cancer on an ongoing basis to inform service improvement and redesign.**

Action 55. **Develop a cancer research strategy for Northern Ireland in partnership with key stakeholders.**

Action 56. **Increase the number of people taking part in clinical trials, including children and young people.**

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Data

Cancer can affect all aspects of a person's life, therefore the information we collect is crucial to understanding how the delivery of services can be improved for the future.

The Northern Ireland Cancer Registry (NICR) is located in the Centre for Public Health, Queen's University Belfast and is funded by the Public Health Agency for Northern Ireland. The registry was established in 1994 and a key function is the production of annual official statistics on cancer incidence, prevalence and survival in Northern Ireland. This includes data on screening, incidence and survival by age, sex, cancer type, variations due to deprivation, stage of disease, treatment and support services received.

The registry has expertise in the coding and analysis of healthcare data in cancerous and precancerous conditions. The level of knowledge within NICR is world leading, and with correct technology support and access to the live working systems of HSCNI their impact could be even greater.

Even with this expertise, Northern Ireland lags behind other UK nations in the range of cancer data it collects, ease of access to and use of the data that is collected. This has led to widespread frustration and dissatisfaction with the inability to link this information and to access routinely collected information from all of the available systems.

Accurate data is essential to underpin all decisions including, commissioning, service improvement and development, performance management and future planning. It is vital that common data sets are developed, agreed and used uniformly across the service.

The lack of routine prospective data collection of cancer treatments and outcomes in Northern Ireland makes assessment of the organisation and effectiveness of cancer services difficult. This highlights the need for routine data collection against the defined minimum datasets for cancer and submission to National Cancer Audits, to allow, not only benchmarking against cancer outcomes elsewhere in the UK, but also interpretation of local data on service provision required to inform and deliver service improvements.

Encompass/IT Systems

The new Encompass IT system is a critical part of the digital future of HSC. It will be transformational in its scope and will deliver a paper-less system in secondary care and enable much greater integration across acute and community services and social care. Encompass will replace many of the disparate systems in place currently and will add greater functionality.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

It will also provide safe and protected individual data on the care provided with every clinical interaction coded in real-time by the care provider. A central component of Encompass is a patient portal, which will bring people closer to the care providers and will enable great transparency and communication between everyone involved in the care pathway.

The programme will start in South Eastern Trust in 2022 and roll out across Northern Ireland over the following two years. In the interim, there is a compelling need to develop and improve data systems which will be compatible with Encompass going forward.

Dedicated IT resources must be made available to support the implementation of this Strategy as we move towards cross-Trust working and a more digitally-enabled service.

Action 57. Review the data required for the effective delivery of cancer services in alignment with Encompass.

Action 58. Develop a cancer data framework to inform and improve cancer services and facilitate research.

Action 59. Review the Northern Ireland Cancer Registry.

Action 60. Make provisions to allow secondary use of data to allow benchmarking of Northern Ireland cancer outcomes across the UK.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Funding and Next Steps

The cancer pathway is complex and interfaces with all aspects of health and social care. Effective governance arrangements, combined with a focus on prevention, early diagnosis, evidenced-based treatment and support services are crucial, to ensure that the Strategy actions are implemented.

The Strategy provides the strategic direction and key steps to achieving the overall vision for improved cancer outcomes for the people of Northern Ireland. It presents a comprehensive and challenging programme of service stabilisation and improvement, reliant on collaborative working and new and innovative approaches to the delivery of care. Many of these require coordinated regional approaches and are likely to be challenging to achieve within the current service commissioning and Trust-based delivery structures. Delivery at this scale and speed will require investment in planning and project support infrastructures both within Trusts and across Clinical Networks, in particular the Northern Ireland Cancer Network (NICaN).

In order to meet these challenges, new governance structures will be established to performance manage and oversee the delivery of the Strategy. Strong clinical leadership and the inclusion of people with lived experience of cancer will be central to these structures.

As we move forward, it is also important that we acknowledge the difficult financial context in which this strategy is being issued. At the time of publication, all actions are subject to confirmation of funding and will therefore require prioritisation, workforce mapping and planning to ensure realistic delivery. The investment required to deliver the Strategy is significant, and is in addition to the existing expenditure in cancer services. It is not possible to fund implementation from within the Department's existing resources and delivery is therefore dependent on the provisions of significant additional funding for the Department. Where it is possible, the Department will also seek to release resources through service efficiencies and reconfigurations; however, this in itself will not be sufficient to fund implementation. The pace of change outlined in this Strategy will also be considered in the context of other service priorities and with regard to the Department's overall financial settlements.

In order for the delivery of the Strategy to be released over the next decade, collaboration and co-production will be crucial. This will involve maintaining and building on the many successful developments implemented over the past years in response to the pandemic, and learning from what could have been done better. Collaboration between HSC organisations, across sectors and with people affected by cancer including families and carers will be a key enabler to effecting meaningful change.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Appendices

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Appendix 1: Cancer Strategy Actions

Action	Actions that can be fully or partially implemented without additional funding.[81]	Time to complete action after confirmation of funding and approval to initiate action.[82]
Theme 1 Preventing Cancer		
1. Increase public awareness of cancer-related risk factors through specific strategies on tobacco, substance use, skin cancer prevention, and overweight and obesity – including diet and physical exercise.	Actions 1-4 are funded through other strategies. Work can commence without additional funding. It is expected these actions are continuous and will not have a completion date.	
2. Support the development and delivery of strategies to improve public health.		
3. Develop a co-ordinated approach towards chemoprevention in line with NICE recommendations.		
4. All people diagnosed with cancer must be offered appropriate and targeted information and support to live well.		
Theme 2 Diagnosing and Treating Cancer		
5. Establish routes to diagnosis reporting and analysis on a regular basis to monitor changes to help improve diagnostic pathways and outcomes for patients.		12 months
6. Deliver regular, effective, targeted evidence-based 'Be Cancer Aware' campaigns harnessing the expertise in the community and voluntary sector.	This action is currently funded until 2024.	It is expected that this action will be ongoing.
7. Reduce sensitivity levels and extend the age range for the bowel screening programme.		The initial implementation project can be completed within 24 months. Implementation of services will take a further 18 months.
8. Implement HPV testing in the cervical screening programme.	Some project work is underway and the action can be partially completed in 12 months.	The action is expected to be completed in 3 phases. Full completion of the project – 12 months. Full roll out of training – 18 months.

[81] Timelines for actions that can be fully or partially implemented without additional funding start at the publication of the Strategy.
[82] Not all actions can be completed simultaneously. The ability to start an action will depend on availability of funding and workforce. The time to implement the action is therefore from approval to initiate the action and not from the publication of the Strategy.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Action	Actions that can be fully or partially implemented without additional funding.[81]	Time to complete action after confirmation of funding and approval to initiate action.[82]
		Implementation of service – 18 months.
9. Increase uptake of all cancer screening programmes.	See action 6.	
10. Implement all UK National Screening Committee recommendations.		The extent and nature of this action depends on recommendations from the national screening programme and will be subject to confirmation.
11. Create surveillance systems for conditions where there is clear evidence regarding the pre-malignant potential of a particular condition to ensure people are not lost to follow up.		12 months
12. Implement NICE guidance including NG12, and in the future, the most current NICE referral guidelines.		Implementation projects – 18 months. Service delivery will be dependent on workforce and is not expected in the first three to five years of the Strategy.
13. A 28-day standard will be introduced to track the time for all people from first referral for suspected cancer to confirmation of a cancer diagnosis, which includes all diagnostic and staging investigations.		This action is not expected to be initiated in the first 3 years of the Strategy.
14. Review current targets to ensure equity across the pathway.		12 months.
15.Develop new pathways and diagnostic services to improve diagnosis.	Planning work underway – to be completed within 12 months.	18 months, subject to unexpected outcomes of the planning project.
16. Develop a specialist integrated haematological diagnostics service for Northern Ireland.	Initial work underway, with partial completion at 12 months.	Full service within 12 months.
17. Develop and implement prehabilitation and rehabilitation services on a regional basis for all those who will benefit.	Initial work underway funded by charities.	It is not expected that full implementation will be initiated in the first 3 years of the Strategy.
18. Reconfigure cancer surgical services alongside any future recommendations for the delivery of emergency and elective surgery.	Work is underway across other policies to consider future service structures.	Implementation need is unknown until outcome of other work.
19. Implement Enhanced Recovery After Surgery programmes on a regional basis for all appropriate major cancer surgery.		It is not expected that full implementation will be initiated in the first 3 years of the Strategy.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Action	Actions that can be fully or partially implemented without additional funding.[81]	Time to complete action after confirmation of funding and approval to initiate action.[82]
20. Introduce and implement new radiotherapy techniques and technology in line with national guidance including staffing and associated training.		24 months. Implementation will be continuous.
21. Implement in full the recommendations of the Oncology Service Transformation Project and the Oncology Haematology stabilisation plan.	This action is ongoing.	Further improvements within 6m of funding. Full completion is expected to take up to 4 years.
22. Ensure timely treatment where services cannot be provided in Northern Ireland due to the specialist nature of services, technology constraints or low number of patients. Continue to monitor the viability of providing these services locally including CAR-T.	Partial completion – 18 months.	24 months
23. Develop near-to-home phlebotomy services.	Partial completion – 12 months.	12 months
24. Review our model of delivery for Systemic Anti-Cancer Treatment Services including the delivery of near/close-to-home SACT.		12 months
25. Develop a 24/7 metastatic spinal cord compression service with rapid access to imaging and treatment.		12 months
26. Extend the acute oncology service across all Trusts to seven day working.		12 months
27. Deliver genetic and genomic testing in cancer pathways in line with NICE recommendations.	Ongoing through other strategies. 24 months.	
28. Develop ambulatory care haematology units in each of the Trusts and establish near-to-home treatment services for suitable patients.		12 months
29. Implement a safe and robust electronic prescribing system for all Systemic Anti-Cancer Treatment regimes.		Initial project – 12 months. Service delivery – 12 months after project.
30. Develop appropriate pathways and accessible services for older people with cancer, adults with learning disabilities, communication needs and chronic mental health problems, rarer cancers and metastatic cancer.	This action is part funded and can be scaled. Partial completion – 18 months.	Full completion – 18 months
31. Every child, young person and adult diagnosed with cancer, and their carers, will have access to staff with the specialist knowledge and skills to provide developmentally appropriate, person-centred care.	See action 52. Partial implementation - 18 months.	

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Action	Actions that can be fully or partially implemented without additional funding.[81]	Time to complete action after confirmation of funding and approval to initiate action.[82]
32. Increase collaboration between Northern Ireland, Great Britain and the Republic of Ireland in the provision of children's oncology services.		18 months
33. Review the provision of services for teenagers and young adults in Northern Ireland including transition arrangements, age appropriate environments, psychological support and long-term follow up.		12 months
34. An effective multi-disciplinary team meeting will be held for all people diagnosed with cancer including cancer of unknown primary and metastatic disease.		12 months
Theme 3 Supporting People to Live and Die Well		
35. Develop a person centred model of care that builds on learning from COVID-19 with increasing use of telehealth and technology.	Actions 35-37 and 42 are linked. Some work can be undertaken within existing funding. Partial completion – 12 months.	12 months
36. Offer all people a holistic needs assessment, an appropriate care plan and provide signposts to relevant sources of help and support.		
37. Develop a comprehensive treatment summary record for all people diagnosed with cancer.		
38. All people who have completed cancer treatment will be assessed and risk stratified to appropriate follow-up pathways.	Work ongoing. Partial completion – 18 months.	Project completion – 12 months Service implementation - 18 months after project depending on outcome of project.
39. All patients, including children and young people, diagnosed with cancer will have access to a Clinical Nurse Specialist throughout the entire care pathway.	Planning is ongoing. Partial completion – 12 months.	The action will be implemented on a phased approach. Implementation plan – 6 months enhanced training – 18 months full implementation – 5 years (depends on training and new/additional workforce)

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Action	Actions that can be fully or partially implemented without additional funding.[81]	Time to complete action after confirmation of funding and approval to initiate action.[82]
40. In alignment with the mental health strategy, develop a model to promote good mental health and wellbeing for people affected by cancer, and develop pathways to ensure that all people with cancer have access to mental health support in line with their needs.	Pilots can be completed without additional funding - charity funding. Partial completion can be achieved on a phased approach: Start of pilot – 12 months. Evaluation – 24 months after pilot. Pathways – 18 months.	Full implementation 18 months after evaluation of pilots - depending on outcomes of pilots.
41. All people with a cancer diagnosis will be referred to a Cancer Information and Support Service at diagnosis.		12 months
42. Timely and appropriate access to therapeutic and practical support services for people affected by cancer targeting emotional, physical, spiritual and social needs will be provided.	See actions 35-37.	
43. All people starting cancer treatment will have their health status assessed and recorded and a plan developed to mitigate potential late effects and consequences of their treatment.	Actions 43-46 are combined. Initial work on service specification and pathways – 18 months.	Implementation is expected on a phased approach depending on outcomes of pathways. Completion of each phase – 6 – 12 months. The full completion is not expected for at least 7 years due to workforce pressures.
44. Develop a regional, multidisciplinary approach to the identification and management of all people at risk of late effects and consequences of their cancer treatment.		
45. Identify people deemed to be at highest risk for late cardiovascular effects and enrol them in a follow-up programme.		
46. Screen children to detect early, subtle cardiac abnormalities that might be treated, or may be reversible. In addition, where children are treated with anthracyclines or cardiac radiation they will have lifelong screening.		
47. Deliver integrated, coordinated and personalised palliative and end-of-life care to people with non-curative cancer when and where they need it.	Actions 47-51 are combined. Partial completion – 12 months	Full implementation – 5 years
48. All people with non-curative cancer will have access to a palliative care keyworker.		
49. Extend palliative and end-of-life support and continuity of care to seven		

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Action	Actions that can be fully or partially implemented without additional funding.[81]	Time to complete action after confirmation of funding and approval to initiate action.[82]
day working for all people with non-curative cancer.		
50. Increase awareness and uptake of advance-care planning for all people with non-curative cancer.		
51. All people living with non-curative cancer, and those important to them, will have access to the bereavement, psychosocial and counselling support appropriate to their needs and preferences before and after death.		
Theme 4 Implementing the Strategy		
52. Develop a regional, multi-professional cancer workforce strategy and implementation plan. This will be underpinned by a training plan to ensure there are appropriately-skilled staff to deliver services for the future.	Partial completion of new ways of working and structures – 12 months. Partial completion on workforce needs – 24 months.	Implementation will be ongoing.
53. All health care professionals who are expected to carry out sensitive communication must complete an advanced communication skills training programme.		12 months
54. Measure the experience of all people with cancer on an ongoing basis to inform service improvement and redesign.	Partial completion – 12 months	12 months
55. Develop a cancer research strategy for Northern Ireland in partnership with key stakeholders.	Partial completion – 18 months	18 months
56. Increase the number of people taking part in clinical trials, including children and young people.	Partial completion of project – 18 months	Project completion – 18 months. Service delivery – 36 months after project completion
57. Review the data required for the effective delivery of cancer services in alignment with Encompass.	Actions 57 and 58 are joined. Partial completion – 18 months	24 months
58. Develop a cancer data framework to inform and improve cancer services and facilitate research.		
59. Review the Northern Ireland Cancer Registry.	18 months	
60. Make provisions to allow secondary use of data to allow benchmarking of Northern Ireland cancer outcomes across the UK.		24 months

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Appendix 2: Bibliography

Belfast Health and Social Care Trust (2017) 'Has Cancer affected your sexuality, sex life and relationships', Belfast: Belfast Health and Social Care Trust; Katz, A. (2005) 'The Sounds of Salience: Sexuality Information for Cancer Patients', Journal of Clinical Oncology, 23(1): 238–241.

Berrino, F. et al (2007) 'Survival for eight major cancers and all cancers combined for European adults diagnosed1995–99: results of the Eurocare-4 study'. The Lancet Oncology, 8, 773–83.

Borras JM, Lievens Y, Barton M. et al (2016) 'How many new cancer patients in Europe will require radiotherapy by 2025? An ESTRO-HERO analysis'.

Brown, H. et al. (2014) An evaluation of cancer surgery services in the UK, Health Services Management Centre, University of Birmingham, and ICF-GHK consulting.

Caird, J., Rees, R., Kavanagh, J. et al. (2010) The Socioeconomic Value of Nursing and Midwifery: A Rapid Systematic Review of Reviews, EPPI Centre, Social Science Research Unit, Institute of Education, University of London.

Cancer Research UK (2020). 'Cancer in the UK 2020: Socio-economic deprivation, s.l: Cancer Research UK' https://www.cancerresearchuk.org/sites/default/files/cancer_inequalities_in_the_uk.pdf

Coleman, M.P. et al. (2011) 'ICBP Module 1 Working Group, Cancer survival in Australia, Canada, Denmark, Norway, Sweden, and the UK, 1995–2007 (the International Cancer Benchmarking Partnership): An analysis of population-based cancer registry data', The Lancet, vol. 377: 127–38.

Cunningham, R. et al. (2015), 'Cancer survival in the context of mental illness: A national cohort study'. General Hospital Psychiatry 37 (2015) 501–506.

Davies, N., Batehup, L. (2011) 'Towards a personalized approach to aftercare: A review of follow-up in the UK', Journal of Cancer Survivorship, 5, 2: 142–151.

Dommett, R.M., Pring, H., Cargill, J. et al. Achieving a timely diagnosis for teenagers and young adults with cancer: the ACE "too young to get cancer?" study. BMC Cancer 19, 616 (2019).https://doi.org/10.1186/s12885-019-5776-0

Downing, A. et al. (2017) 'High hospital research participation and improved colorectal cancer survival outcomes: A population-based study', Gut, 66(1): 89–96

ESMO (2020) 'ESMO Consensus Guidelines 2020 Management of cardiac disease in cancer patients throughout oncological treatment: ESMO

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

consensus recommendations - ScienceDirect' https://www.annalsofoncology.org/article/S0923-7534(19)36080-6/fulltext.

Faculty of pain medicine of the Royal College of Anaesthetists (2019) 'Framework for pain services cancer and life limiting disease 2019.pdf', https://fpm.ac.uk/sites/fpm/files/documents/2019-07/Framework%20for%20pain%20services%20cancer%20and%20life%20limiting%20disease%202019.pdf

Gannon, C., Dando, N. (2010) 'Dose-sensitive steroid-induced hyperglycaemia', Palliat Med., 24(7): 737-9.

GOSH 2011. The Adolescents and Young Adults with Cancer.

Habib, S.L., Roina, M. (2013) 'Diabetes and risk of cancer', ISRN Oncology 583786

Hafeez, S. Singhera, M. and Huddart, R. (2015) Exploration Of The Treatment Challenges In Men With Intellectual Difficulties And Testicular Cancer As Seen In Down Syndrome: Single Centre Experience', BMC Medicine 13:152

HeadSmart Early Diagnosis of Brain Tumour https://www.headsmart.org.uk/

Health Research Board, 'Annual Report' https://www.hrb.ie/fileadmin/2._Plugin_related_files/Publications/2019_Publication_files/Health_Research_ Board_Annual_Report_2018.pdf.

HSC Public Health Agency (2018) 'Northern Ireland Cancer Patient Experience Survey 2018'| https://www.publichealth.hscni.net/publications/northern-ireland-cancer-patient-experience-survey-2018

Jacob, P., Chowdhury, T.A. (2015) 'Management of Diabetes in Patients with Cancer', Q J Med. 108: 443-448.

Jefford, M., Rowland, J., Grunfeld, E. et al. (2013) 'Implementing improved post-treatment care for cancer survivors in England, with reflections from Australia, Canada and the USA', British Journal of Cancer, 108, 1: 14-20.

Joint British Diabetes Societies for Inpatient Care Guidelines Group and UK Chemotherapy Board (2021) The management of glycaemic control in patients with cancer, London: Joint British Diabetes Societies for Inpatient Care.

Karjalainen, S., Palva, I. (1989) 'Do treatment protocols improve end results? A study of survival of patients with multiple myeloma in Finland', BMJ, 299(6707): 1069-72.

Lancet 'Progress in cancer survival, mortality, and incidence in seven high-income countries 1995-2014 (ICBP SURVMARK-2): A population-based study', The Lancet Oncology, 2019.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Ljungqvist, O., Scott, M., Fearon, K.C. (2017) 'Enhanced Recovery After Surgery: A Review'. JAMA Surg. Mar 1;152(3): 292–298. doi: 10.1001/jamasurg.2016.4952. PMID: 28097305.

Macfarlane, M. and Carduff, E. (2018) 'Does place of death vary by deprivation for patients known to specialist palliative care services?' BMJ Support Palliat Care, 8 (4).

Macmillan (2019) 'Prehabilitation Guidance for People with cancer', www.macmillan.org.uk/assets/prehabilitation-guidance-for-people-with-cancer.pdf.

Macmillan (2021) 'Statistics Fact Sheet' https://www.macmillan.org.uk/_images/cancer-statistics-factsheet_tcm9-260514.pdf

Macmillan Cancer Support (2020) 'Prevalence - People living with cancer '. https://www.macmillan.org.uk/_images/cancer-statistics-factsheet_tcm9-260514.pdf.

Macmillan Cancer Support (2020) Evaluation of Macmillan Information and Support Services in Northern Ireland, Rocket Science.

Majumdar, S.R., Roe, M.T., Peterson, E.D., Chen, A.Y., Gibler, W.B., Armstrong, P.W. (2008) 'Better outcomes for patients treated at hospitals that participate in clinical trials', Arch Intern Med. 168(6): 657–62.

Marie Curie (2018) 'Lost retirement: The impact on older people of caring for someone with a terminal illness' https://www.mariecurie.org.uk/globalassets/media/documents/policy/policy-publications/lost-retirement-the-impact-on-older-people-of-caring-for-someone-with-a-terminal-illness.pdf.

Marie Curie (2020) 'The vicious cycle of fuel poverty and terminal illness'. pdf https://www.mariecurie.org.uk/globalassets/media/documents/policy/policy-publications/2020/fuel-poverty-and-terminal-illness.pdf

McCormack, B. and McCance, T. (2017) Person-Centred Practice in Nursing and Health Care: Theory and Practice. Oxford: Wiley Blackwell.

Mullen, L. & Hanan, T. (2019) National Cancer Survivorship Needs Assessment: Living with and beyond cancer in Ireland, Dublin, https://www.hse.ie/eng/services/list/5/cancer/profinfo/ survivorship-programme/living%20with%20and%20 beyond%20cancer%20in%20 ireland.pdf.

Mulrooney, D.A. et al. (2009) 'Cardiac Outcomes in a cohort of adult survivors of childhood and adolescent cancer: Retrospective analysis of the Childhood Cancer Survivor Study cohort', BMJ 339: b4606.

Myelnoma: Diagnosis and Management, NICE Guideline NG35, 2016, https://www.nice.org.uk/guidance/ng35.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

National Cancer Action Team (2013) 'Cancer Rehabilitation, Making Excellent Cancer Care Possible'.

National Cancer Intelligence Network (2015) 'NCIN, Older People and Cancer (version 3)'.

National End of Life Care Intelligence Network (2012) 'Deprivation and death: Variation in place and cause of death'. https://www.scie-socialcareonline.org.uk/deprivation-and-death-variation-in-place-and-cause-of-death/r/a11G00000017z9GIAQ

National Institute for Health Research (2019) Annual Report 2019/2020 https://www.nihr.ac.uk/about-us/our-contribution-to-research/research-performance/12228_NIHR_Annual_Report_18_19.pdf

NHS (2011) 'Quality in Nursing Excellence in Cancer Care: The Contribution of the Clinical Nurse Specialist', https://www.england.nhs.uk/improvement-hub/wp-content/uploads/sites/44/2017/11/Clinical-Nurse-Specialists-in-Cancer-Care_Census-of-the-Nurse-Workforce_Eng-2011.pdf

NHS England (2018) 'Quick Guide: The role of allied health professionals in supporting people to live well with and beyond cancer. Transforming health, care and wellbeing with allied health professionals', London:Allied Health Professions team, https://www.england.nhs.uk/wp-content/uploads/2018/10/ quick-guide-ahp-cancer.pdf

NICE (2008) 'Diagnosis and management of adults at risk of and with metastatic spinal cord compression' http://www.nice.org.uk/CG75.

NICE, 2015, Suspected Cancer: Recognition and Referral https://www.nice.org.uk/guidance/ng12/resources

NICS 'National Institute for Health and Clinical Excellence, 2005, Improving Outcomes in Children and Young People with Cancer -The Manual' pdf. https://www.nice.org.uk/guidance/csg7.

Northern Ireland Department of Agriculture, Environment and Rural Affairs (2020) Clean Air Strategy for Northern Ireland – Public Discussion Document

Paice, J.A. (2011) 'Chronic treatment-related pain in cancer survivors', Pain, 152(Supplement): S84–S89.

Pilkey, J., Streeter, L., Beel, A., Hiebert, T., Li, X. (2012) 'Corticosteroid-induced diabetes palliative care', J Palliat Med. 15(6): 681–9.

Public Health Board HSCNI (2019)'Northern Ireland Cancer Patient Experience Survey 2018 All Trusts Report - Draft v0.3' https://www.publichealth.hscni.net/sites/default/files/2019-01/Northern%20Ireland%20Cancer%20Patient%20Experience%20Survey%202018%20All%20Trusts%20Report.pdf.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Queen's University Belfast (2018) 'Official Stats 2018' https://www.qub.ac.uk/research-centres/nicr/FileStore/OfficialStats2018/Factsheets2018/Filetoupload,957488,en.pdf.

Ruelen, R.C., Winter, D.L., Frobisher C. et al. (2010) 'British Childhood Cancer Survivor Study Steering Group. Long-term cause-specific mortality among survivors of childhood cancer', JAMA, 304(2): 172-9.

Santin, O., McShane, T., Hudson, P., Prue, G. (2018) 'Using a six-step co-design model to develop and test a peer-led web-based resource (PLWR) to support informal carers of cancer patients', Psycho-oncology https://doi.org/10.1002/pon.4969

Santin, O., Mills, M., Treanor, C., Donnelly, M. (2012) 'A comparative analysis of the health and wellbeing of cancer survivors to the general population', Journal of Supportive Cancer Care, 20,10: 2545-2552.

Santin, O., Murray, L., Prue, G., Gavin, A., Gormley, G., Donnelly, M. (2015) 'Self-reported psychosocial needs and health-related quality of life of colorectal cancer survivors', European Journal of Oncology Nursing, 24: 121-129.

Santin, O., Treanor, C., Mills, M., Donnelly, M. (2014) 'The health status and health service needs of primary caregivers of cancer survivors: A mixed methods approach', European Journal Cancer, Volume 23, Issue 3: 333-339.

Scottish Government, Chief Scientist Office (2018) 'Health Research Board Annual Report' https://www.cso.scot.nhs.uk/wp-content/uploads/CSO1819OTsummary.pdf 39.https://www.hrb.ie/fileadmin/2._Plugin_related_files/Publications/2019_Publication_files/Health_Research_Board_Annual_Report_2018.pdf.

Semple, C.J. & Lynas, C. (2018) 'Development, integration and evaluation of nurse- led follow-up across five tumour sites at a cancer unit in Northern Ireland', Cancer Nursing Practice, doi: 10.7748/cnp.2018.e1460.

Semple, C.J. & McCance, T. (2010) 'Parents' experience with cancer who have young children: A literature review', Cancer Nursing 33 (2) 110-118.

Semple, C.J., McCaughan, E. & Smith, R. (2017) 'How education on managing parental cancer can improve family communication', Cancer Nursing Practice 16, 34-40.

Seretny, M., Currie, G.L., Sena, E.S., Ramnarine, S., Grant, R., MacLeod, M.R., Colvin, L., Fallon, M. (2014) 'Incidence, prevalence, and predictors of chemotherapy-induced peripheral neuropathy: A systematic review and meta-analysis', Pain, 155(12): 2461-2470.

Smittenaar CR, et al. (2016) Cancer Incidence and Mortality Projections in the UK Until 2035. Brit J Cancer 115,1147-1155

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Tan, C MD & Denlinger C. MD (2018) American College of Cardiology Cardiovascular Toxicity in Cancer Survivors: Current Guidelines and Future Directions https://www.acc.org/latest-in-cardiology/articles/2018/06/29/12/57/cv-toxicity-in-cancer-survivors.

Teenage Cancer Trust (2022) https://www.iamportal.co.uk.

The New England Journal of Medicine (2020) 'Lung Cancer Screening and Nelson Trial', N Eng J Med 2020, 382: 2164-2166.

Treanor, C., Santin, O., Mills, M., Donnelly, M. (2012) 'Cancer survivors with self-reported late effects: Their health status, care needs and service utilisation', Psycho-oncology, 22: 2428-35.

UK Air Quality Expert Group (2019) Non-Exhaust Emissions from Road Traffic

UK Department for Environment, Food and Rural Affairs (2020) National Statistics - Emissions of air pollutants in the UK, 1970 to 2018 – Particulate matter (PM10 and PM2.5)

UK Department for Environment, Food and Rural Affairs (2020) National Statistics - Emissions of air pollutants in the UK, 1970 to 2018 – Particulate matter (PM10 and PM2.5) (https://www.gov.uk/government/statistics/emissions-of-air-pollutants/emissions-of-air-pollutants-in-the-uk-particulate-matter-pm10-and-pm25).

UKLCC, 25 by 25A ten year Strategy to improve lung cancer survival rates, 2016, https://www.uklcc.org.uk/our-reports/october-2016/25-25.

Waddell, G., Burton, A.K. (2006) Is work good for your health and well-being? London: The Stationery Office

Wales Cancer Network, http://www.walescanet.wales.nhs.uk/single-cancer-pathway

Walker, D.A. (2021) 'Helping GPs to diagnose children's cancer', British Journal of General Practise 2021; 71 (705): 151-152.

Walker, D.A. (2021) *Helping GPs to diagnose children's cancer* British Journal of General Practice 2021; 71 (705): 151-152 https://bjgp.org/content/71/705/151 https://www.cclg.org.uk/ChildCancerSupport.

Welsh Government (2020) 'Explore the Welsh Government's Final Budget 2020-2021' https://research.senedd.wales/research-articles/explore-the-welsh-government-s-final-budget-2020-21/.

Woods LM, et al.(2009). 'Large differences in patterns of breast cancer survival between Australia and England:a comparative study using cancer registry data'. International Journal of Cancer, 124, 2391-9.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Appendix 3: Glossary of Terms

Age Standardised
The rates are calculated by applying the age-specific rates for the location being studied to a theoretical world-wide standard population, usually expressed per 100,000 persons per year.

Adjuvant Therapy
Another treatment used together with the primary treatment. Its purpose is to assist the primary treatment. Also called adjunctive or adjunct therapy.

Benign
Not cancerous. Benign tumours may grow but do not spread.

Brachytherapy
A type of radiation therapy where a radioactive source is placed in or near a cancerous tissue.

Cancer Incidence Rate
The number of new cancers of a specific site/type occurring in a specified population during a year.

Cancer Prevalence
The number of people now living who have ever been diagnosed with cancer. It includes people diagnosed with cancer in the past as well those who were recently diagnosed.

Clinical Nurse Specialist or CNS
A clinical nurse specialist (CNS) is a nurse specially trained to provide expert advice on treatment and care for a particular type of cancer.
Colposcopy
A procedure that allows a physician to take a closer look at a woman's cervix and vagina. It is used to check for precancerous or abnormal areas.

Cytosponge
A single-use device used to collect cells from the lining of the oesophagus. It is known as a 'sponge on a string' pill test. Cytosponge consists of a spherical spongein a dissolvable capsule, which is attached to a thread.

Digital pathology
This means that pathology samples can be shared and interpreted in the digital environment, so samples such as biopsies can be reviewed anywhere and it allows greater flexibility in how we utilise our pathology staffing.

Endoscopy
A nonsurgical procedure used to examine a person's digestive tract using a long, thin, flexible tube called an endoscope.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Genomics
A discipline in genetics that applies recombinant DNA, DNA sequencing methods, and bioinformatics to sequence, assemble, and analyse the function and structure of genomes (the complete set of DNA within a single cell of an organism).

qFIT or the Faecal Immunochemical Test
A stool test designed to identify possible signs of bowel disease. It detects minute amounts of blood in the faeces and can help to identify patients who may be at risk of bowel cancer.

Haematological malignancies
Types of blood cancers

Health and Social Care Board (HSCB)
A statutory organisation that arranges or 'commissions' health and social care services for the population of Northern Ireland.

Holistic Needs Assessment (HNA)
A questionnaire that enables professionals involved in supporting patients to understand all of the care and support needs a patient might have from concerns about their physical health through to issues around emotional, spiritual and social support.

HPV or Human papillomavirus
A virus that can cause cervical and other cancers.

Immunotherapy
A treatment which uses the immune system to fight cancer. It works by helping the immune system recognise and attack cancer cells.

Invasive cancer
Cancer that has spread beyond the layer of tissue in which it developed and is growing into surrounding, healthy tissues.

KPI or Key Performance Indicator
A quantifiable measure used to evaluate the success of an organisation, employee, etc. in meeting objectives for performance.

Metastatic Cancer
The spread of cancer from the primary site to other places in the body.

Molecular Diagnostics
A technique used to analyse biological markers in the individual's genetic code in order to diagnose and monitor disease, detect risk, and decide which therapies will work best for individual patients.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Mortality rate
The number of deaths occurring in a specified population during a year, usually expressed as the number of deaths per 100,000 population.

Multidisciplinary teams
A group of healthcare workers who are members of different disciplines or professions each providing specific services to the patient.

Northern Ireland Cancer Network (NICaN)
This brings together Health and Social Care organisations, charities, cancer specialists and service users to improve cancer outcomes and experiences for patients.

Prehabilitation
The process of supporting patients to enhance their functional capacity or fitness ahead of treatment to enable them to cope with the treatment and to improve their outcomes after treatment.

Public Health Agency (PHA)
The major regional organisation for health protection and health and social wellbeing improvement.

Rapid diagnostic centres/hubs
These are designed to provide earlier and faster cancer diagnosis by providing a single point of access to diagnostic tests for all patients with symptoms that might suggest cancer.

Safety netting
This is about ensuring that there is a management system in place to ensure that patients receive the appropriate diagnostics and treatment in a timely way.

Stage of presentation
The stage at presentation describes the severity of a person's cancer based on the size and/or extent of the primary tumour and whether or not cancer has spread in the body.

Survival rate
The percentage of people in a study or treatment group who are alive for a given period of time after diagnosis.

Systemic Anti-Cancer Treatment (SACT)
The two main types of systemic therapy are chemotherapy (which uses drugs) and hormone therapy (which uses hormones). They can be given to increase long-term survival, control tumour growth and sometimes manage symptoms arising from the cancer.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Appendix 4: Abbreviations

ACE programme
Accelerate Coordinate Evaluate programme

ACP
Advance Care Planning

ADRT
Advance Decisions to Refuse Treatment

ADOG
All Departments Officials Group

AHP
Allied Health Professionals

AICC
The All Ireland Cancer Consortium

AOS
Acute Oncology Service

BAME
Black, Asian and minority ethnic

CAR-T
Chimeric Antigen Receptor T cell Therapy

CaPPS
Cancer Patient Pathway System

CCR
Cancer Care Review

COSD
Cancer Outcomes and Services Dataset

CPES
2018 Cancer Patient Experience Survey

CRUK
Cancer Research UK

DNACPR
Do Not Attempt Cardiopulmonary Resuscitation

CT scans
Computerised tomography scans

ERAS
Enhanced Recovery After Surgery

HDU
High dependency units

HNA
Holistic Needs Assessment

ICU
Intensive Care Unit

JCVI
Joint Committee on Vaccination and Immunisation

KPI or Key Performance Indicator

LINAC
A medical linear accelerator

LGBTQ+
Lesbian, gay, bisexual, and transgender queer and questioning

MRI Scan
Magnetic Resonance Imaging Scan

MSCC
Malignant spinal cord compression

MDMs
Multidisciplinary meetings

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

NCEPOD
National Confidential Enquiry into Patient Outcome and Death

NICaN
Northern Ireland Cancer Network

NCIN
National Cancer Intelligence Network

NICC
Northern Ireland Cancer Centre

NICTN
Northern Ireland Cancer Trials Network

NMSC
Non-melanoma skin cancer

NWCC
North West Cancer Centre

OST
Oncology Services Transformation Programme

PCiP
Palliative Care in Partnership programme

PET
Positron emission tomography

PROMs
Patient Reported Outcome Measures

PREMs
Patient Reported Experience Measures

PTC
Principle treatment centres

q-FIT
Faecal Immunochemical Test

SABR
Stereotactic Ablative Radiotherapy

TSR
Treatment Summary Records

WHO
World Health Organisation

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

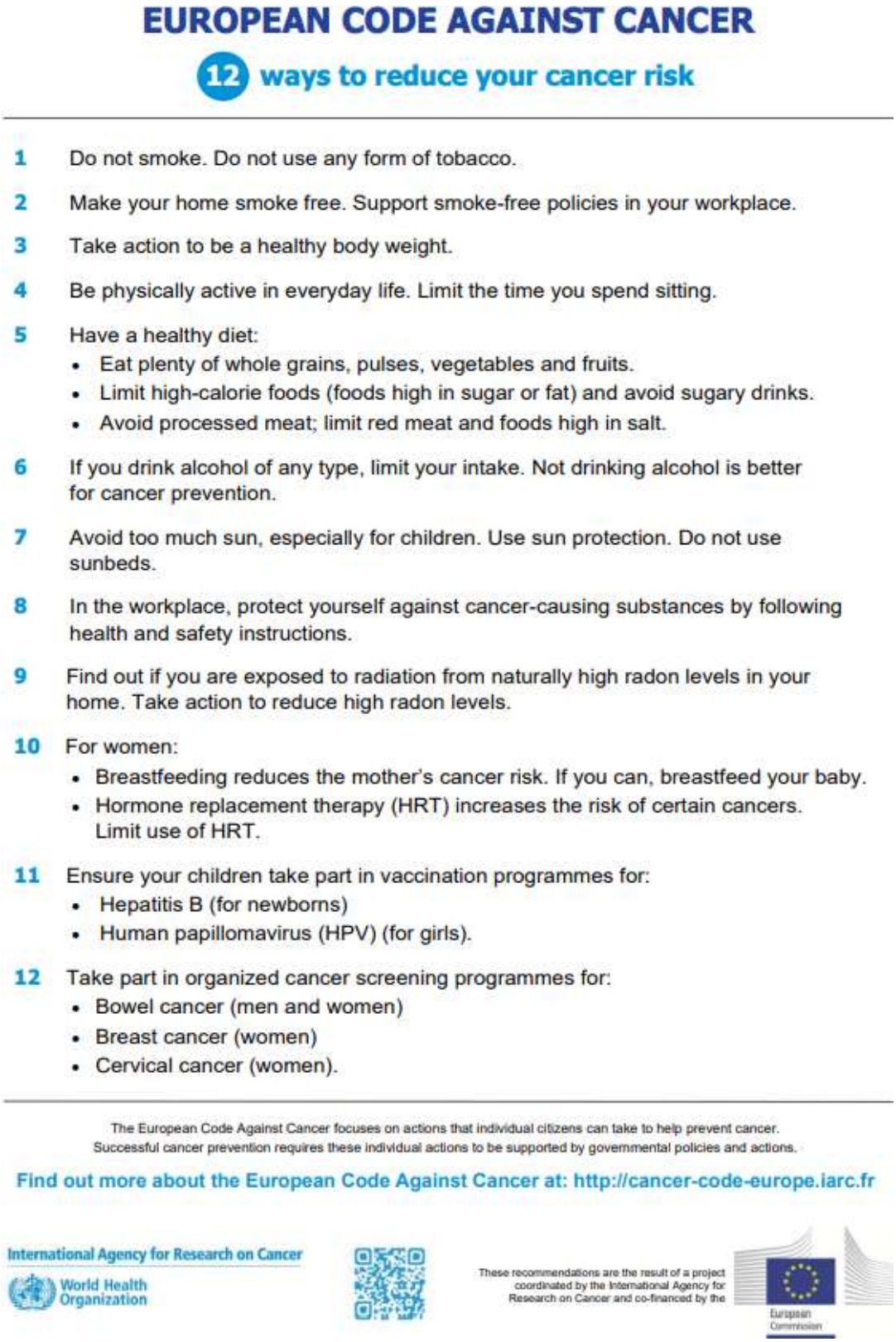
Appendix 5: Steering Group Members

Name	Organisation / Job Title
Charlotte McArdle	Chief Nursing Officer, Department of HealthChair
Brid Farrell	Public Health Agency, Public Health
Cathy Harrison	Chief Pharmacist, Department of Health
Dr Anna Gavin	Northern Ireland Cancer Registry
Dr Anne Kilgallen	Chief Executive Representative, WesternHealth & Social Care Trust
Dr Martin Eatock	Oncology, Belfast Health & Social Care Trust
Dr Miriam McCarthy/ Cara Anderson	Public Health Agency, Commissioning
Dr Naresh Chada	Deputy Chief Medical Officer, Department ofHealth
Dr Paul Molloy	General Practitioner Representative
Gay Ireland	Head of Cancer Policy/Cancer Strategy Project Manager, Department of Health
Heather Monteverde	Macmillan Cancer support/Chief NursingAdviser, Department of Health
Ivan McMinn	Lived with experience/ Co-chair
Joan McEwan	Marie Curie
Joanne McClean	Public Health Agency, Paediatrics
Loretta Gribben	Public Health Agency, Nursing
Margaret Carr	Cancer Research UK
Mary Jo Thompson	Nurse Manager, South Eastern Health &Social Care Trust
Michael Bloomfield	Chair of Northern Ireland Cancer NetworkBoard
Vivian McConvey	Patient Client Council

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Appendix 6: Diagrams

Figure 9: European Code Against Cancer - 12 ways to reduce your cancer risk



EUROPEAN CODE AGAINST CANCER

12 ways to reduce your cancer risk

1. Do not smoke. Do not use any form of tobacco.
2. Make your home smoke free. Support smoke-free policies in your workplace.
3. Take action to be a healthy body weight.
4. Be physically active in everyday life. Limit the time you spend sitting.
5. Have a healthy diet:
   - Eat plenty of whole grains, pulses, vegetables and fruits.
   - Limit high-calorie foods (foods high in sugar or fat) and avoid sugary drinks.
   - Avoid processed meat; limit red meat and foods high in salt.
6. If you drink alcohol of any type, limit your intake. Not drinking alcohol is better for cancer prevention.
7. Avoid too much sun, especially for children. Use sun protection. Do not use sunbeds.
8. In the workplace, protect yourself against cancer-causing substances by following health and safety instructions.
9. Find out if you are exposed to radiation from naturally high radon levels in your home. Take action to reduce high radon levels.
10. For women:
    - Breastfeeding reduces the mother's cancer risk. If you can, breastfeed your baby.
    - Hormone replacement therapy (HRT) increases the risk of certain cancers. Limit use of HRT.
11. Ensure your children take part in vaccination programmes for:
    - Hepatitis B (for newborns)
    - Human papillomavirus (HPV) (for girls).
12. Take part in organized cancer screening programmes for:
    - Bowel cancer (men and women)
    - Breast cancer (women)
    - Cervical cancer (women).

The European Code Against Cancer focuses on actions that individual citizens can take to help prevent cancer. Successful cancer prevention requires these individual actions to be supported by governmental policies and actions.

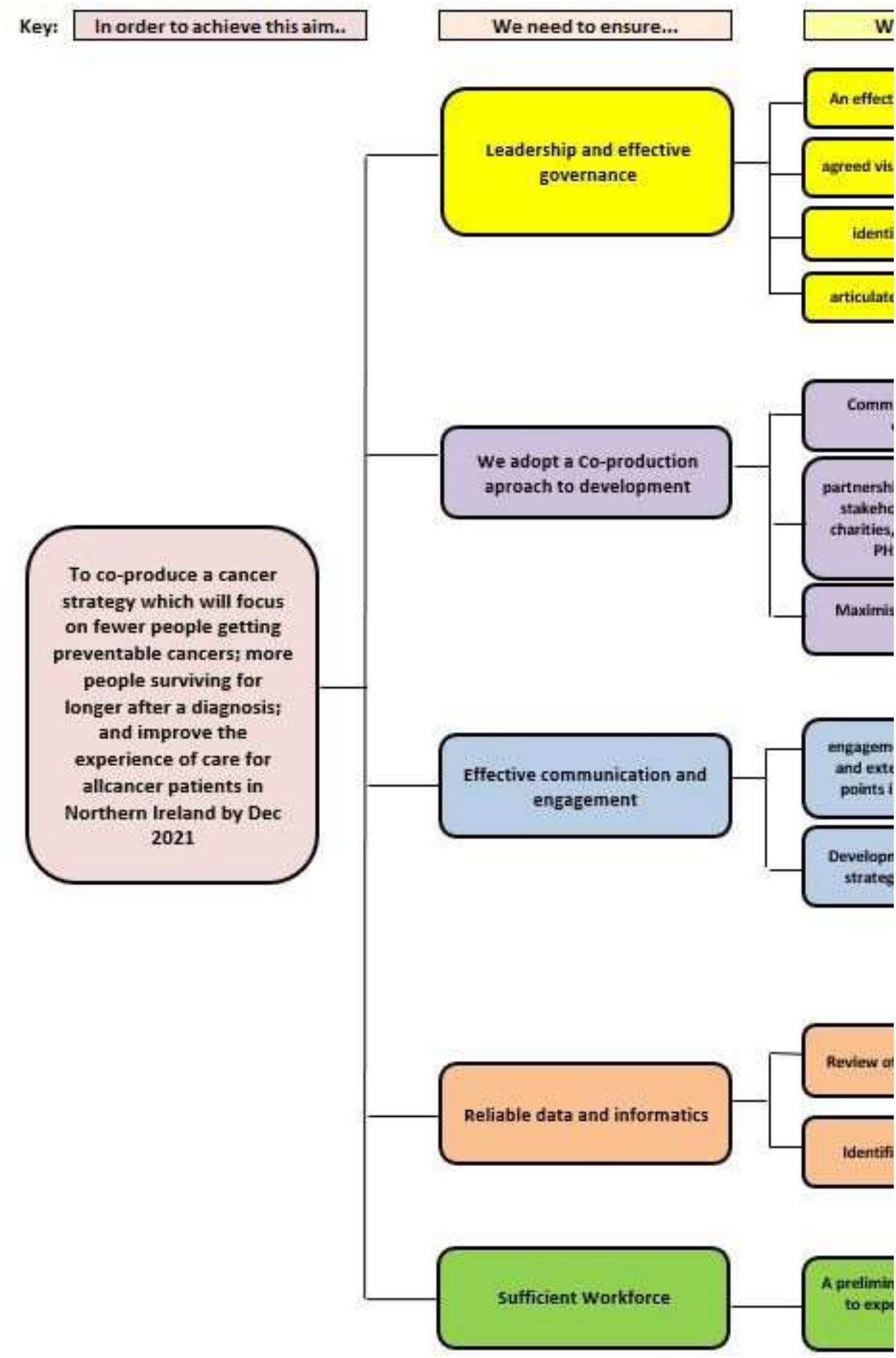
Find out more about the European Code Against Cancer at: http://cancer-code-europe.iarc.fr

International Agency for Research on Cancer
World Health Organization

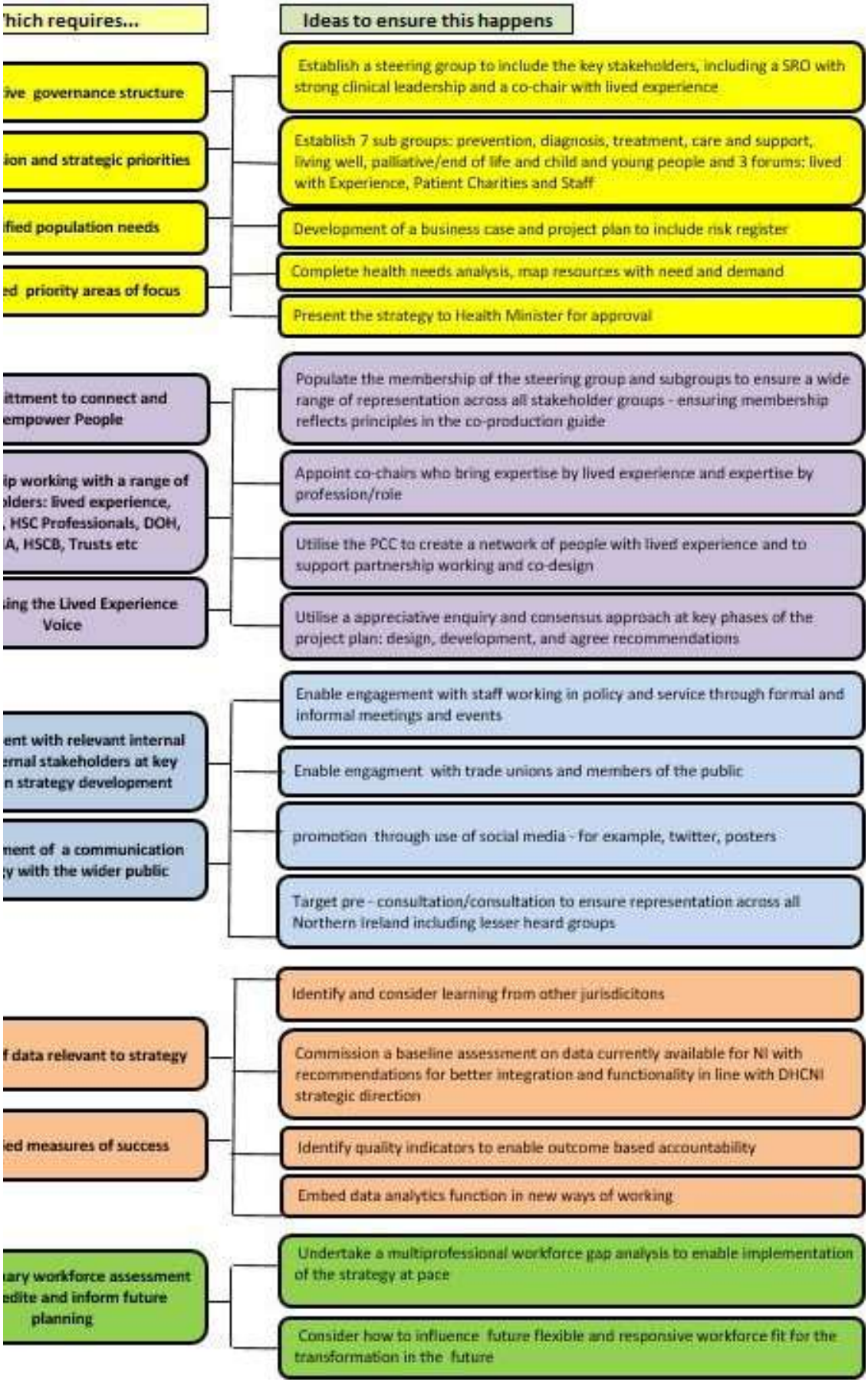
These recommendations are the result of a project coordinated by the International Agency for Research on Cancer and co-financed by the European Commission

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Figure 10: Driver Diagram 1 - Developing the Strategy



Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry



Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Review of General Surgery in Northern Ireland

Standards and a way forward



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

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

MINISTERIAL FOREWORD



Just over a year ago I commissioned a Review of General Surgery in Northern Ireland and set an ambitious deadline for completion of the Review by the end of June 2022.

The Review was established in response to challenges to the delivery of a safe and sustainable general surgery service for the population of Northern Ireland. As with other areas of care, there is significant variation in practice and in waiting times across the region and, specific issues relating to the requirement to maintain 24/7 rotas for emergency general surgery across multiple sites and the difficulties this creates in terms of staffing and meeting professionally mandated standards of care.

Currently we are not providing the best possible care for our patients. Whilst our surgeons and wider multi-disciplinary team do outstanding work, our systems are not providing them with the tools to do the best they can. This has led to people not receiving the care I would expect – something we must change going forward!

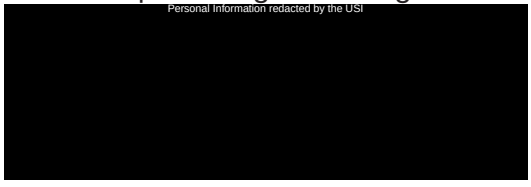
There is therefore an unassailable need for a new approach to ensure that general surgery, both emergency and elective, can be provided safely and sustainably.

The Bengoa report set a vision: "To create a fair and sustainable, including financially sustainable, Health and Social Care system that delivers universal, high quality, safe services that meet the Northern Ireland population's needs and which deliver world class outcomes for patients and service users."

I firmly believe that implementation of the standards and actions set out in the Review of General Surgery Report will be an important step on the journey to achieving this vision. This would mean our patients would have better services, with better outcomes for all – disregarding where they live. Implementing the standards will mean that our patients can receive a more precise diagnosis and potentially less invasive treatments.

I would like to thank all who were involved in the development of this Report – service users, clinicians and other stakeholders. I have been delighted by the level of engagement from the general surgical community which continues to be relentless in its pursuit for improved patient outcomes. This includes the Review's Chair, Professor Mark Taylor, whose enthusiasm and commitment has ensured that the challenging deadline for completion of the Review has been met.

We must now move ahead with the next phase of this journey – implementation of the standards and actions in the report. We cannot stand still. We owe it to our patients and staff to deliver the best possible general surgical service.



Robin Swann
Minister of Health

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

FOREWORD FROM CHAIR OF REVIEW – PROF MARK A TAYLOR



In June 2021, Minister Swann published an Elective Care Framework and commissioned an urgent review of General Surgery. Such a service review was very much in keeping with the findings of previous reports into the Health and Social Care Service in Northern Ireland.

It was a great honour to be asked to Chair this review on behalf of the Minister and Department of Health. The review process involved a project team, a number of work streams, an external critical friend, Mr Simon Patterson Brown, Consultant Surgeon Edinburgh Royal Infirmary and numerous engagements with Trust Chief Executives and other stakeholders.

It is particularly important to thank our service user representatives who have been involved with this project from its inception. Co-production is essential when addressing change and service redesign. I am extremely grateful to all the members of the service users group. Their collective voice has transferred over into actions found within this report.

In 2016, the Bengoa report “Systems not Structures” the issue of service redesign and rationalisation was discussed. The delivery of acute services in Northern Ireland, similar to many other parts of the UK, has been the focus of many previous reports. Workforce vulnerability, use of high costing locums, service user outcomes, subspecialisation, supporting services required to deliver modern emergency surgery; lack of training opportunity and the desire for a better work life balance, have all challenged the status quo. The Bengoa report summarised this as - no meaningful choice to make in terms of the redesign of acute services, the alternative is to see planned change or change prompted by crisis.

The review has been an extremely robust, evidence-based process and I am indebted to everyone involved in data collection, interpretation, evidence gathering and critical appraisal. One of the principle aims was to develop a set of standards for the delivery of emergency general surgery with the recognition that separation from elective practice greatly benefits both aspects of General Surgery. The landscape of emergency general surgery has changed in recent years within the UK. We do not have the General Surgeon of the past who was trained in all aspects of General Surgery. The future is all about subspecialisation with colleagues providing expert care in one part of General Surgery. Such subspecialisation has brought about the necessity to consider new ways of working (e.g. separating emergencies of an upper GI nature from emergencies of a lower GI nature). Similarly, modern emergency general surgery has much more dependency on the use of interventional radiology and other disciplines.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

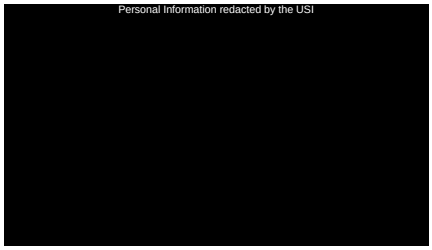
In elective surgical practice, there is an abundance of evidence for the creation of high volume centres of excellence, which are associated with a much better outcome for the individual service user and a fertile environment for training development of skills, and modernisation of practice. Another key aim of this review is therefore the creation of elective overnight stay centres of excellence. Such centres will not only address the required increase in capacity but also make significant inroads to the horrendous waiting lists.

We acknowledge from the work on day procedure centres that our public have graciously confirmed that they are willing to travel as long as they get the 'right treatment by the right person in a timely fashion'. This review also requires surgeons and other members of the multidisciplinary team to embark upon a different way of working.

This review should not be seen as a way of reducing hospital activity or lead to closure of a particular hospital. In order to deliver the very best of timely care we need our entire hospital infrastructure, whether that be an emergency centre or elective centre. The creation of a general surgical network will ensure that no matter where one lives in Northern Ireland they will have equal access to high quality care both in the emergency setting and in the elective setting.

Finally, it is critical that we as a society grasp this opportunity to use the evidence based standards and actions from this review to bring about a new system of general surgery in Northern Ireland. Such implementation has the potential to unlock the door to further reviews of surgical specialties all with the aim of ensuring that no matter where one lives in Northern Ireland they will have access to timely emergency and elective surgical care. Future proofing our health care system has never been more important.

I would like to take the opportunity to express my sincere thanks to the many individuals who have worked on the review of General surgery.



Mark A Taylor, Chair Of Review

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

INDEX

Ministerial Foreword 2
Foreword from Chair of Review – Prof Taylor 3
Index 5
List of Actions 6

1. Introduction 8
What is General Surgery? 8
Policy Context 9
Where General Surgery is currently delivered in Northern Ireland 10

2. The Burning Platform for General Surgery – The Case for Change 13
The Changing Landscape 13
Workforce Challenges 14
Separation of Scheduled and Unscheduled Care 15
Lack of appropriate Infrastructure 16
Increasing demands for service 16
Patient Pathways and Models of Care 18
Why do we need to change? 19

3. Emergency/Unscheduled General Surgery 21
Reviewing the Evidence and Setting Standards 22
What is the Impact of these Standards? 24
Implementation of the Standards 25

4. Elective General Surgery 27
Delivery of Elective Care 28
Standards for Elective General Surgery 29

5. Pre-operative and Post-Operative Care 32
The Development of Post Anaesthetic Care Units (PACU) for Northern Ireland 32
National, Regional and Local Context 33
Variation in Care 34

6. Paediatric General Surgery 35
Emergency Paediatric General Surgery 35
Elective Paediatric General Surgery 36

7. Workforce 38
Staffing levels 39
The Medical workforce 39
The Nursing Workforce 39
Skills Mix 40
Training 40

8. Making this Happen 41

9. Monitoring the Impact 42
Patient Experience 42
Quality and Safety of Care 42
Activity and Access to Care 42

10. Next Steps and Funding the Implementation 44

Annex A – Standards for Emergency and Elective General Surgery 45
Annex B – Effects of introducing new standards for general surgery 50

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

LIST OF ACTIONS

ACTION 1.

HSC Trusts to implement the standards for Emergency General Surgery (Annex A) at pace and work with the Department to develop co-produced implementation plans.

Primary Outcome: Regionally cohesive and comprehensive implementation with equity of provision for patients.

Consequential Outcomes: More efficient and effective service provisions, with higher activity levels and improved outputs. Better recruitment and retention of staff, improved rotas.

ACTION 2.

A). Trusts to develop a model for the delivery of complex and non-complex elective care informed by the implementation of the standards for emergency general surgery and elective surgery.

B). As part of implementation, Elective Overnight Stay Centres will be established in line with the wider elective care policy direction and the changing picture of health and social care delivery across Northern Ireland. In the initial phase – subject to Trust decision making processes and public engagement – we will consider the Mater Hospital as an initial site. We will also identify a further centre in the wider design plan intended to be published in the Autumn.

Primary Outcome: Regionally cohesive and comprehensive implementation with equity of provision for patients.

Consequential Outcomes: More efficient and effective service provisions, with higher activity levels and improved outputs.

ACTION 3.

As the model for elective general surgery is implemented there will be a focus on streamlined and consistent pre-operative assessment processes that follow best practice.

Primary Outcome: patient centred pre-operative assessment that ensures that patients are managed in the most appropriate setting to provide best patient outcomes.

Consequential Outcome: reduced elective cancellations.

ACTION 4.

PACUs will be established across Northern Ireland on a phased basis, initially in all DGHs undertaking complex surgery that meet agreed criteria. The PACUs will be ring fenced for elective care.

Primary Outcome: Better patient outcomes, shorter hospital stay, tailored care and less reliance on level 2 & 3 beds.

Consequential: Reduced elective cancellations.

ACTION 5.

BADS targets regarding the proportion of specific procedures which should be carried out as daycases will be used to compare daycase rates for specific procedures at a local and regional level and will be used to drive performance and efficiency.

Primary Outcome: Reduction in in-patient cases which will save bed days and lead to improved patient outcomes and patient satisfaction.

Consequential Outcome: Reduction in pressures on in-patient services meaning more efficient services, with an increase in the number of patients treated.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

ACTION 6.

Continued regional collaboration to rebuild elective paediatric lists.

Primary Outcome: Increase in elective paediatric general surgery activity with more patients being treated.

Consequential Outcome: Better joined up working will lead to more efficient processes with higher activity levels and better patient outcomes.

ACTION 7.

Continued support for the Child Health Partnership as it develops age appropriate pathways, training opportunities and models for delivery of paediatric surgery.

Primary Outcome: Better patient outcomes as the patients are treated by those with best knowledge and skills.

Consequential Outcome: Better joined up working will lead to more efficient processes with higher activity levels and better patient outcomes.

ACTION 8.

As part of implementation of the emergency and elective standards there will be a review of current surgical services in each Trust to ensure that workforce aligns with the new service model. This will cover medical, specialist nursing, AHP and pharmacy. Consideration will be given to the optimum skills mix required to deliver the new service model.

Primary Objective: Successful and sustainable delivery of the emergency and elective general surgery standards, with better patient outcomes.

Consequential Objective: A sustainable workforce that is content with the working environment, maximising the resource potential across the health and social care system.

ACTION 9.

Establishment of a Regional General Surgery Network to drive forward a multifaceted transformation programme for general surgery at a regional level, incorporating best practice from other parts of the UK.

Primary Objective: A network to drive regional cooperation and cohesion ensuring general surgery services are available on an equitable basis ensuring consistent good outcomes for general surgery patients.

Consequential Objective: A regional tool for co-production and co-design ensuring clinical staff buy in, with resultant better cooperative working and improved morale.

ACTION 10.

The Department of Health will develop an Integrated Dashboard for General Surgery made up of on the interlinked components of Patient Experience, Quality and Safety of Care; and Activity and Access to Care.

Primary Objective: Data and information to drive decision making to make sure that every decision is in the patient's best interests and will provide value for money.

Consequential Objective: Identification of areas where Northern Ireland is strong and areas where improvement can be made. This can be used as a learning tool across Northern Ireland and wider jurisdictions.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

1. INTRODUCTION

What is General Surgery?

General Surgery is a wide-ranging surgical specialty that focuses on diseases of the alimentary (digestive) tract. Over the years more sub-specialism has developed across general surgery; for example, colorectal surgery, upper gastrointestinal surgery etc. As one of the largest surgical specialties in the UK, general surgery plays a key role in the provision of elective and emergency care. As such, a sustainable general surgery service is a key element of delivering planned and unscheduled care in our acute hospitals.

Emergency general surgery relates to the treatment of patients presenting with acute abdominal pain, infections, bleeding, trauma and similar. It covers seven simultaneous areas of care:

1. undertaking emergency surgery at any time, day or night;
2. providing assessment and management of patients presenting with an acute surgical problem;
3. providing ongoing care to patients who have had surgery and to other patients in the hospital (including patients in hospital for other reasons and unexpectedly require surgical intervention);
4. undertaking further 'rescue' surgery for complications in patients who have recently undergone surgery, whether following initial planned (elective) surgery or after emergency surgery;
5. providing assessment and advice for patients referred from other areas of the hospital, other hospitals in the network and from their GP;
6. providing early and effective acute pain management and supervising out-of-hours palliative care; and
7. communicating with patients and their relatives[1].

One objective of this review is to differentiate elective surgery from emergency surgery. Elective general surgery means surgery that is planned in advance, as opposed to emergency or unplanned treatment. This can be multifaceted and the patient journey involves a number of different processes, including GP referral, outpatient appointment, diagnostic tests, pre-operative assessment, inpatient/daycase admission and outpatient post-operative review.

We also differentiate between care that is complex and less complex. Examples of less complex elective general surgery include the likes of inguinal hernia (normally a daycase surgery) and cholecystectomy (either day case or requiring a short stay in hospital). These surgeries are currently provided by all Health and Social Care Trusts. Examples of complex elective general surgery include oesophageal cancer, colorectal cancer and intestinal failure which all may require specialised equipment and teams that are not available at every hospital.

General surgery also relates to children and young people. In children, the most frequently performed emergency surgeries are appendicectomy, testicular conditions, treatment of obstructed hernias and abscesses. The most frequently performed paediatric elective surgeries are hernia repairs, testicular surgery, congenital abdominal surgery and intraabdominal cancer surgery.

1 https://www.rcseng.ac.uk/.../emergency-general-surgery.pdf

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Policy Context

In October 2016 the Department of Health launched 'Health and Wellbeing 2026: Delivering Together'[2], which seeks to radically reform the way health and social care services are designed and delivered in Northern Ireland. This overarching strategy for transforming the health and social care system in Northern Ireland focuses on person-centred care, rather than on buildings and structures. Through Delivering Together we aim to improve the health of our people, improve the quality and experience of care, ensure the sustainability of our services, support and empower staff; while also recognising the challenges that need to be overcome if this is to be achieved.

Delivering Together was the Department's response to the 2016 Bengoa Report[3], 'Systems Not Structures'. This report recognised that there was clear and unambiguous evidence to show that specialised surgeries, concentrated on a smaller number of sites and dealing with a higher volume of patients, led to improved outcomes. Continuing to invest large sums of money in trying to keep unsustainable services in place will only serve to delay their collapse and represents a significant opportunity cost to reforms elsewhere in the system. More importantly, it is critical that we ensure that the quality of care in terms of surgical outcomes, accessibility, cost and performance are as equitable across Northern Ireland as possible.

In June 2021 the Elective Care Framework[4] was published by Minister Swann. The framework sets out a five-year plan with firm, time bound proposals for how we will systematically tackle the backlog of patients waiting longer than Ministerial standards, and how we will invest in and transform services to allow us to meet the population demands in future.

In this review the focus has, therefore, been on the population of Northern Ireland. We have focused on how we can improve outcomes – to ensure a healthier population in general and to deliver high quality general surgery. As such, this review has been driven by systems, not structures.

2 Health and Wellbeing 2026 - Delivering Together | Department of Health (health-ni.gov.uk)
3 Systems, Not Structures - Changing Health and Social Care - Full Report | Department of Health (health-ni.gov.uk)
4 Elective Care Framework - Restart, Recovery and Redesign | Department of Health (health-ni.gov.uk)

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Where General Surgery is currently delivered in Northern Ireland

Adults presenting with acute and emergency general surgical symptoms are seen across Northern Ireland's five Health and Social Care Trusts. Prior to March 2022, there were emergency surgical units in eight hospital sites across these Trusts as highlighted in the map below. In March 2022, emergency surgical services were suspended at Daisy Hill Hospital (Southern HSC Trust), due to issues sustaining a consultant surgical rota. Emergency general surgical services are currently provided at all the remaining seven sites.

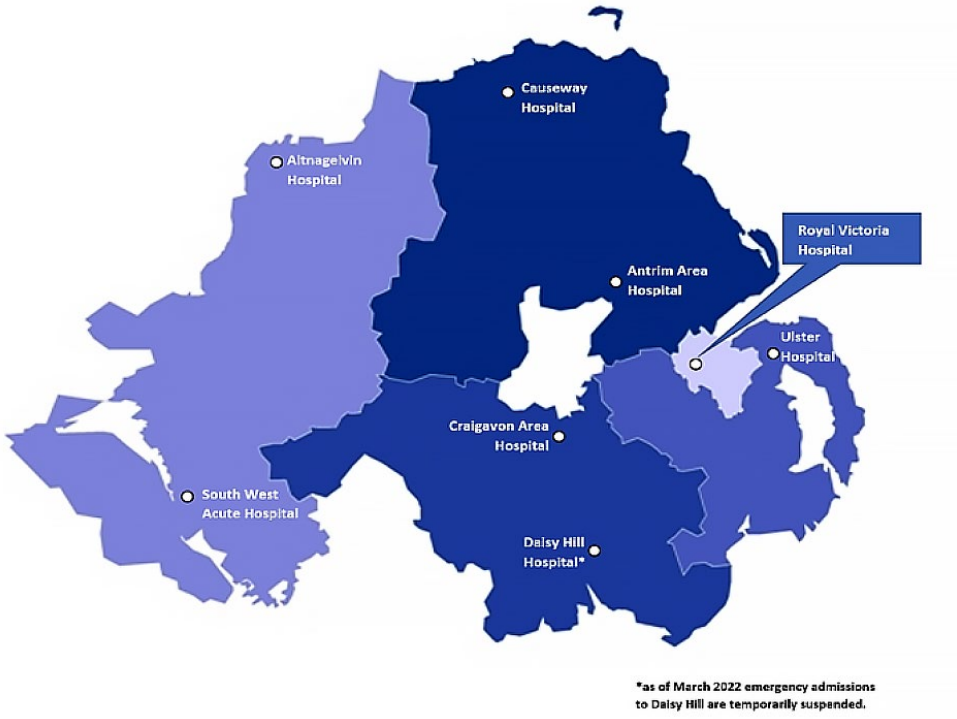


Figure 1: Map of hospitals admitting adult emergency general surgery admissions

Adult elective inpatient activity is undertaken in the larger hospital sites across the five Trusts. The Northern, Western and Southern Trusts have two inpatients sites in their catchment area – Antrim Area Hospital (AAH), Causeway Hospital (CAU), Altnagelvin Hospital (ALT), South West Acute Hospital (SWAH), Craigavon Area Hospital (CAH) and Daisy Hill Hospital (DHH) respectively, while the South Eastern Trust carries out its inpatient activity at the Ulster Hospital (UHD) site. The infrastructure of the Belfast Trust changed during the COVID-19 pandemic with inpatient services temporarily moving from the Mater Hospital (MIH) to Belfast City Hospital (BCH), leaving BCH as the primary elective inpatient site for the Trust.

Daycase activity also includes endoscopy and is provided on multiple sites across each Trust. Larger estates such as CAH, UHD and ALT have daycase procedure units on site, while other centres are used solely as daycase centres within each Trust – for example, Lagan Valley Hospital and Omagh Hospital are two sites which are used as regional daycase centres.

The management of acute and emergency paediatric patients is dependent on the age of the child and Trust of admission. There is, however, some variation across HSC Trusts. The Royal Belfast Hospital for Sick Children (RBHSC) accepts children of any age up to 16 with a surgical issue that cannot be managed at a local level. Approximately 80% of paediatric elective activity is daycase, the majority of which is undertaken in the Belfast and South Eastern Trusts, with inpatient activity predominantly taking place in RBHSC.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Table 1: Hospital sites and services provided for Adult General Surgery as of March 2022

Trust	Site	Emergency surgery	Elective Inpatient surgery	Daycase Procedures (Including endoscopy)	Surgical Outpatients
Belfast	RVH	X		X	X
	BCH		X	X	X
	MIH			X	X
Northern	AAH	X	X	X	X
	CAU	X	X	X	X
	WAH			X	X
	MUH			X	X
South Eastern	UHD	X	X	X	X
	LVH			X	X
	Downe			X	X
	Ards				X
Southern	CAH	X	X	X	X
	DHH		X	X	X
	STH			X	X
	Banbridge				X
Western	ALT	X	X	X	X
	SWAH	X	X	X	X
	Omagh			X	

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Table 2: Hospital sites and services provided for Paediatric general surgery

Trust	Site	Emergency admissions			Inpatient surgery	Daycase Procedures	Paediatric Surgical Outpatients
		0-5 y/o	5-14 y/o	14-16 y/o			
Belfast	RVH			X			X*
	RBHSC	X	X	X	X	X	X
Northern	AAH		X	X			
	CAU		X	X		X	X
South Eastern	UHD			X		X	X
Southern	CAH		X	X			
	DHH						X
Western	ALT		X	X		X	X
	SWAH		X	X		X+	

* 14-16 year olds

+ from May 2022

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

2. THE BURNING PLATFORM FOR GENERAL SURGERY – THE CASE FOR CHANGE

Northern Ireland has the worst waiting lists for surgery in the United Kingdom, with general surgery patients being in the top four of both those waiting longest, and the number of people waiting. The reasons for this are many and are not limited to general surgery – with waiting lists unacceptably long across all elective care services in Northern Ireland.

One of the underlying causes is the co-existence of elective and emergency/unscheduled care. It is, unfortunately, standard operational practice for elective surgery to be cancelled when there is an escalation of emergency/unscheduled service pressures in hospitals in which both elective and emergency/unscheduled services co-exist. There is evidence that cancellations occur in significant numbers of cases because:

- the bed for the elective patient is taken during the night by the emergency patient;
- there are no critical care beds available for the elective care patient; and/or
- the operating surgeon is unable to carry out elective surgery as they have been up all night dealing with an emergency.

Also, the changing management of the emergency/unscheduled patient, with greater reliance on interventional radiology, endoscopy and non-operative management has led to inequalities in the delivery of emergency general surgery, depending on where the individual lives and what capabilities the local hospital has. Other changes that impact on how services are delivered include focused specialisms, workforce challenges, increases in demand and infrastructure changes.

The Changing Landscape

There have been major changes in general surgery over the last two decades with delivery of care becoming much more sub-specialised and focused. With sub-specialisation, nearly every surgeon has a specific area of interest in their elective practice (for example, colorectal surgery, upper gastrointestinal surgery, endocrine surgery etc). Some general surgeons provide regional specialised surgery (e.g. oesophagogastric cancer surgery, hepatobiliary and pancreatic surgery, intestinal failure surgery), whilst others focus on the delivery of local elective and emergency general surgery.

The changing landscape of sub-specialisation has also influenced emergency surgery, with some centres splitting the emergency take into patients with upper gastro-intestinal (GI) conditions being looked after by upper GI surgeons, and patients with lower GI conditions being looked after by colorectal surgeons. Whilst this provides challenges, there are also benefits to the patients. For example, evidence exists that patients are more likely to avoid a long-term stoma when operated on by a colorectal surgeon.

Modern radiological intervention has also led to a greater multidisciplinary management of surgical patients – with enhanced patient outcomes. However, as a result, there is greater dependency on the interventional radiology service, 24-hour imaging, gastroenterology, anaesthesia, critical care, allied health professionals and clinical nurse specialists. This has led to shifting practices, where the management of some acute conditions has moved away from the option of major surgery, to alternative procedures such as radiological insertion of drains or stents (e.g. tube cholecystostomy, perforated colon abscess drain, colonic stents).

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Traditionally managed by surgical teams, gastrointestinal bleeding has now become the domain of gastroenterologists, with improvements in endoscopic management leading to the creation of bleeding rotas in some hospitals. Such advanced therapeutic endoscopic interventions, and the number of procedures required, have resulted in challenges for surgical trainees acquiring the recommended experience. Such issues will ultimately influence the future management of gastrointestinal bleeding.

Vascular and breast surgery were traditionally also the responsibility of general surgeons, but vascular surgeons have now formed their own specialty advisory committee (SAC). Increasingly in most Trusts, breast surgeons no longer take part in the general surgical take in rota, which has resulted in reductions in the numbers available for the cover of such rotas.

This significantly changes the staffing requirements when providing cover for 24 hour emergency/unscheduled care services – which in the past one general surgeon could do, now may require a combination of surgeons with different areas of interest. Similarly, seeking to achieve this balance through a reliance on e.g. the regular use of temporary locum staff, is neither sustainable nor resilient.

Workforce Challenges

Many general surgeons have specialised their practice in order to concentrate on treating particular conditions (for example breast and upper or lower gastrointestinal surgery). While this has resulted in improved outcomes for patients requiring planned specialist intervention, it has also created difficulties in having an appropriately trained and available surgical workforce for the treatment and management of emergency/unscheduled patients. Changes to the intercollegiate surgical curriculum, and the certificate of completion of training, have led to newly appointed consultants having less exposure to the generality of surgery, particularly in areas out with their specialised training.

The changing nature of surgical speciality means delivering emergency/unscheduled general surgery across multiple smaller sites with a lower patient turnover is becoming increasingly difficult in terms of rotas, succession planning, skill mix, supporting services and disciplines, best practice and maintaining quality care.

The problem of having a sufficiently skilled workforce at sites providing emergency/unscheduled care is not restricted to the smaller hospital sites, as larger sites are also experiencing difficulties maintaining rotas, albeit on a more limited level. Adding to the challenge, there are other specialties that often require input from emergency general surgery, such as gynaecology, gastroenterology and emergency medicine.

Sectors of the service have experienced significant challenges in the recruitment of staff and hence a heavy reliance on expensive locum and agency staff. Whilst such staff can provide excellent care, they invariably bring inconsistencies, can cause difficulties in continuity of care to patients, and can lead to problems with surgical training.

Another factor impacting on the workforce is a greater understanding of the importance of maintaining a healthy work life balance, and this has been supported by the implementation of the European Working Time Directive. Whilst this change in working practices is likely to create a healthier and better workforce, it also leads to challenges in surgical cover. It also provides issues for the training of new general surgeons. Currently trainees declare a sub-specialist interest as their training progresses (generally three years before the end of their training); however, compared to the past there is a reduction in overall training hours. This combination has resulted in newly appointed surgeons being less experienced in managing surgical emergencies outside their chosen sub-specialty. Therefore, for a newly appointed consultant it is important to be part of a cohesive surgical unit with good support and mentoring across a wide range of sub-specialities.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Fragmentation of the workforce is also an issue. Despite many attempts to break down silos, the workforce is still fragmented by organisational and professional boundaries. In the past decade, there have been numerous examples of one Trust recruiting to fill vacancies, only for the successful candidate to come from a neighbouring Trust, thereby creating another vacancy in the service. In practice, this simply serves to move the problem around Northern Ireland, rather than offering any additional capacity. To ensure good patient outcomes through a sustainable service, in the future there needs to be a greater level of regional planning when tackling workforce issues. The move to a single HSC employer as described in the Health & Social Care Workforce Strategy 2026 would be a key enabler for these changes.

Case study - Daisy Hill Hospital, Southern HSC Trust

As a result of ongoing consultant recruitment difficulties at Daisy Hill Hospital (DHH), in March 2022 the Southern HSC Trust determined that it would not be possible to deliver a safe emergency general surgery service on the site and that contingency arrangements would be needed. In response the Trust moved the delivery of emergency general surgery services from the DHH site to the Craigavon Area Hospital site.

This was an emergency temporary service change to ensure the delivery of safe and sustainable services. In developing plans for sustainable services, the Trust are considering the challenges noted in this chapter, and it is expected that the outcomes will align with this review.

The issue of retaining a consultant workforce is not unique to Daisy Hill Hospital as other hospitals across Northern Ireland are experiencing similar challenges. It is therefore more important now than ever to have a cohesive approach to general surgery with clear regional priorities and plans.

Separation of Scheduled and Unscheduled Care

There is invariably a conflict between scheduled (elective) and unscheduled (emergency) care. By nature scheduled care can be rescheduled if there is urgent need for unscheduled care. The effect where this manifests, results in long waiting lists and sub-optimal outcomes for patients requiring elective general surgery.

Before surgery can be carried out, a range of resources have to be brought together at the right time and the right place to ensure good patient outcomes which includes surgical staff, nursing staff, anaesthetic staff, theatre space and recovery/ward beds. Remove any one of these components and the surgery has to be cancelled. Where the same staff and resources are required to be available for both unscheduled and elective care, unscheduled care will always take precedence, with the inevitable result of cancellation for the elective patient.

Locally, nationally, and internationally, there are multiple working examples of how efficiently elective care can be provided where there is no competition from unscheduled pressures. Going forward finding solutions that avoid this conflict will be a priority.

Due to the interdependencies with other specialist services, such as critical care, it is difficult to fully separate the most complex elective general surgery from emergency/unscheduled care. However, every effort must be made to protect the beds associated with the elective practice. For the less

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

complex surgery to be as efficient as possible, there is a strong case for attempting to insulate the services from unscheduled care pressures within completely ring fenced environments.

In the COVID-19 environment the benefits of separating elective and unscheduled care for infection control purposes was even starker. The Elective Care Framework published in June 2021 outlines a series of actions to expand the implementation of 'green pathways and sites.' These pathways and sites strive to protect staff and patients from the potential risk of catching COVID-19. Examples of green pathways and sites, such as the Day Procedure Centre in Lagan Valley Hospital (LVH) demonstrated benefits for the wider system. While other sites had to downturn elective cases throughout each surge period, the Day Procedure Centre at LVH, continued to provide a range of priority surgical and diagnostic procedures for the region. This ensures good patient outcomes even in the most difficult of times.

Lack of appropriate Infrastructure

As general surgery has evolved, the need for a wider range of supporting infrastructure has developed. Some of our hospitals that are currently providing emergency/unscheduled general surgery may not have the supporting infrastructure to ensure the best patient outcomes. This may mean their continued provision of emergency general surgery may become unsustainable. For example, lack of access to 24/7 emergency CEPOD (Confidential Enquiry into Patient Outcome and Death) theatres, a lack of critical care capacity and limited access to diagnostic and interventional radiology support (particularly out of hours), often means that patients require transfer to larger hospital sites pre or post-surgery to meet their clinical needs. Delays in carrying out such activity may have an impact on the care delivered to the patient and the clinical outcomes. Such transfers may also lead to further demand on the Northern Ireland Ambulance Service (NIAS) and associated support services – further providing challenges to sustainability.

In some of our hospitals the delivery of emergency general surgery is also constrained by the available infrastructure – lack of beds, competition for emergency theatres and pressures of other specialties' clinical requirements (e.g. fractures, acute medicine, ward space and office accommodation). Going forward, appropriate reconfiguration of services and investment in infrastructure is required to optimise the space available for the delivery of a high-quality emergency general surgery service.

Increasing demands for service

Our population is changing, with increasing demand for hospital based services due to demographic changes, particularly an aged population with more chronic health problems and complex health needs. In simple terms, the longer we live, the more likely we are to require hospital treatment at some point in our lives. Demand for care has been outstripping the ability of the system to meet it for many years. Unless we take action to increase capacity – both in terms of activity and efficiency – we will not be able to meet the future needs of our population.

Before the pandemic there was already a significant shortfall in the capacity of the health and social care system in Northern Ireland to meet the demand for elective care services which was reflected in the unacceptably long waiting times. The spread of COVID-19 has caused serious disruption to our health and social care system and it was unavoidable that elective care activity would reduce due to the need to redeploy staff to address rising unscheduled/COVID-19 demand.

At the same time, our urgent and emergency services are continuing to face significant pressures and the number of acutely ill patients presenting to emergency departments and likely to require admission, is also increasing. Every emergency surgical service is experiencing an increase in

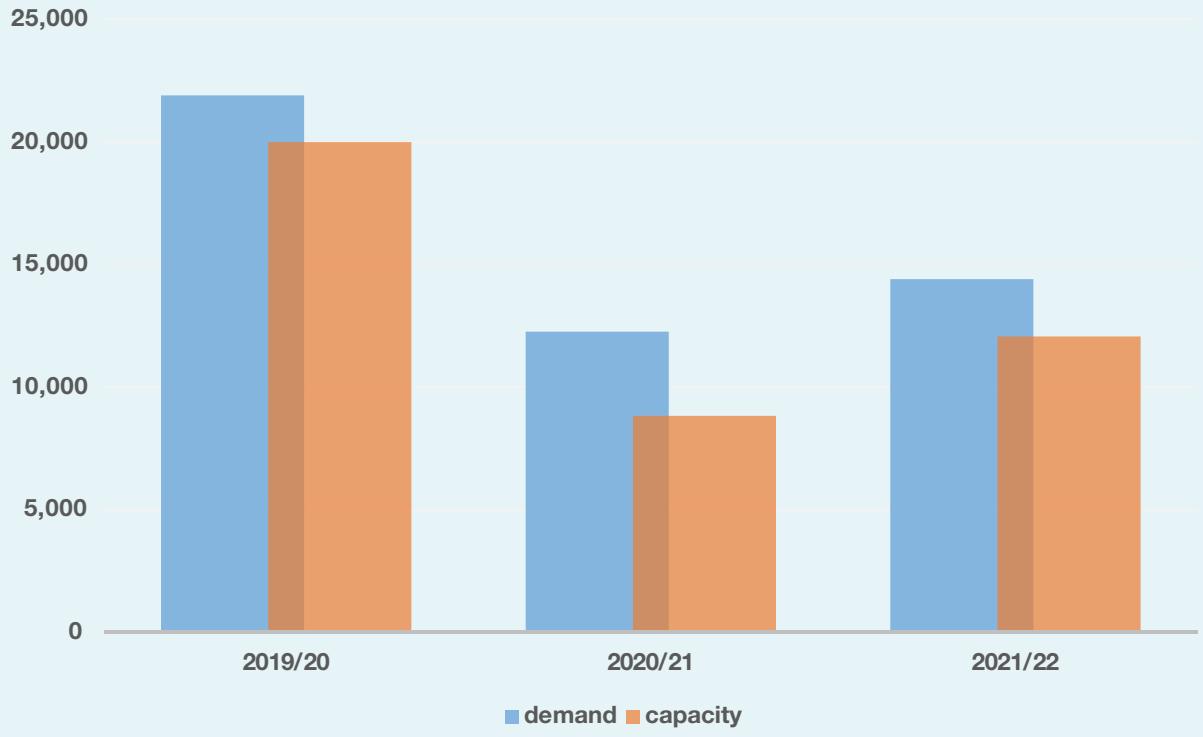
Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

admission of patients with ostensibly surgical disease who will not have an operation, as it is not appropriate given their circumstances (e.g. a bowel perforation in a very frail elderly patient in which best supportive care is required). Such pressure in the system results in planned elective surgeries being cancelled because hospital theatres, beds or staff are needed for urgent and emergency cases. The increasing waiting lists are also placing a burden on emergency departments as patients on these long lists present with complications relating to the condition that they are awaiting surgery for (e.g. recurring acute cholecystitis waiting for gallbladder surgery).

Over the last three years the number of people waiting for a general surgery outpatient appointment has grown by almost 70% from 28,400 to 48,000. Assuming demand has not increased since 2019/20 (the last full year before the pandemic) our general surgery outpatient activity has to increase by 140% just to ensure the waiting lists do not increase (using 2021/22 activity levels).

Similarly, the number of people needing inpatient day case general surgery far outstrip the available capacity. In 2021/22 there were over 2,300 patients more needing treatment than there was capacity – building on the already long waiting times. Comparing capacity in 2021/22 with pre-COVID demand the picture is even more serious, with 2021/22 capacity at 55% of 2019/20 demand – meaning a shortfall of 9,800 treatment sessions.

Figure 2 -Inpatient day case demand/capacity 2019/20-2021/22



Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Patient Pathways and Models of Care

Our data shows that almost 40% of people admitted for emergency general surgery go on to have no surgery. This raises the possibility that a proportion of patients could be managed through an alternative model of care not requiring admission. This would lead to better outcomes for patients, and would save bed days. A range of models exist across the UK, some have been in place for many years - others are more recent, and one size does not fit all. There are different terms that are used describe these models of care – surgical assessment, ambulatory, hot clinics and similar. This is used to describe the investigation, care, and treatment of patients on the same day who otherwise would have been admitted to hospital for one night or more[5].

There are some examples of such practice evolving in Northern Ireland but at different pace and scale depending on the Trust concerned. Therefore, even in terms of new models of care there is great variation. Going forward, we must ensure that there is consistency of practice throughout Northern Ireland and that only patients who need hospital inpatient care are in a hospital bed.

Case study

The Emergency Surgical Ambulatory Clinic was set up at the Royal United Hospitals Bath NHS Foundation Trust (RUH) for patients suffering from acute surgical problems to facilitate rapid diagnosis and access to surgery.

It operates as a clinic five days a week and provides a more ad hoc service at the weekend.

A pilot that took place in 2013 identified that 71% of patients were seen by a designated emergency consultant, diagnosed and discharged on the same day with a planned operating date. Only 5% of patients seen required admission. The consultant-delivered service reduces unnecessary hospital admissions and lengthy inpatient stays which has released approximately 90 bed days per month.

Patient satisfaction is high with 99% reporting they would be extremely likely or likely to recommend the service to friends and family if they needed similar care or treatment.

There have been no adverse clinical incidents in patients being managed on an ambulant basis.

5 www.ambulatoryemergencycare.org.uk

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Case study

The Emergency Surgical Unit (EmSU) at Antrim Area Hospital (AAH) was established in March 2020 to reduce inefficiencies and improve patient safety and experience in Emergency Surgical Care. It provides a 24/7 service for hospital and GP referrals and is using an electronic booking system to concentrate work in weekday daylight hours to facilitate effective planning of staffing resources.

The EmSU includes a consultant led ambulatory hot clinic between 09.30 and 12.30 5 days a week which has also provided medical students with learning opportunities and increased contact with consultants.

Data on staff and patient experience is not available yet however the indications are that the EmSU has been well received by staff and patients. The EmSU has increased patient outcomes and produced significant efficiencies including improving zero day length of stay from 5% to 35 % and a 48 hour reduction in average length of stay.

Why do we need to change?

The current model for delivering general surgery in Northern Ireland is neither sustainable nor providing uniformly high-quality care. Going forward we need to ensure that the system is person centred with a focus on patient outcomes – with services structured around the needs of those who require care and treatment.

The Bengoa report and Delivering Together clearly stated that the stark options facing our health and social care system was to either resist change and see services deteriorate to the point of collapse over time – with poor patient outcomes – or embrace transformation and work to create a modern, sustainable service that is properly equipped to help people stay as healthy as possible and to provide them with the right type of care when they need it – with improved patient outcomes as a result. The latter is already happening in general surgery and we need to ensure, through this review, that it continues to do so.

Going forward, we must accept that the current approach does not provide the best care for patients and is inefficient. Stretching staff resources to maintain emergency surgery on too many sites leads to an over-reliance on locums, increased pressure on small teams, short term decision making and services vulnerable to collapse at short notice. This puts further pressure on health and social care services and impacts on our ability to deliver safe and effective care to our population.

Going forward, it may be necessary to focus resources on specialist sites – to ensure that the patient need is always at the centre. This means:

- Patients are seen in the right place and by the right person as soon as possible – thus improving the patient outcomes;
- Staff have the necessary support and equipment to allow them to deliver the highest quality care to patients – thus improving patient outcomes;
- It is possible to attract and recruit sufficient staff to deliver a safe, high quality, 24/7 service – thus maintaining patient outcomes;

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

- The services are more stable and there is a better environment for patients and staff; there are the right conditions for professional development, quality improvement, leadership, teaching and other activities that are essential to a vibrant workforce expert in delivering care to acutely unwell patients – thus improving patient outcomes;
- There is capacity for research and a greater ability to engage with academia and industry in generating new solutions and accelerating testing, adoption and introduction of existing solutions – thus improving patient outcomes; and,
- This achieves the triple aim of better population health, better quality care and better use of resources – thus improving patient outcomes[6]

It is also clear that any changes to service configuration must be carefully planned, through joined up implementation projects which are fully co-produced and subject to public scrutiny, as they may have implications for other services in hospitals. The availability of, or access to, 24/7 surgical services is a key aspect of the safe provision of acute adult and paediatric services. While this underlines the importance of sustainable general surgery teams at District General Hospitals, it also underlines that the unplanned collapse of a vulnerable general surgery service could have implications across other hospital services. If services remain vulnerable to short term collapse, there is therefore a cumulative risk with regard to the impact this could have on other services.

If there are changes to service reconfiguration as part of implementation of this review, it is essential that we learn from the experience of reforms in other regions in terms of how other non-surgical acute services can be retained, and how we get the best out of our hospitals – whether they retain emergency general surgery or become specialist elective sites supported by general surgeons but without surgical emergencies.

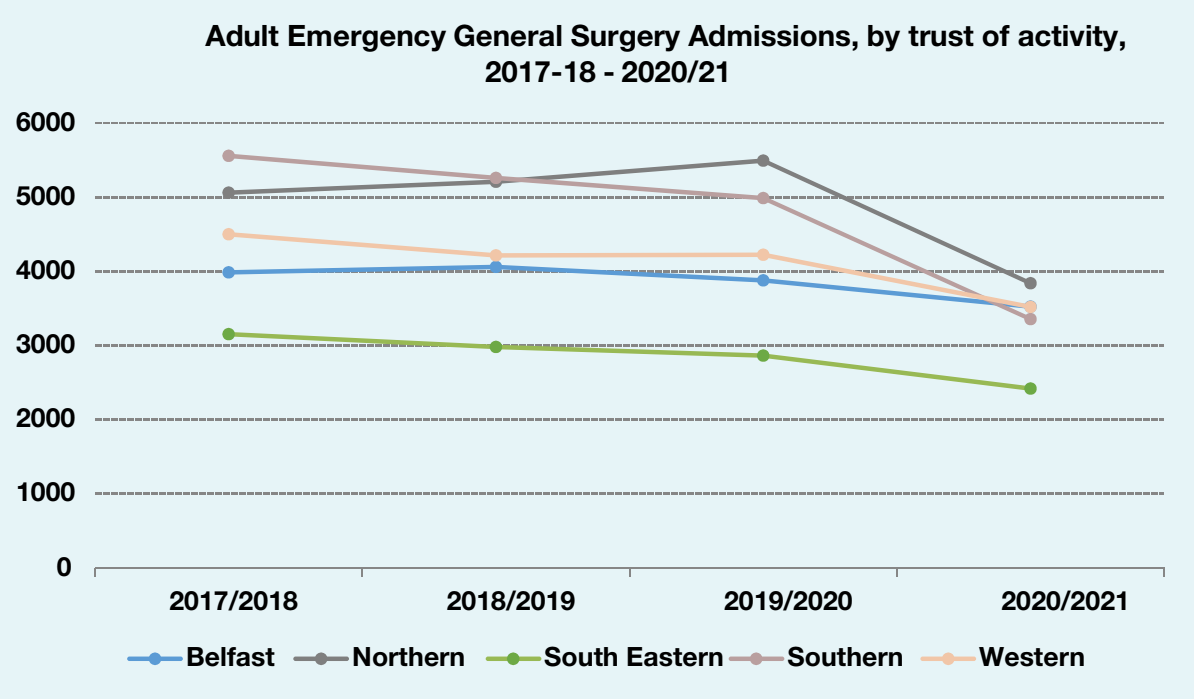
6 Systems, not structures - Changing health and social care - Full Report (health-ni.gov.uk)

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

3. EMERGENCY/UNSCHEDULED GENERAL SURGERY

In the years 2017/18 – 2019/20 there were approximately 21,800 emergency adult general surgery admissions per year across Northern Ireland. Emergency general surgery services continued to be accessible throughout the COVID-19 pandemic. However, despite this it should be noted that during the COVID-19 pandemic there was a decrease in admissions. Figure 3 shows the number of admissions per year in each Trust.

Figure 3: Number of adult emergency general surgery admissions by trust of activity, 2017/18 - 2020/21



The most common emergency general surgery 'procedure' is CT imaging (and this is an investigation not surgery), which accounted for 27% of all procedures. The most common surgery was appendicectomy, which accounted for 6% of all procedures. Approximately 35-40% of people admitted under emergency general surgery have no surgical procedure. Table 1 shows the most commonly performed emergency general surgical procedures in 2020/21 across all Trusts.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

	Total	
Procedure	No.	%
No procedure*	6144	37%
CT scan	4376	27%
Appendicectomy	1055	6%
MRCP	673	4%
Upper GI endoscopy	465	3%
Drainage of perineal or perianal abscess	414	3%
Excision of gall bladder	328	2%
Hernia repair	314	2%
ERCP	250	2%
Lower GI endoscopy - sigmoidoscopy	240	1%
Drainage of skin lesion	182	1%

Table 3: Primary procedures carried out during adult emergency general surgery admissions, all trusts, 2020/21. *Excludes laboratory and ultrasound investigation

Reviewing the Evidence and Setting Standards

In this document we have highlighted the burning platform for general surgery in Northern Ireland and articulated the clear case for changing the way in which we deliver both emergency and elective general surgery. This is needed to ensure good patient outcomes.

We have highlighted the workforce issues associated with maintaining expertise across multiple sites and, in particular, the impact that this has had in the Southern HSC Trust where emergency general surgery has been temporarily removed from Daisy Hill Hospital to ensure patient safety through safe and sustainable service provision. The deficiencies in the perioperative nursing workforce also compound the difficulties faced.

We have set out the need for an elective/emergency split to drive efficiency and we have articulated the changing landscape for delivering general surgery and the interdependencies that are required to deliver a safe service. Our data also shows that our current emergency general surgery service delivery model is not efficient and around 40% of patients do not go on to have surgery.

We have highlighted the need for alternative pathways such as surgical assessment and ambulatory clinics to save bed days and improve patient outcomes.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Case study

A frail 87 year old lady with multiple co-morbidities including heart and kidney disease and poorly controlled diabetes is admitted into the surgical ward with a diagnosis of acute cholecystitis (inflammation of the gallbladder). She is extremely sore and has a high pulse rate and temperature.

Ultrasound shows a very thickened gallbladder with a large stone in it. There is definite evidence of severe acute cholecystitis.

She is not fit for emergency surgery to remove her gallbladder and it is clear from the findings that she requires an urgent tube cholecystostomy (interventional radiological (IR) insertion of a tube into the gallbladder to relieve infection) as well as prompt intravenous antibiotics.

Unfortunately the hospital in which she was admitted to does not have IR support which limits the options to: a) attempt surgery which is extremely high risk; b) arrange transfer to another site for IR tube cholecystostomy placement, which is also high risk; or c) attempt to manage this situation with antibiotics alone with high risk of a poor outcome.

The lack of appropriate services does not serve the patient's need effectively, and is evidence of services focused on structures, not systems and good patient outcomes.

The evidence base for this review has been established with reference to guidance from the Royal Colleges, Association of Surgeons of Great Britain and Ireland (ASGBI), CEPOD, Nuffield Trust and NHS organisations including Getting It Right First Time (GIRFT), regulatory bodies and benchmarking programmes.

The evidence articulates the standards required for a safe and effective emergency general surgical service, as well as describing the restructuring of general surgical services in Trusts across the UK.

We have used this evidence as the basis to develop a set of clinical standards for the delivery of emergency general surgery in Northern Ireland. In light of the challenges articulated in this review, going forward these standards must be in place in hospitals receiving emergency general and paediatric surgery patients to ensure safe outcomes for patients through the delivery of high quality, sustainable and equitable care for the people of Northern Ireland wherever they live.

These evidence based standards have been developed and refined with input from all general surgeons in Northern Ireland, other clinicians, HSC Trusts, managers and service users.

The standards are built around six areas, and are attached at Annex A.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

1

Model of Emergency Surgical Care

The model for how emergency general surgery must be delivered on a hospital site to provide a safe and efficient service for patients and to optimise patient outcomes.

2

Clinical Infrastructure

The resources, equipment and services required to deliver a safe and efficient emergency general surgery service for patients and optimise patient outcomes.

3

Clinical Interdependencies

The services that must be in place to support the delivery of a safe and efficient emergency general surgery service for patients and optimise patient outcomes.

4

Workforce

The emergency general surgery rota must be of a sufficient size and be sustainable with access to sufficient training opportunities.

5

Process and Protocols

The process and protocols that must consistently be in place on or across hospital sites to deliver a safe and efficient emergency general surgery service for patients and optimise patient outcomes.

6

Quality Assurance

The assurance processes that must be in place to monitor and measure a range of indicators to drive a safe and efficient emergency general surgery service for patients and optimise patient outcomes.

What is the Impact of these Standards?

The standards must be used to drive regional and local decisions on the future delivery of emergency general surgery in Northern Ireland.

Some hospitals will be able to meet these standards with developments within their existing footprints and within existing budgets. However, some hospitals will not meet these standards as currently configured. This means a higher standard of care will be delivered by reconfiguration of service delivery and cross-organisational working. The result may be a change in provisions – to ensure better patient outcomes.

More detail on the effects of introducing the standards is set out at Annex B.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Implementation of the Standards

The Department will work closely with Trusts to implement the standards and to develop reconfiguration/implementation plans where required. This work will be fully co-produced and will include consultation and engagement as necessary.

Service users have been part of the review process from the outset and their continued involvement will be pivotal as implementation progresses.

Implementation will be informed by data, including case numbers, surgical procedures and associated bed days to model and understand the impact of proposed changes on other hospital sites and Trusts.

The implementation of the standards will also drive forward changes to ways of working at a regional level. For example, during the engagement on standards, clinicians raised the need for a regionally agreed protocol on the treatment of head injuries for both adults and children. As a consequence of this, work is now underway to develop a regional paediatric head injury pathway. The standards also provide an opportunity for work at a regional level to explore and streamline the interfaces between emergency general surgery and other specialties such as trauma and orthopaedics, urology etc.

The development of the standards also flagged the need for the HSC to join the National Emergency Laparotomy Audit (NELA). This is a data gathering audit that collects data on compliance with standards, and provides trusts with benchmarked reports on their compliance and performance. The findings of this audit therefore drive patient safety and quality. This has now been taken forward and regional membership of NELA is being progressed.

The growing demand for elective general surgery procedures means that any reconfiguration cannot mean a reduction in bed capacity. The review is not seeking any hospital or bed closure – merely to ensure best patient outcomes, even if this may mean some change in how services are provided.

Simon Paterson-Brown (Consultant General Surgeon in Scotland), who was involved in the re-organisation of emergency general surgical services in Lothian several years ago and who is a 'critical friend' to the review, has often quoted that "fixing the emergency surgical service will automatically lead to an enhanced elective surgical service". Therefore, implementation of these standards will also shape how elective general surgery is delivered in Northern Ireland. Going forward, implementing the standards will facilitate the separation of emergency and elective surgery and, as such, will create and protect more capacity for elective care – with better patient outcomes across the whole general surgery spectrum.

ACTION 1.

HSC Trusts to implement the standards for Emergency General Surgery (Annex A) at pace and work with the Department to develop co-produced implementation plans.

Primary Outcome: Regionally cohesive and comprehensive implementation with equity of provision for patients.

Consequential Outcome: More efficient and effective service provisions, with higher activity levels and improved outputs. Better recruitment and retention of staff, improved rotas.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Case Study

Over the period 2000 – 2005 the Lothian Region in Scotland improved surgical services by introducing infrastructural changes which addressed rota, recruitment, retention, and training problems. Three of its four hospitals provided 24 hour on call cover.

This was reduced to two with the third site retaining A&E and a surgical presence from Monday to Friday for daycase/elective overnight stay procedures, clinics, endoscopy and GP/A&E. Triage criteria was established with patients requiring surgical admission transferred to one of the two main hospitals and ambulances bypassing smaller hospitals with trauma and obvious surgical problems.

This reconfiguration has provided a better environment for training and retention of expertise for consultants, better care of complex patients, and better access to day surgery in outreach sites.

The introduction of a hot clinic for acute referrals has led to a significant reduction in patients requiring admission to hospital. Only about 40-50% of surgical referrals need admission and only 25% of admissions require surgery.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

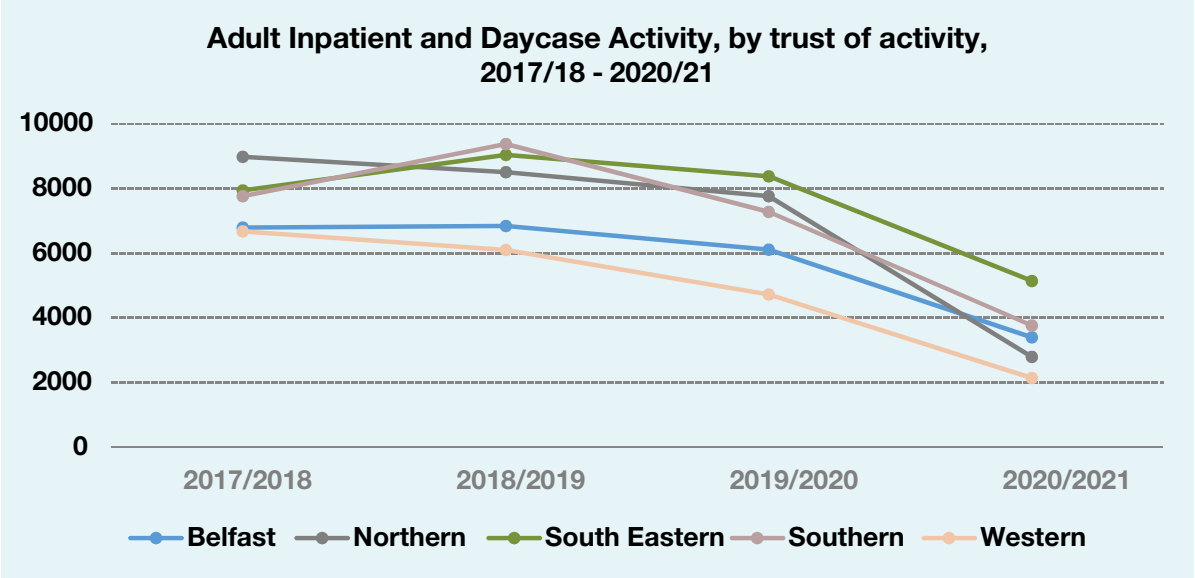
4. ELECTIVE GENERAL SURGERY

There is a significant shortfall in the capacity of the HSC in Northern Ireland to meet the current demand for elective care services and this is reflected in the unacceptably long waiting times.

With regards to general surgery, as of March 2022 there were approximately 5,500 patients awaiting inpatient elective surgery, 66% waiting more than 52 weeks. As of March 2022 there were almost 19,000 patients awaiting daycase elective surgery, 57% waiting more than 52 weeks. As of March 2022 there were 24,000 patients awaiting a new consultant-led outpatient appointment, 49% waiting more than 52 weeks.

During the COVID-19 pandemic, elective and diagnostic services were curtailed as staff and resources were necessarily redeployed to support unscheduled/COVID-19 pressures, with adverse impacts on our existing waiting lists. Figure 4 shows the decline in the number of Inpatient and Daycase (IPDC) cases per Trust in adults over the pandemic.

Figure 4 Number of adult inpatient and daycase attendances, by Trust of activity, 2017/18 - 2020/21



Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Delivery of Elective Care

A key component of ensuring good patient outcomes and an efficient, cost effective, high quality, patient centred elective surgical service is the principle that the patient is treated in the most appropriate setting, at the right time, by the right person, with as short a stay as possible. All elective care patients should therefore be cared for in a setting appropriate to their clinical needs. No matter where they live in Northern Ireland, patients require equitable access to all levels of elective general surgery in a hospital facility that has the appropriate infrastructure to meet clinical need.

Across the region, this includes models for:

- Complex inpatient surgery and surgery for patients with a high risk of morbidity and mortality – where patients require a longer recovery period and a lengthier stay in hospital;
- High Volume, Intermediate Complexity surgery at elective overnight stay centres - where the nature of the surgery or the patients' clinical circumstances mean they may require one (or more) overnight stay in hospital; and
- High Volume Daycase Surgery - at day procedure centres - for lower complexity procedures and lower risk patients that do not require an overnight stay.

Case Study

A patient needs their gallbladder removed for biliary colic. They are a 35 year old female weighing 65kg and have no other medical conditions.

They are considered clinically suitable for a laparoscopic cholecystectomy (a minimally invasive surgery to remove the gallbladder).

They have been pre-operatively assessed as suitable for daycase surgery. They undergo the surgery with no complication and are discharged on the same day.

Case Study

A patient needs their gallbladder removed for recurrent cholecystitis. They are a 69 year old female with a BMI of 35 and they are an ex-smoker.

They have been reviewed in a surgical outpatient clinic and are suitable for a laparoscopic cholecystectomy. They have been pre-assessed and given their weight and smoking history were felt too high risk for daycase surgery and a period of observation following anaesthesia was advised.

They underwent their surgery in a facility providing 24 hour care. The surgery itself was uncomplicated and the patient had a planned overnight stay for observation. They were reviewed the following morning and were suitable for discharge.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Case Study

A patient needs their gallbladder removed due to cancer of the gallbladder. They are a 54 year old female with a normal BMI and mild hypertension.

They have been reviewed in the surgical outpatient clinic, discussed at a regional MDT and undergone pre-assessment.

Due to the nature of surgery required and the specialist input needed this patient requires an inpatient admission. They undergo their surgery and are suitable for discharge on day 3 post-op.

The current approach to delivery of elective care in Northern Ireland is inefficient, and elective surgery is often a casualty of this, as resources are channelled into responding to unscheduled demand resulting in last minute cancellations.

Elective Care Centres are designed to provide a dedicated resource for planned surgery/procedures and are a means to increase productivity, efficiency and reliability of the service. Crucially, they operate separately from emergency hospital care – meaning they will not be competing for operating rooms, staff and other resources, leading to fewer cancellations of operations. These centres can be in hospitals away from the emergency/complex elective surgery work.

Regional day procedure centres (DPC) providing general surgery are already in place at Lagan Valley Hospital and, more recently, Omagh Hospital. Since October 2020 the DPC has treated over 2500 regional patients across a range of specialties including plastic surgery, Ear Nose & Throat, General Surgery, Breast Surgery, Urology and Ophthalmology. Going forward we will expand the centre model to also include regional elective overnight stay centres.

Standards for Elective General Surgery

In line with the Emergency General Surgery Standards, we have developed a set of standards to help inform planning and to shape the delivery of elective general surgery. There is more flexibility around these standards as they relate to both complex and non-complex elective surgery across the range of elective settings.

The standards are attached at Annex A and are built around similar areas to the standards for emergency general surgery.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

1

Model of Care

The model for how elective general surgery must be delivered on a hospital site to provide a safe and efficient service for patients and to optimise patient outcomes.

2

Clinical Infrastructure

The resources, equipment and services required to deliver a safe and efficient elective general surgery service for patients and optimise patient outcomes.

3

Clinical Interdependencies

The services that must be in place to support the delivery of a safe and efficient elective general surgery service for patients and optimise patient outcomes.

4

Workforce

The workforce that must be in place to support elective general surgery and access to sufficient training opportunities.

5

Process and Protocols

The process and protocols that must consistently be in place on or across hospital sites to deliver a safe and efficient elective general surgery service for patients and optimise patient outcomes.

As Trusts develop their plans to implement the standards for emergency general surgery this will drive and inform decisions around elective general surgery. For example, a hospital that does not provide a 24hr emergency general surgical services can still have an emergency department and be a busy elective centre. Therefore, a higher standard of care can be delivered by reconfiguration of service delivery and cross-organisational working and lead to better patient outcomes.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Case Studies

Hospital A has a 24/7 Emergency Department (ED). While it provides elective general surgery it does not have a 24/7 emergency general surgical service. The emergency general surgical service is located at Hospital B.

Patient A is a 36y/o male, he is a cyclist who had fallen off his bike onto his left side. He had initially felt well but became increasingly unwell at home and was taken to ED at Hospital A via ambulance. He was acutely unwell on arrival and found to be in shock. He remained unstable despite fluid resuscitation and was deemed not fit for transfer to Hospital B for emergency surgery. The elective surgical team are contacted in theatre and alerted to the patient in ED requiring urgent attention. The patient is reviewed on site and the elective list is paused to facilitate emergency surgery for this patient. He undergoes surgery and once stable post-op he is transferred to hospital B for ongoing emergency general surgical care.

Patient B is 45y/o female who presents to Hospital A with sudden onset abdominal pain. The patient is discussed with the surgical team in Hospital B and they believe she has a likely perforated ulcer requiring urgent attention. She is transferred by blue light ambulance directly to theatre in Hospital B. The surgical team proceed to surgery and repair of a perforated ulcer.

Patient C is a 73y/o female who had colon cancer 5 years ago. She presents to Hospital A with vomiting and mild abdominal pain. She is discussed with the surgical team at Hospital B and proceeds to a CT scan which shows likely small bowel obstruction. She has a tube inserted and is transferred to Hospital B were she is successfully managed without surgery.

ACTION 2.

A). Trusts to develop a model for the delivery of complex and non-complex elective care informed by the implementation of the standards for emergency general surgery and elective surgery.

B). As part of implementation, Elective Overnight Stay Centres will be established in line with the wider elective care policy direction and the changing picture of health and social care delivery across Northern Ireland. In the initial phase – subject to Trust decision making processes and public engagement – we will consider the Mater Hospital as an initial site. We will also identify a further centre in the wider design plan intended to be published in the Autumn.

Primary Outcome: Regionally cohesive and comprehensive implementation with equity of provision for patients.

Consequential Outcomes: More efficient and effective service provisions, with higher activity levels and improved outputs.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

5. PRE-OPERATIVE AND POST-OPERATIVE CARE

All patients are different and to ensure the best possible outcomes we need a patient centred approach across the whole service model. In particular, patients who have co-morbidities come with a higher level of risk than those who do not. Going forward this needs to be managed in the most appropriate setting to provide the best patient outcomes and efficient use of resources.

Pre-operative assessment provides a comprehensive evaluation for each surgery, which allows the development of an agreed perioperative plan based on patient need after discussion with the patient and, if appropriate, their families about the risks involved. At present, high quality pre-operative assessment is delivered across all Trusts in Northern Ireland and the service has risen to the challenges of the COVID-19 pandemic with innovative developments, including virtual assessments and support of the regional day procedure centres. However, to meet the increasing demand for services, the new ways of working and to ensure consistency of approach across the region, significant workforce expansion, enhanced digital infrastructure and collaborative working across specialities is required. This is to not only stabilise and streamline the pre-operative assessment service, but to expand the delivery of pre-operative assessment in conjunction with the necessary increase in elective care provision required to resolve the significant waiting times across all Trusts. The roll out of Encompass will facilitate such delivery of pre-operative services and will have a single repository for each person, ensuring timely transfer of all data and 'live' checking of results prior to the procedure. Such a system will result in a reduction of last minute cancellations.

ACTION 3.

As the model for elective general surgery is implemented there will be a focus on streamlined and consistent pre-operative assessment processes that follow best practice.

Primary Outcome: patient centred pre-operative assessment that ensures that patients are managed in the most appropriate setting to provide best patient outcomes.

Consequential Outcome: reduced elective cancellations.

The Development of Post Anaesthetic Care Units (PACU) for Northern Ireland

Going forward, we must not only improve the pre-operative care, but we must also provide better post-operative care to ensure good patient outcomes.

Enhanced Perioperative Care is part of the planned surgical patient pathway and is not unique to general surgery. It supports the delivery of holistic, high-quality care to surgical patients at increased risk of adverse outcomes. Enhanced care services should provide benefit to patients (reduced likelihood of cancellation and postoperative complications) and to systems (more efficient care, reduced length of stay and reduced pressures on critical care services). Learning from the COVID-19 pandemic, there are obvious benefits of creating Enhanced Perioperative Care Services, to deliver the best quality care, even when critical care units are at or above their baseline capacity. We can do this by establishing Post Anaesthetic Care Units (PACU).

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

PACUs are an intermediate level of care where a higher degree of observation, monitoring and interventions can be provided for patients (who do not require HDU/organ support) than in a general ward. PACU beds are for patients who do not meet the criteria of a high dependency (HDU) or intensive care (ICU) bed, but who could use more enhanced care than in a ward. PACU is a time limited intervention, with the expectation that the majority of patients will be discharged from a PACU facility within 12-24 hours, with a small number staying for a maximum of 48-72 hours.

As well improving the quality of care and safety of high-risk surgical patients, the development of PACU will also release critical care capacity previously used to support initial postoperative care for high-risk patients. This means that there will be increased protection of surgical capacity during times of increased critical care activity, such as during emergency surges or winter pressures. In addition, it will reduce 'last minute' cancellation of inpatient surgery, for which one of the biggest risk factors is patients requiring postoperative critical care[7]. This will provide better outcomes for individual patients and for services as a whole.

National, Regional and Local Context

PACUs are not a new concept and have been evidenced as providing a positive impact to the management of high-risk surgical patients in the UK. The role of a PACU as part of a patient's integrated surgical pathway has been evidenced by a range of professional bodies[8]:

However, with the exception of Belfast City Hospital, where a PACU service is currently being piloted, these units have not been developed within Northern Ireland.

Using NCEPOD Surgical Outcome Risk Tool (SORT) methodology it has been possible to determine PACU bed requirements across our hospital sites. The establishment of PACUs will be taken forward on a phased basis from 2023 with 21 PACU beds across Northern Ireland in hospitals providing complex surgery that meet the criteria. Funding for the PACU beds has been secured on a recurrent basis. The implementation of phase 1 will be underpinned by robust performance and efficiency metrics that will inform further phases.

ACTION 4.

PACUs will be established across Northern Ireland on a phased basis, initially in all DGHs undertaking complex surgery that meet agreed criteria. The PACUs will be ring fenced for elective care.

Primary Outcome: Better patient outcomes, shorter hospital stay, tailored care and less reliance on level 2 & 3 beds.

Consequential: Reduced elective cancellations.

7 Guidance on Establishing and Delivering Enhanced Perioperative Care Services, October 2020, The Faculty of Intensive Care Medicine and Centre for Perioperative Care. https://www.ficm.ac.uk/standardssafetyguidelinescriticalfutures/enhanced-perioperative-care

8 Royal College of Anaesthetists - 21075 RCoA Audit Recipe Book_12 Section B.3_p131-154_AW.pdf
Association of Surgeons of Great Britain and Ireland
Royal College of Surgeons
National Institute for Health and Care Guidance (NICE) - Perioperative care in adults (nice.org.uk)
Centre for Perioperative Care - Perceptions of perioperative care - rapid review.pdf (cpoc.org.uk)

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Variation in Care

Across Northern Ireland, there is wide variation in performance across surgical specialties both with regard to time spent in hospital and the levels of surgery carried out as daycase. Belfast HSC Trust and the Western HSC Trust manage a higher proportion of cases as inpatients (26-30% pre-2020/21) compared to the Northern, Southern and South Eastern HSC Trusts (<15% pre-2021/21).

There may be clinical, cultural or infrastructural reasons as to why a surgery is carried out in a particular way. However, if we put the patient first, we must understand such variations to ensure we get the best patient outcomes. Further, given the pressures on our system, it is unacceptable that we continue to admit patients into hospital unnecessarily. We need to understand this significant variation, scale up best practice and standardise patient pathways to ensure consistency and equity of service provision.

The British Association of Day Surgery (BADS) produces a directory of procedures that includes targets for daycase surgery rates. Achieving the targets set by BADS would improve patient outcomes by minimising the intervention in patients lives and generate potential efficiencies that would be manifested in saved bed days releasing beds so that more patients can be treated, and reducing overcrowding and long waits in emergency departments.

ACTION 5.

BADS targets regarding the proportion of specific procedures which should be carried out as daycases will be used to compare daycase rates for specific procedures at a local and regional level and will be used to drive performance and efficiency.

Primary Outcome: Reduction in in-patient cases which will save bed days and lead to improved patient outcomes and patient satisfaction.

Consequential Outcome: Reduction in pressures on in-patient services meaning more efficient services, with an increase in the number of patients treated.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

6. PAEDIATRIC GENERAL SURGERY

In May 2010, the Department of Health introduced standards for general paediatric surgery; 'Improving Services for General Paediatric Surgery – Policy and Standards of Care for General Paediatric Surgery in Northern Ireland' . The Department's 10 year strategy, 'A Strategy for Paediatric Healthcare Services Provided in Hospitals and in the Community', was published in 2016. As part of the remit of the overall Paediatric Strategy, a Child Health Partnership (CHP) was created. Its primary role is to oversee delivery of the Paediatric Strategy and improve working relations within Paediatric and Child Health Services.

In 2019, RQIA published a Review of General Paediatric Surgery. This review assessed arrangements for the provision of general paediatric surgery in Northern Ireland against the 2010 Standards and it proposed a future service model aligned to the 2016 strategy published by DoH . The review made a total of 13 recommendations which aim to improve general paediatric surgical services across Northern Ireland.

It is not the intention of the Review of General Surgery to duplicate the work of the RQIA review. The Review of General Surgery fully supports the RQIA recommendations being implemented at pace.

Emergency Paediatric General Surgery

While some emergency paediatric general surgery is undertaken at District General Hospitals (DGHs), feedback from the Trusts indicates that in some areas adult general surgeons are becoming increasingly reluctant to perform emergency surgery for children, particularly within younger age groups. This is due to concerns around appropriate training and skills set, particularly with regard to fluid management in the perioperative period. With the low volume of surgeries performed in DGHs it is difficult for adult general surgeons to sustain the required experience and maintain their skills and competence.

Paediatric General Surgery cases that are time critical, such as testicular torsion, should be performed in the DGH. All general surgery of childhood, such as emergency appendicectomy, management of abscesses and minor injuries in children over the age of 5 should be managed in the local DGH. Children under the age of five requiring surgery should all be transferred to RBHSC unless time sensitive and the local team have the appropriate surgical and anaesthetic skills.

Training for consultants, trainees and permanent members of staff in DGHs is therefore paramount for the success of the regional delivery of these services, and consultants in DGHs must have protected time in their job plan to support the delivery of paediatric surgery.

This Review supports the work of the Child Health Partnership (CHP) as it champions access to support from both the RBHSC and local paediatricians to ensure the safe delivery of paediatric services, in an age appropriate setting, ensuring that appropriate training opportunities are embedded in pathways. Shared care between a paediatrician and an adult general surgery should be central to the ongoing management of emergency procedures in District General Hospitals.

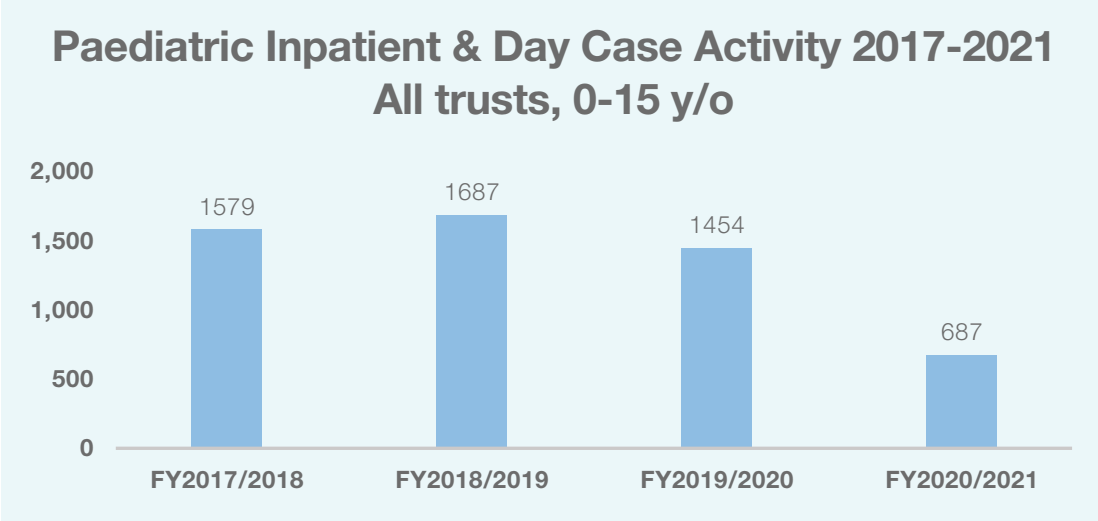
9 Improving Services for General Paediatric Surgery - Policy and Standards of Care for General Paediatric Surgery in Northern Ireland
10 RQIA Review of General Paediatric Surgery in Northern Ireland

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Elective Paediatric General Surgery

The waiting list for a paediatric general surgery outpatient appointment is in excess of 2,000 patients, with over 800 patients waiting over 52 weeks and there is a wide regional variation in how long children are waiting for new outpatient visits.

Over 1,000 children are waiting on surgery, with 484 waiting over 52 weeks at February 2022. The majority of these cases are suitable for daycase surgery. Since 2019/20 there has been over a 50% reduction in paediatric inpatient and daycase activity.



Elective paediatric general surgery activity has been significantly impacted by the pandemic with dramatic reductions in patient throughput and potential adverse outcomes for patients. These surgeries are often not considered urgent from a strictly physical/ surgery perspective. However, they are often time sensitive in terms of the impact on the development and long term wellbeing of the child. To ensure good patient outcomes, we need to increase elective paediatric general surgery activity.

Prior to the pandemic there were commissioned paediatric daycase lists in the Ulster Hospital and regular activity in the children's hospital in Belfast. Arrangements across the other hospitals were less formal, but in place nonetheless. These lists were reduced during the pandemic as a consequence of the severe pressures on the health and social care system.

We are clear that re-establishment of the commissioned paediatric lists in the Ulster Hospital and two paediatric daycase lists per month in the DGHs, in addition to Belfast Trust returning to pre-pandemic capacity, would facilitate the clearance of the longest waiting daycase patients for paediatric general surgery within one year.

On that basis, the Department has been working with Trusts to ensure that commissioned paediatric daycase procedure theatre lists for general surgery were re-established as a priority, with procedures in place that ensures that these lists are normally not cancelled due to other pressures. Further, Trusts without commissioned lists were asked to prioritise two paediatric daycase procedure lists per month.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

ACTION 6.

Continued regional collaboration to rebuild elective paediatric lists.

Primary Outcome: Increase in elective paediatric general surgery activity with more patients being treated.

Consequential Outcome: Better joined up working will lead to more efficient processes with higher activity levels and better patient outcomes.

ACTION 7.

Continued support for the Child Health Partnership as it develops age appropriate pathways, training opportunities and models for delivery of paediatric surgery.

Primary Outcome: Better patient outcomes as the patients are treated by those with best knowledge and skills.

Consequential Outcome: Better joined up working will lead to more efficient processes with higher activity levels and better patient outcomes.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

7. WORKFORCE

The delivery of general surgical services depends on the skills and combined efforts of a wide range of staff comprising the Surgical Care Team. This team has changed over the years and now includes a wide range of health care professionals and vital support staff, working together in new ways, often reflective of advances in technology and clinical practice and changing standards of care and service.

The development of a comprehensive multi-disciplinary team in the general surgical environment in Northern Ireland has progressed at a slower pace than in other parts of the United Kingdom, particularly in the development of the wider multi-disciplinary team. Going forward we need to not only strengthen the core team, but ensure that the contribution of the wider comprehensive surgical care team is maximised to improve outcomes, efficiency and safety for patients.

The wider surgical care team is illustrated below:



Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Staffing levels

Defining optimum staffing levels is a first step in designing a surgical care team, as each staff group is often dependent on colleagues if their contribution is to be maximised. For example, using clinically expert staff to carry out roles where this expertise is not required is potentially a waste of scarce resource. However, there is no 'one size fits all' formula for staffing numbers, but a range of factors which should be included when developing and commissioning the right staffing model for the services to be delivered, including

- Service Model
- Service Demand
- Hours of Service
- Patient Acuity
- Supporting Infrastructure Required
- Training Requirements.
- Physical Environment.

The Medical workforce

Evidence on the requisite size of general surgical teams / rotas is limited and outdated. In relation to out-of-hours rotas, there is also no standard or evidence as to an appropriate number of consultants to make up the rota. What is clear is that the surgical consultant team (and specialty trainee teams also) should be of sufficient size to deal with the demand for emergency and elective general surgery and provide safe and sustainable services for the patient, while maintaining a work/life balance for the surgical care team[11]. Such a system also provides improved opportunities for surgical training, with such a unit attracting more trainees and subsequently leading to better recruitment of Consultants.

A recent UK State of the Nation Report completed by the Royal College of Anaesthetists indicates that Northern Ireland faces a significant and growing shortages of anaesthetists[12]. There can be no development of general surgical services without consideration of the role of the anaesthetist as part of the integrated Surgical Care team.

The Nursing Workforce

The scope of practice and range of roles nurses execute in the general surgical environment is extensive, ranging from surgical inpatient nursing and pre-operative assessment, perioperative practice, post-operative care and a range of specialist and advanced practice roles.

Delivering Care 2014 and the more recent work on Perioperative Nursing indicates that there are significant nursing workforce challenges. Vacancies are a consistent problem, with a lack of opportunity for career development and continued challenges, both when giving nursing students the opportunity to experience the perioperative environment and when recruiting new staff. Both reports set out a series of actions and recommendations to address these challenges. It is not our intention to duplicate these actions/ recommendations, but rather suggest that they should be implemented at pace.

11 RCS 2018
12 Royal College of Anaesthetists 2022

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Skills Mix

Despite actions taken to date to address the challenge of recruiting and retaining nurses and surgeons they have not had the significant or sustainable impact anticipated. It is therefore important that we consider opportunities to develop a multi-skilled workforce that is both flexible and sustainable. This is essential for the delivery of high-quality care.

Developing new roles can enhance multi-disciplinary team working, free up others' workloads and reduce agency spend on hard to recruit to positions. The issue of workforce skills mix is not unique to general surgery. However, there are some roles that merit further consideration in the context of the delivery of general surgery.

A Physician Associate (PA) is a new healthcare professional who, while not a doctor, works to the medical model, with the attitudes, skills and knowledge base to deliver holistic care and treatment within the general medical and/or general practice team under defined levels of supervision.

The role of the Advanced Nurse Practitioners (ANP) complements the wider medical team and will undertake comprehensive health assessments and manage a range of illnesses and conditions. To date there has been no ANP programme for surgical nursing commissioned in Northern Ireland.

Operating Department Practitioner (ODPs) are the only non-medical profession specifically educated for perioperative care. They can work in the operating theatre in the three phases of care during surgery – anaesthetics, surgery and recovery, and more recently have contributed to the management of the COVID-19 pandemic through redeployment to critical care units.

Training

The review of general surgery in Northern Ireland will influence the type of training placements available at various hospitals and will therefore guide the allocation of surgical trainees to hospitals in the province.

As described in the burning platform there are a number of challenges relating to surgical training in Northern Ireland. The present number of general surgical training places in Northern Ireland will need to be carefully reviewed in view of these challenges and to ensure that we meet that we meet the future demands of general surgery on a sustainable basis. Workforce planning will be required to ensure adequate numbers of trainees are trained to take up consultant posts. This is to ensure that the 'Surgical Care Team' is adequately resourced to cope with the demands of general surgery in Northern Ireland.

ACTION 8.

As part of implementation of the emergency and elective standards there will be a review of current surgical services in each Trust to ensure that workforce aligns with the new service model. This will cover medical, specialist nursing, AHP and pharmacy. Consideration will be given to the optimum skills mix required to deliver the new service model.

Primary Objective: Successful and sustainable delivery of the emergency and elective general surgery standards, with better patient outcomes.

Consequential Objective: A sustainable workforce that is content with the working environment, maximising the resource potential across the health and social care system.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

8. MAKING THIS HAPPEN

During the pandemic we have seen first-hand the benefits of Trusts working collaboratively to deliver services for patients across the region. This has included the development of the DPC at Lagan Valley as a resource for the region for high priority cases and the establishment of a Regional Prioritisation Oversight Group (RPOG) to ensure a clinically led network approach to the optimisation of all available theatre capacity during the pandemic.

An Elective Care Management Team has also been established to lead a strategic, whole system, integrated approach to the delivery of elective care in general and specific actions - as articulated in the Elective Care Framework in particular, including elective care centres. In practice this will mean governance and organisational structures to ensure better services for patients, with reduced waiting times and improved quality and outcomes.

Learning from these initiatives, it is clear that delivery of an equitable and sustainable model for general surgery across Northern Ireland will require a combination of intra and inter-Trust working. While regional collaboration will be essential, each Trust has a unique set of circumstance for change in terms of drivers, constraints, challenges and opportunities that are rightly dealt with at a local level.

Trust teams will be required to work within Trust boundaries, maximising workforce and facilities, as well as working as part of a "Regional General Surgery Network" to oversee the transformation and reconfiguration of Emergency General Surgery at a regional level, and to develop proposals for surgical hubs for short stay inpatient and daycase surgery which will build on the work already in progress for Elective Care Centres.

The NI Ambulance Service (NIAS) and GPs will also play a key role in the reconfiguration of services to ensure appropriate access arrangements, protocols, bypass and transfer arrangements are in place.

The delivery of complex elective care will also benefit from regional oversight to improve equity of access to services, to improve outcomes for patients and to drive efficiency. The network will also work as a mechanism to ensure that pathways for new service developments are evidence based, fully encompassing and established in response to regional need. The network is expected to report to the Elective Care Management Team to ensure a cohesive structure across the wider health and social care work.

ACTION 9.

Establishment of a Regional General Surgery Network to drive forward a multifaceted transformation programme for general surgery at a regional level, incorporating best practice from other parts of the UK.

Primary Objective: A network to drive regional cooperation and cohesion ensuring general surgery services are available on an equitable basis ensuring consistent good outcomes for general surgery patients.

Consequential Objective: A regional tool for co-production and co-design ensuring clinical staff buy in, with resultant better cooperative working and improved morale.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

9. MONITORING THE IMPACT

As we implement the actions from this review we will draw on a broad range of information and data from across the health and social care system to ensure delivery of a patient centred, high quality, value for money service. Analysis of this information will provide an opportunity to identify and share best practice, identify and address variation in practice and identify areas of performance that require improvement.

An Integrated Dashboard will be developed that consist of three components: Patient Experience; Quality and Safety of Care; and Activity and Access to Care.

Patient Experience

The input of our service users is central to shaping a high quality service. HSC Care Opinion launched in 2020 and is an online user feedback system that enables service users, and their families, to give feedback on their care and share their stories with others.

Care Opinion has the ability to analyse patient experiences, identifiable by Trust and by treatment category. Analysis of this data will be used at a local level by Trusts and at a regional level by the network to identify any common or emerging themes, inform targeted action and ultimately improve outcomes for our patients.

Quality and Safety of Care

In line with the standards for Emergency General Surgery it is important that there are mechanisms in place at a local and regional level to audit performance against a set of recognised quality and performance indicators.

There is a wealth of valuable UK benchmarking data and National Audits that are already available to the HSC, including but not limited to; Getting it Right First Time (GIRFT), CHKS (a leading provider of healthcare intelligence and quality improvement services), the National Emergency Laparotomy Audit and the National Hiatal Surgery database.

The HSC currently has a contract with CHKS, and CHKS will gather data in support of mortality, flow and efficiency, and safety and quality metrics. Reports will be provided on a monthly basis to assess and track safety and quality indicators. This information will then be used to identify areas where performance falls below expected levels and targeted action can be taken to address the underlying issues.

Activity and Access to Care

The Department has developed an extensive, interactive data set covering activity and access to care that is updated on a regular basis. This will be interrogated for aspects of demand, activity and performance for inpatients and outpatients, and can be filtered at regional, Trust, and hospital level. This data will be used to inform the development of services models and to understand the impact of any proposed changes to service delivery.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

ACTION 10.

The Department of Health will develop an Integrated Dashboard for General Surgery made up of on the interlinked components of Patient Experience, Quality and Safety of Care; and Activity and Access to Care.

Primary Objective: Data and information to drive decision making to make sure that every decision is in the patient's best interests and will provide value for money.

Consequential Objective: Identification of areas where Northern Ireland is strong and areas where improvement can be made. This can be used as a learning tool across Northern Ireland and wider jurisdictions.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

10. NEXT STEPS AND FUNDING THE IMPLEMENTATION

Implementation of the actions in this Review Report will require significant work. A number of work-streams will be required and the support of all stakeholders will be essential. The Department is fully committed to implementing the actions based on the principles in Delivering Together and the Bengoa Report, with the overall aim of ensuring better outcomes for the people in Northern Ireland who require general surgery, their friends and family and others affected. As such the Department is fully committed that the implementation will be fully co-designed and co-produced. This will include service users, clinicians, managers, HSC Trusts, the Department and anyone else who has a stake in the implementation of the actions.

As we move forward, it is important that we acknowledge the difficult financial situation in which this review is being published. There is a demand for extra funding across many areas of health and social care. At the time of publication of this report the cost to implement each action has been considered, with the only significant cost identified in the creation of PACU. To fund 21 PACU beds is expected to cost approximately £3.5m recurrently per year. However, funding for this development has already been secured and approved, with money being available at the start of the 2023/24 financial year. Implementation planning for this action is already underway.

There may be further, minor, costs around the implementation of other actions, depending on how they are implemented. This may include change planning and project management. These costs are also funded through the development of more effective services as part of the Elective Care Framework.

There is undoubtedly a long term need to increase service provisions across general surgery. However, the quantification of this need is not possible before detailed implementation planning, and costing of such increase in provisions are therefore not possible at the time of publication. This is, however, not a barrier for implementation of the actions as increase in service provisions would be over and above what is currently being delivered, and even without increase in provisions it is expected that the implementation of the actions will create both better outcomes for patients, and a more efficient and effective general surgery service.

Where additional resources are identified – as additional service provisions – it is currently not possible to fund these within the existing expenditure of the Department, and such additional service provisions would therefore be dependent on the provision of significant additional funding for the Department. Where this is not possible, the Department will also seek to release resources through service efficiencies and reconfiguration – both of which are areas which this reports provides actions on.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

ANNEX A – STANDARDS FOR EMERGENCY AND ELECTIVE GENERAL SURGERY

Emergency General Surgery – Standards

The standards are a product of an extensive review of evidence which scrutinised guidance, standards, best practice, and reviews published by expert stakeholders such as the Royal Colleges, other professional bodies, NHS organisations including Getting It Right First Time, regulatory bodies and benchmarking programmes.

They are presented under 6 categories:

1. Model of Emergency Surgical Care
2. Clinical Infrastructure
3. Clinical Interdependencies
4. Workforce
5. Process and protocols
6. Quality Assurance

1. Model of Emergency Surgical Care

1.1 Given their clinical interdependencies, emergency and high risk elective surgery will co-exist on a hospital site; however, there must be a separation of emergency and elective general surgery pathways in terms of teams, time and facilities to ensure safety and access for all.

1.2 In a hospital with emergency surgical admissions, the consultant and their team must be available and fully focused on emergency general surgery and be free from elective and Independent Sector commitments.

1.3 Consultant surgeons covering emergencies must not cover, nor be expected to be in attendance, on more than one site.

1.4 In a hospital where emergency surgery patients are admitted the responsible consultant must be available during day time hours and there must be an out of hours (OOHs) on call rota.

1.5 The emergency inpatient surgical model must have the following in place to provide a safe and effective service, as well as reduce the demand for inpatient beds and improve patient flow:

- Processes for direct clinical assessment of emergency surgical patients by a senior surgical decision maker (ST3 and above);
- Processes for the admittance of patients to an inpatient surgical ward; and
- Processes to see and treat patients in an ambulatory setting as an alternative to hospital admission when clinically appropriate to do so.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

1.6 When a hospital has a functioning Emergency Department and an acute inpatient medical service but does not have an emergency surgery inpatient service, there must be clear pathways for access to the off-site emergency general surgical team for advice, assessment and agreed protocols for ambulance by-pass and / or transfer of patients as required, to a surgical inpatient facility.

2. Clinical Infrastructure

2.1 The hospital with emergency inpatient surgery must have the required resources and equipment to stabilise and resuscitate the emergency surgical patient at all times.

2.2 The hospital with emergency inpatient surgery must have access to a fully staffed emergency theatre available 24/7 (National Confidential Enquiry into Patient Outcome and Death [NCEPOD]). A scheduling process must be in place to maximise the utilisation and efficiency of this emergency theatre.

2.3 The hospital with emergency inpatient surgery must have access to critical care services including 24/7 access to level 3 and level 2 care beds and a critical care outreach team.

3. Clinical Interdependencies

3.1 Radiology (diagnostic) – All hospitals admitting surgical emergency patients must have 24 hours a day access to diagnostic services such as plain film x-ray, computerised tomography (CT) and timely access to MRI and ultrasound scanning on-site.

3.2 Radiology (interventional) - All hospitals admitting surgical emergency patients must have on-site access to simple interventional radiological procedures such as drainage, ideally 7 days per week but a minimum of 5 (Mon-Fri). More complex IR procedures must be accessed either onsite or through a formalised network.

3.3 Hospitals with emergency inpatient surgery must have clinically appropriate access to laboratory services, either on-site or through a formalised network.

3.4 The hospital admitting surgical emergency patients must have access to a gastroenterology service and an on-site “bleeding rota” with the ability to undertake urgent upper and/or lower endoscopy on emergency surgery patients as required for diagnostic and therapeutic purposes.

3.5 A hospital admitting paediatric emergency surgical patients must have a local and networked model of care in place that involves advice and input from paediatricians and/or paediatric surgeons as required.

3.6 The hospital admitting surgical emergency patients must have access to timely assessment / review from other clinical specialities such as cardiology, renal, diabetes, care of the elderly, etc.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

4. Surgical Workforce

4.1 The emergency surgical service must be delivered by a 24/7 emergency surgical team led by a consultant surgeon. Day time working and OOHs rotas (consultant and junior) to be constructed and working practices in place to maximise continuity of care for emergency surgery inpatients.

4.2 Consultant rotas must be of sufficient size, with [the majority] of posts occupied by substantive post-holders, to deal with the demand for emergency general surgery and provide a safe and sustainable service.

4.3 Surgical Trainees must have access to training that is delivered in a supportive environment and have access to sufficient volume and diversity of emergency surgical practice necessary to meet required competences in emergency surgery.

5. Process and Protocols

5.1 The hospital admitting surgical emergency patients must have in place ward based early warning scoring protocols for adults and children, including escalation processes to identify and treat the deteriorating patient.

5.2 In hospitals where children are admitted for emergency surgery they must be admitted to an age appropriate environment and care must reflect paediatric protocols and clinical guidelines

5.3 To identify the high risk patient and direct clinical decision making, the hospital admitting emergency surgical patients must have a process for predicting post-operative morbidity and mortality and ensure the patient and their family are fully informed of potential outcomes.

5.4 There must be a morning meeting to facilitate the handover of patients from the overnight emergency team to the consultant surgeon responsible that day for the emergency service.

5.5 There must also be a handover of patients from the emergency day team to the on call emergency team.

5.6 There must be a policy for review of all inpatient emergency surgery patients by a consultant, every day including weekends, whilst they remain under the care of the emergency team.

5.7 Patients not considered high risk should be seen by a senior decision maker (ST3 and above) within 12 hours from admission and timing of the ward rounds must be that patients are generally seen by a consultant within 24 hours.

5.8 In a hospital where head injuries, fractures, trauma, urology conditions are admitted under emergency general surgery, there must be protocols in place for management of these patients, with appropriate and sustainable networking and support arrangements in place.

5.9 Discharge – All admitted patients must have an estimated discharge date as part of their management plan.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

6. Quality Assurance

6.1 Subject to funding, all Trusts' emergency surgical care teams must submit data to National Emergency Laparotomy Audit (NELA) and also audit practice against a range of local indicators such as:

- Activity:
  - Acute assessments - includes ED referrals, direct GP referrals and other inpatient speciality referrals
  - Number of emergency surgery inpatient admissions
  - Emergency Surgery operation (NCEPOD theatre activity)
  - Hot Clinic attendances
  - Ambulatory treatments (including ambulatory theatre activity)
- Return to theatre
- Emergency surgery inpatient length of stay parameters
- Readmission rates (7 day & 28 day)
- Patient Experience

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Standards for Elective General Surgery

	Complex Elective Inpatient Surgery	Short Stay Inpatient & Day Surgery (to be adapted according to setting)
Model of Care	• There must be a separate stream from emergency surgery provision in terms of working patterns, access to theatre, critical care and dedicated ring-fenced beds	• There must be a separate stream from emergency surgery provision in terms of working patterns, access to theatre and dedicated ring-fenced beds • There must be agreed protocols in place for transfer of patients who require a higher level of care
Clinical Infrastructure	• There must be access to a fully staffed theatre available 24/7. A scheduling process must be in place to maximise the utilisation and efficiency of this theatre. • There must be 24/7 access to an anaesthetic service • There must be a Post Anaesthetic Care Unit (PACU) • There must be access to critical care services including 24/7 access to level 3 and level 2 care beds and a critical care outreach team.	• There must be daytime and OOH access to an anaesthetic service • There must be access to emergency theatre with transfer protocols if required • There must appropriate facilities for day surgery and minor / intermediate inpatient surgery to ensure care is delivered in the appropriate setting
Clinical Interdependencies	• There must be 24 hours a day access to diagnostic services such as plain film x-ray, computerised tomography (CT) and timely access to MRI and ultrasound scanning on site. • There must be on-site access to simple interventional radiological procedures such as drainage, ideally 7 days per week but a minimum of 5 (Mon-Fri). More complex IR procedures must be accessed either on-site or through a formalised network. • There must be access (on-site where appropriate) to timely assessment / review from other clinical specialities such as cardiology, renal, diabetes, care of the elderly, etc. • A hospital admitting complex elective paediatric surgical patients must have a local and networked model of care in place that involves advice and input from paediatricians and/ or paediatric surgeons as required.	• A hospital admitting paediatric elective inpatients must have a local and networked model of care in place that involves advice and input from paediatricians and paediatric surgeons as required

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Workforce	• There must be a separate stream from emergency surgery provision in terms of working patterns, access to theatre, critical care and dedicated ring-fenced beds	• There must be a separate stream from emergency surgery provision in terms of working patterns, access to theatre and dedicated ring-fenced beds • There must be agreed protocols in place for transfer of patients who require a higher level of care
Process and protocols	• Clinical protocols must be in place that are in line with best practice for perioperative care for complex inpatient surgery and high risk patients • In hospitals where children are admitted for elective surgery they must be admitted to an age appropriate environment and care must reflect paediatric protocols and clinical guidelines	• Clinical protocols must be in place that are in line with best practice for perioperative care for day surgery and minor / intermediate inpatient surgery • In hospitals where children are admitted for elective surgery they must be admitted to an age appropriate environment and care must reflect paediatric protocols and clinical guidelines

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

ANNEX B – EFFECTS OF INTRODUCING NEW STANDARDS FOR GENERAL SURGERY

An Expert Panel, led by Professor Rafael Bengoa, recommended criteria for assessing the sustainability of HSC services. The criteria, proposed by the Panel, were the subject of public consultation in 2017. These criteria must be at the heart of informing decisions about reconfiguring HSC services that are not able to meet the standard and experience of care we all rightly expect, with the potential to replace these services with new models of care delivering better health and wellbeing outcomes for patients.

Criteria for Reconfiguring HSC Services

Criterion 1: There is evidence that the outcomes for people using HSC services are below standards recognised by the Department of Health, or statutory requirements are not met, or safety concerns are evident and impact on the long term sustainability of services.

Criterion 2: There are clear pathways for the patient and client population at local and region wide levels.

Criterion 3: The service cannot meet professional standards or minimum volumes of activity, as recognised by the Department of Health, that are needed to maintain expertise.

Criterion 4: The workforce required to safely and sustainably deliver the service is not available/cannot be recruited, developed or retained, or can only be secured with high levels of agency/locum staff.

Criterion 5: There are effective alternative care models as recognised by the Department of Health in place.

Criterion 6: The delivery of the service to the required standard is costing significantly more than that of peers or of alternative models due to a combination of the above factors

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

As part of the development of the emergency standards, each HSC Trust was asked to apply the standards to existing services. If the standards were applied without new investment it is clear that services could not be delivered across all current sites that currently deliver emergency general surgery.

Some standards, such as implementation of NELA, are expected to take place regionally, meaning that all sites across all Trusts will meet the quality assurance standards.

Two out of the eight hospitals currently meet the standards (Ulster Hospital and Royal Victoria Hospital). Three hospitals (Antrim Area Hospital, Craigavon Area Hospital and Altnagelvin Hospital) do not fully meet the standards, however, they could be met by putting the necessary processes or resource in place. The remaining hospitals (Causeway Hospital, Daisy Hill Hospital and South West Acute Hospital) require more fundamental changes in a number of areas to meet the standards.

It will be for each Trust to consider what the response to the standards will be. However, there is an expectation that following implementation that all sites that deliver emergency general surgery will meet the standards. This means Trusts will have to consider if there has to be service reconfiguration as a result of implementation of the standards.

As a consequence there would also need to be changes to elective general surgery. Whilst these standards are more flexible, as the patient flow and demand can be controlled, a reconfiguration could be required. The implementation of the emergency standards could potentially inform decisions around elective care.

However, as the purpose of the general surgery review is to ensure good patient outcomes and efficient delivery of services, the decision making on potential reconfiguration of services would need to be taken by each HSC Trust, in collaboration with the new General Surgery Network and the Elective Care Management Team. It is expected – as always – that where any reconfiguration proposals would mean change in delivery method or change delivery place, each HSC Trust would have to consider how to engage with the public, including consideration for public consultation.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

GLOSSARY OF TERMS

24 hour imaging

This is the provision of a 24-hour diagnostic radiology service.

Allied Health Professions

Allied Health Professions (AHPs) are a diverse group of clinicians who deliver high-quality care to patients and clients across a wide range of care pathways and in a variety of different settings. They play an important role in modern health and social care services. Their focus is on prevention and improvement of health and wellbeing to maximise the potential for individuals to live full and active lives within their family circles, social networks, education/training and the workplace.

Ambulatory clinics

Ambulatory clinics offer same day care to patients at the hospital. This means that patients are assessed, diagnosed, treated and are able to go home the same day, without being admitted into hospital overnight.

Anaesthesia

Medicines that cause anaesthesia are called anaesthetics. Anaesthetics are used during tests and surgical operations to numb sensation in certain areas of the body or induce sleep.

Appendicectomy (appendectomy)

Removal of the appendix is carried out under general anaesthetic using either keyhole or open surgery.

CEPOD theatres

In 1987 a joint venture between surgical and anaesthetic specialties named the Confidential Enquiry into Perioperative Deaths (CEPOD) was initiated. In 1988 the National Confidential Enquiry into Perioperative Deaths (NCEPOD) was then established.

Since then NCEPOD has moved away from reviewing the care of surgical patients only and now covers all specialties and its name changed to National Confidential Enquiry into Patient Outcome and Death. Historical NCEPOD recommendations relating to early reviews of surgical mortality resulted in dedicated emergency theatres called 'CEPOD' theatres which are now a prominent feature of many UK hospitals.

Cholecystectomy

A cholecystectomy is gallbladder removal surgery and is a very common procedure. Laparoscopic (keyhole) cholecystectomy is more common, but open cholecystectomy also is performed.

Cholecystitis

Acute cholecystitis is inflammation of the gallbladder. It usually happens when a gallstone blocks the cystic duct.

Chronic pancreatitis

Chronic pancreatitis is a condition where the pancreas has become permanently damaged from inflammation and stops working properly.

Clinical Nurse Specialists

A Clinical Nurse Specialist (CNS) provides direct care to patients in one of a range of specialties, such as paediatrics, geriatrics, emergency care and oncology.

Colorectal surgery

Colorectal surgery covers operations to the colon and rectum and includes the treatment of colitis and rectal inflammation, haemorrhoids, anorectal disorders and colorectal cancer.

Congenital abdominal procedures

Abdominal surgery on conditions that are present from birth.

Critical care

Critical care units are specialist hospital wards that treat patients who are seriously ill and need constant monitoring. These units are staffed by specially trained health care professionals who deliver intensive levels of care and treatment.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

CT scan

A computerised tomography (CT) scan uses X-rays and a computer to create detailed images of the inside of the body. CT scans are sometimes referred to as CAT scans or computed tomography scans.

Diagnostic radiology

Diagnostic radiology involves undertaking a range of imaging procedures to obtain images of the inside of the body. The diagnostic radiologist then carefully interprets these images to diagnose illness and injury. Diagnostic radiology is at the core of clinical decision-making in modern medicine.

Elective care

Care that is planned in advance is known as elective care. It involves specialist clinical care or surgery, generally following a referral from a GP or community health professional.

Emergency medicine

Emergency medicine is the medical speciality concerned with the care of illnesses or injuries requiring immediate medical attention. Emergency physicians continuously learn to care for unscheduled and undifferentiated patients of all ages

Endocrine surgery

Endocrine surgery is a subspecialty of general surgery that focuses on diseases of the thyroid, parathyroid, and adrenal glands.

ERCP (Endoscopic retrograde cholangio-pancreatography)

ERCP is a procedure that can be used to remove gallstones from the bile duct.

Endoscopy

An endoscopy is a test to look inside your body by which a long, thin tube with a small camera inside, called an endoscope, is passed into your body through a natural opening such as your mouth.

There are different types of endoscopy that look at different parts of the body and the type of endoscopy you have will depend on your symptoms.

Gastroenterology

Gastroenterology is the branch of medicine that looks at diseases of the oesophagus (gullet), stomach, small and large intestines (bowel), liver, gallbladder and pancreas.

Gynaecology

Gynaecology is the area of medicine that involves the treatment of women's diseases, especially those of the reproductive organs.

Hepatobiliary and pancreatic surgery

Hepatobiliary and pancreatic surgery consists of surgical procedures to treat cancer and other disorders that affect the liver, bile ducts, gallbladder and pancreas.

Hernia

A hernia occurs when an internal part of the body pushes through a weakness in the muscle or surrounding tissue wall. A hernia usually develops between your chest and hips. In many cases, it causes no or very few symptoms, although you may notice a swelling or lump in your abdomen or groin.

Inguinal hernia

An inguinal hernia is the most common type of hernia and can appear as a swelling or lump in your groin, or as an enlarged scrotum.

Interventional radiology

Interventional radiology refers to minimally invasive, image-guided medical treatments. Procedures use real-time imaging techniques, including X-rays and ultrasound, to guide the operator. It can be used as a quicker and safer alternative to many types of traditional surgery, resulting in better outcomes for patients and shorter stays in hospital.

Intestinal failure

Bowel or intestinal failure means a person's bowel is not able to absorb enough nutrients from food. Treatment will depend on the severity of the damage done to the intestines.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Intra abdominal cancer surgery

Intra abdominal cancer surgery is any cancer related procedure that needs to be done within the abdominal cavity.

Locum

A locum doctor is one who temporarily fills a rota gap within a hospital, clinic or practice. This can often be on a relatively short-term basis, although in the healthcare sector, it is not uncommon for locums to hold their post as part of a practice's core medical team for more extended periods.

MRCP (Magnetic resonance cholangio-pancreatography)

MRCP is a special type of magnetic resonance imaging (MRI) exam that produces detailed images of the hepatobiliary and pancreatic systems, including the liver, gallbladder, bile ducts, pancreas and pancreatic duct.

MRI

Magnetic resonance imaging (MRI) is a type of scan that uses strong magnetic fields and radio waves to produce detailed images of the inside of the body.

Oesophageal cancer

Oesophageal cancer is a cancer that's found anywhere in the oesophagus, sometimes called the gullet or food pipe. The term oesophagogastric refers to cancers of the oesophagus and stomach.

Ophthalmology

Ophthalmology is the branch of medicine concerned with the study and treatment of disorders and diseases of the eye.

Perianal abscess

A perianal abscess is a superficial infection that appears as a tender red lump under the skin near the anus.

Perineal abscess

A perineal abscess is an infection that causes a painful lump in the perineum.

Sigmoidoscopy

A sigmoidoscopy is a diagnostic test used to check the sigmoid colon, which is the lower part of your colon or large intestine.

ST (Specialty Trainee)

Specialty Trainee means a doctor in training after completion of the Foundation programme for a Foundation Doctor in Training, applying to trainees who have undertaken a specialty training programme approved by the GMC**.**

Stoma

A colostomy is an operation to divert one end of the colon (part of the bowel) through an opening in the stomach. The opening is called a stoma.

Testicular torsion

Testicular torsion is an emergency condition which happens when the spermatic cord, which provides blood flow to the testicle, rotates and becomes twisted.

Upper gastrointestinal (G.I.) surgery

Upper gastrointestinal surgery provides care for patients with problems affecting the oesophagus (gullet), stomach, gallbladder, bile ducts and pancreas.

Urology

Urology is the branch of medicine that focuses on surgical and medical diseases of the female urinary system and the male genitourinary tract, as well as disorders of the kidneys, ureters, bladder, prostate and male reproductive organs.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry



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

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

2021

Elective Care Framework

Restart, Recovery and Redesign

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

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

CONTENTS

MINISTERIAL FOREWORD 4
ELECTIVE CARE FRAMEWORK – ACTIONS AND TIMESCALES 6
5 YEAR TARGETS 6
IMMEDIATE ACTIONS – JULY – DECEMBER 2021 7
TREATMENT CAPACITY 7
EXPANSION OF ELECTIVE CARE CENTRES 8
OUTPATIENT REFORM 8
ELECTIVE PATIENTS WITH AN URGENT NEED 9
IMAGING & PATHOLOGY 9
CROSS BORDER HEALTHCARE 10
SPECIALTY SPECIFIC ACTIONS 10
PERFORMANCE MANAGEMENT 11
MEDIUM TERM ACTIONS – JANUARY 2022 – DECEMBER 2022 12
ANNUAL DELIVERY PLAN 12
SEPARATION OF ELECTIVE AND UNSCHEDULED CARE 12
WORKFORCE 13
COMMISSIONING AND TARGETS 15
PRIMARY CARE 15
ADMINISTRATION OF WAITING LISTS 15
LONGER TERM ACTIONS – JANUARY 2023 ONWARDS 16
INFRASTRUCTURE 16
TARGETS 16
7-DAY WORKING 16
DIGITAL 16
SECTION 1. INTRODUCTION 18
IMPACT OF THE PANDEMIC 18
WAITING TIMES PRE-PANDEMIC 19
TIMESCALE AND INVESTMENT 20
CONCLUSION 21
SECTION 2. ELECTIVE CARE IN NORTHERN IRELAND – DEMAND, CAPACITY, AND CURRENT WAITING TIMES 23
WHAT IS ELECTIVE CARE? 23
CURRENT WAITING TIMES 24
HOW DOES THIS COMPARE WITH OTHER PARTS OF THE UK? 26
WHY ARE OUR WAITING TIMES SO HIGH? 27
THE IMPACT OF COVID-19 29

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

WHAT WILL BE THE LONG TERM IMPACT? 30
THE POLICY CONTEXT 31
DAYCASE ELECTIVE CARE 32
WHAT IS THE IMPACT ON PATIENTS? 33
PHYSICAL IMPACT 33
MENTAL IMPACT 33
SOCIAL IMPACT 33
FINANCIAL IMPACT 33
SECTION 3. RESTART: RESUMPTION OF ACTIVITY 35
APRIL – SEPTEMBER 2021 35
RESTART: KEY ACTIONS 36
DEMOBILISATION OF REDEPLOYED STAFF 36
CONTINUE REGIONAL PRIORITISATION OF THEATRE CAPACITY 36
MAINTAIN 'GREEN' PATHWAYS FOR ELECTIVE SURGERY 37
GREEN SITES 38
HSC TRUST DELIVERY PLANS 39
DEVELOP NEW UNSCHEDULED PATHWAYS 39
INDEPENDENT SECTOR CAPACITY 40
SURGICAL TRAINING 41
EMBED DIGITAL TRANSFORMATION 41
SECTION 4. RECOVERY: SYSTEMATIC WAITING LIST REDUCTION 42
APRIL 2021 – MARCH 2026 42
HSC DEMAND AND CAPACITY 42
NEW OUTPATIENT APPOINTMENTS 43
INPATIENT/DAYCASE TREATMENT SERVICES 43
DIAGNOSTIC SERVICES 44
BACKLOG 44
ASSUMPTIONS 45
BACKLOG FUNDING REQUIREMENTS: 2021/22 – 2026/27 47
CLOSING THE CAPACITY GAP 49
PERFORMANCE MANAGEMENT 51
SECTION 5. REDESIGN: ENHANCE AND PROTECT ELECTIVE CAPACITY 55
PROTECTING ELECTIVE SERVICES AND ENSURING EQUITY OF ACCESS 55
SEPARATION OF SCHEDULED AND UNSCHEDULED CARE 56
ESTABLISHING ELECTIVE CARE CENTRES IN NORTHERN IRELAND 58
ELECTIVE CARE CENTRES – REGIONAL MANAGEMENT 60
ORTHOPAEDIC SURGERY 62

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

WORKFORCE PLANNING 63
REGIONAL WORKFORCE PLANNING 65
WORKING ACROSS TRUST BOUNDARIES 65
COMMISSIONING MODEL AND PERFORMANCE MANAGEMENT 66
COMMISSIONING ELECTIVE CARE 66
PRIMARY CARE – EXPAND CAPACITY AND CAPABILITY 68
OUTPATIENTS 69
INFRASTRUCTURE 70
HEALTH INEQUALITIES & PREVENTION 71
CONCLUSION 74

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

MINISTERIAL FOREWORD

I am very pleased to be publishing this framework today - a roadmap for tackling the scourge of Northern Ireland's hospital waiting lists

When devolution was restored in early 2020, waiting times were identified as a major priority for the new Executive.

Tragically, the global Covid-19 pandemic has not only delayed the necessary actions, but has made the situation even worse.

While the pandemic is not yet over, the success of our vaccination programme has brought us to a better place in NI.

We owe to it patients and our great health and social care staff to push ahead with the painstaking process of rebuilding our health service.

That must include a relentless drive to bring down waiting times. These are not statistics, but real life stories of people waiting far too long in pain and discomfort.

We can do better and we will.

This framework contains a range of short term, medium term and longer term actions.

Our waiting list crisis has been building up for some seven years. There are no quick fixes.

The plans detailed in this document include: implementation of "green pathways" with every effort made to keep elected care services entirely separate from any exposure to Covid-19; expansion of the elective care centre model with surgeries provided in ring fenced specialist hubs; a relentless regional NI-wide approach rather than a disjointed postcode lottery system; delivery of megaclinics for outpatient, assessment and pre-operative assessment clinics; improved data, reporting and accountability; continued focus on performance management; ongoing close cooperation with the independent sector; development of in-house HSC capacity

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

including continued investment in staffing and use of temporary, enhanced rates for targeted shifts.

These are just some of the examples of a suite of initiatives. It will take all these and many more to properly turn the situation around.

I want long waits to have been fully banished by March 2026.

That will require sustained investment in building up the in-house capacity of our health service.

If we don't eradicate the gap between demand and capacity then the backlogs in care will keep re-occurring. Up until 2014, the gap was managed through in year funding injections to facilitate additional activity. Those monies have been in shorter supply since then and waiting times have climbed relentlessly as a result.

Investment and reform are now both required - targeted investment to get many more people treated as quickly as possible; reform to ensure the long-term problems of capacity and productivity are properly addressed.

The required investment will involve more than £700m over five years. I realise this is a big ask at a time when there are many financial demands on our public sector. However, we should have no illusions that this is a crisis that has already dragged on far too long.

The time for talk is over. What we need now is concerted action.

Robin Swann MLA
Minister of Health

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

ELECTIVE CARE FRAMEWORK ACTIONS AND TIMESCALES

This document sets out a five year plan to reduce the backlog of patients currently waiting for assessment and treatment.

£707.5 million of additional investment will be required over this period to ensure that no patient waits more than a year for assessment or treatment and to build Health and Social Care (HSC) capacity to meet annual demand for services. Without a commitment to additional investment on this scale, it will not be possible to reduce and sustain waiting times at acceptable levels.

A number of the actions are likely to require investment in infrastructure and, consequently, the associated additional capital funding would need to be provided. These requirements will be assessed as part of the proposals.

5 YEAR TARGETS

- **Subject to a commitment from the NI Executive that the necessary backlog funding will be made available, the Department's clear aim is that, by March 2026, no-one should wait more than 52 weeks for a first outpatient appointment and inpatient/day case treatment; or, 26 weeks for a diagnostics appointment.**

- **Subject to a commitment from the NI Executive that the necessary capacity funding will be made available, the Department's clear aim is that, by March 2026, we will have eradicated the gap between demand and capacity for elective care.**

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

IMMEDIATE ACTIONS – JULY – DECEMBER 2021

TREATMENT CAPACITY

In order to increase capacity, the HSCB will:

- **Support HSC staff to deliver greater levels of in-house elective care activity by increasing the use of existing bank and on-call arrangements, including the introduction, by July 2021, of temporary, enhanced rates for targeted shifts and priority activities**

- **Make recommendations on medium term contracts to lease theatres to independent providers to address current backlogs. This will include theatre capacity that is not in active use, including use of HSC theatres in evenings and weekends where HSC activity cannot be delivered – by December 2021**

- **Where independent providers can provide value for money and the same standard of service as the HSC, the HSCB will bring forward proposals for multi-year arrangements with independent sector providers to address backlogs – by December 2021 (subject to confirmation of multi-year funding before 31 July 2021)**

The HSC Estate

- **While retaining the ability in the medium term to flip back to a Covid-19 focus if required, the Whiteabbey Nightingale will be repurposed as a regional facility to support advanced rehabilitation – by September 2021**

- **The Duke of Connaught (DoC) Unit at the Musgrave Park Hospital site will be refurbished as a daycase surgery unit for orthopaedics commissioning work is expected to complete by the end of summer 2021**

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

EXPANSION OF ELECTIVE CARE CENTRES

Building on the success of the elective care centre prototypes in cataracts and varicose veins, and the development of the first Regional Day Procedure Unit, the Department will establish:

- **A new Elective Care Centre Management Team to oversee planning of services at regional elective facilities – by September 2021**

- **The new Team will make recommendations on the next site for expansion of the day procedure programme – by October 2021**

OUTPATIENT REFORM

The scale of the waiting lists means that we need to accelerate reform of outpatients.

- **All HSC Trusts will move to provide a minimum of 25% of outpatient attendances virtually, either by telephone or by video conference by October 2021**

- **The NI Orthopaedic Network will oversee the development of megaclinics for orthopaedic outpatients by September 2021**

- **The HSCB will introduce assessment megaclinics for cataracts by September 2021**

- **The HSCB will oversee the introduction of pre-operative assessment megaclinics by September 2021**

- **Breast assessment clinics for symptomatic patients will move to a regional booking system by December 2021**

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

ELECTIVE PATIENTS WITH AN URGENT NEED

With the current scale of the waiting lists, it is becoming more common for patients with an elective need to be referred to Emergency Departments as their condition deteriorates. Through the No More Silos network, the Department will invest in specialty assessment units that will be directly bookable and accessed from primary care – by September 2021

IMAGING & PATHOLOGY

- **Extending radiography advanced practice in diagnostic radiography to enable radiographers to report a greater volume of less complex work traditionally carried out by consultants – by June 2022**

- **Services will be developed in line with the recommendations of the Strategic Framework for Imaging Services, 2018 which outlines the future vision for imaging services over the next 10 year period to meet the needs of the population of NI.**

Support the Pathology Network in ensuring that HSC Pathology Services are equipped to support delivery across all relevant Rebuild programmes, in line with the modernisation and transformation of HSC Pathology Services. This will include:

- **Continuing to support delivery of COVID-19 testing across the HSC whilst ensuring routine laboratory services are restored and equipped to support Rebuilding activity across all relevant areas (diagnostics, elective care etc);**

- **Continuing the programme of HSC Pathology Transformation to improve long term resilience through: regional standardisation of laboratory processes; procurement of replacement of Laboratory Information Management Systems (LIMS) by April 2021; implementation of regional digital pathology solution by summer 2021.**

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

CROSS BORDER HEALTHCARE

The Minister will introduce a new limited administrative version of the Cross-Border Healthcare Directive for the Republic of Ireland for a 12 month period. Applications will be accepted by the Health and Social Care Board from 30 June 2021.

The Republic of Ireland Reimbursement Scheme sets out a framework, based on the Cross-Border Healthcare Directive and will allow patients to seek and pay for routinely commissioned treatment in the private sector in Ireland and have the costs, up to the cost of the treatment to the HSC in Northern Ireland, reimbursed.

The Republic of Ireland Reimbursement Scheme will be open to ordinary residents of Northern Ireland and be managed by the HSCB and all treatments are subject to prior authorisation. Further details will be available in the coming days.

SPECIALTY SPECIFIC ACTIONS

Cancer surgery makes up a significant proportion of all surgical activity. It is estimated that cancer surgery accounts for approximately 26% of all surgery across the region. The actions in this Framework will therefore have significant benefits for cancer patients. In order to address wider cancer services, the Department will publish a Cancer Recovery Plan setting out key actions to stabilise and reform cancer services over the next three years – by June 2021

The Northern Ireland Orthopaedic Network will deliver a recovery plan setting out priority actions and timescales to bring orthopaedic activity back to commissioned levels, and to increase activity as rapidly as possible – by August 2021

The Department will carry out a clinically led review of General Surgery in Northern Ireland. The first phase of this review will include a rapid assessment

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

of the actions required to stabilise general surgery in the short to medium term. This is likely to have implications for how elective and emergency surgical services are planned and delivered – by October 2021

PERFORMANCE MANAGEMENT

The investment required to deliver these targets over the next five years is set out in more detail in section 4.

To ensure additional investment is used as effectively as possible, the performance management function within the Health and Social Care Board (HSCB[1]) will be enhanced to:

- **Measure and monitor accurate and timely data on theatre utilisation, productivity and efficiency;**
- **Identify underperformance and put measures in place to support improvement;**
- **Learn from international experience to identify best practice and promote adoption and spread of learning;**
- **Identify and invest in high performing services;**
- **Provide monthly performance updates including:**
    - **levels of activity delivered in the HSC and the independent sector;**
    - **Theatre utilisation and productivity for lists delivered through the HSC and productivity in the independent sector, benchmarked against NHS good practice.**

A new Waiting List Management Unit will be in place at the HSCB by summer 2021

HSC Trusts will produce three-monthly delivery plans setting out how they will continue to restore services and reach required activity levels.

[1] By 31 March 2022, the functions of the Health and Social Care Board will transfer to the Strategic Planning and Performance Group within the Department of Health. References to HSCB after March 2022 should therefore be understood in this context.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

MEDIUM TERM ACTIONS – JANUARY 2022 – DECEMBER 2022

ANNUAL DELIVERY PLAN

Subject to confirmation of the available budget, the HSCB will produce an annual Elective Care Delivery Plan setting out:

- **Performance in the previous year;**
- **Realistic annual activity targets;**
- **Projected activity for independent sector contracts and in-house additionality;**
- **Overall demand/capacity information for each specialty.**

SEPARATION OF ELECTIVE AND UNSCHEDULED CARE

The new Elective Care Centre Management Team will make recommendations on the development of a regional 23 hr Elective Care Centre – by March 2022

In line with the recommendations in the Cancer Recovery Plan, the Department and HSCB will bring forward proposals for the development of one or more Rapid Diagnostic Centres – by March 2022

The HSCB will bring forward proposals to redesign endoscopy services.

- **This will include the possibility of consolidation on fewer sites delivering a higher volume of procedures – by January 2022; and,**
- **A scoping exercise on the feasibility of a new regional endoscopy centre(s) to deliver high volume scopes – by March 2022**

Taking into account the work of the General Surgery Review, the HSCB will bring forward proposals for the introduction of Post-Anaesthetic Care Units (PACU) at all sites providing complex surgery. This will provide postoperative high-dependency or intensive care for high-risk surgical patients in an area separate from the general intensive care unit (ICU) – by March 2022

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

WORKFORCE

New recurrent investment to be targeted at increasing capacity in each of the 15 largest elective specialties.

In addition to ongoing medical, pharmacy, nursing & AHP workforce planning:

- **The new Elective Care Centre Management Team will lead on the development of a multi-disciplinary workforce plan to ensure each centre can deliver its full capacity using the most appropriate skills mix and in line with appropriate professional regulation and standards – by March 2022**

- **The Department will shortly finalise work on a review of perioperative nursing in Northern Ireland that is intended to stabilise and grow the perioperative nursing workforce. As part of the Safe Staffing budget allocation for 2021/ 2022 there will be an additional 30 WTE Band 6 senior nursing posts recruited across the Region and one dedicated Band 7 Clinical Education Facilitator per Trust to support staff development recruited into post by October 2021. This work will also support and promote advanced and specialist practice.**

- **Building on success to date, we will continue our international recruitment programme, as a complement to our ongoing investment in training, and to ensure we have sufficient workforce supply to meet the demands being placed on our HSC system.**

- **In line with the findings of the Regional Imaging Review, the Regional Imaging Board will bring forwards proposals for a new Imaging Academy to deliver training, research and collaboration – by March 2022**

- **Progress and explore options to establish a new single regional management structure for HSC Pathology Services, to underpin the ongoing Pathology transformation programme, better equip the service to**

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

respond to current and future challenges and improve the quality and efficiency of HSC Pathology Services delivered on a regional basis.

Increase opportunities for skills mix, including:

- **An extended role for orthoptists as assistant in theatre, which would support Consultant Ophthalmologists by September 2022;**

- **Expand opportunities in ENT with Speech and Language Therapists by March 2022;**

- **Introduction of a new multidisciplinary approach to treatment, pre-habilitation and rehabilitation as part of consultant led orthopaedic services – by October 2021**

- **Introduction of a podiatric surgery pilot as part of consultant led orthopaedic services – by January 2022**

- **Nurse led pre-assessment for endoscopy by September 2022**

- **Cross sector pharmacist led medicines optimisation reviews – by March 2022**

- **Development of core roles, including specialist and advanced practice, consultant nurse roles which will enable us to maximise the contribution of nursing to perioperative care and treatment and the expansion of advanced and specialist roles such as advanced practice in anaesthetics, and expanded capacity in nurse endoscopists - as part of a five year plan to develop capacity and capability of staff within the perioperative workforce;**

- **The role of Operating Department Practitioners, including options for a Northern Ireland training programme – by September 2022**

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

COMMISSIONING AND TARGETS

The introduction of a tariff/incentivisation model is expected to make it simpler to monitor activity, tackle underperformance and reward productivity. The HSCB is currently piloting a shadow tariff model in several high volume specialties. The HSCB will:

- **Carry out an evaluation of shadow tariff models by July 2022**

- **Using the learning from this evaluation, a new tariff/incentivisation model will be developed for elective care services. The HSCB will bring forward proposals for a new funding model by January 2023**

PRIMARY CARE

Where care can be provided appropriately in a primary care setting, this has benefits for patients who may be able to receive their treatment faster, in a more convenient setting, and for our system in preventing unnecessary attendance at our hospitals.

- **The HSCB will continue to develop and expand the delivery of appropriate elective procedures in a primary care setting. Plans for the next phase of this work are expected to be ready by March 2022 and should include activities that can move to be delivered by community pharmacies or other primary care providers to reduce workload pressure in general practice.**

ADMINISTRATION OF WAITING LISTS

Strong administration ensures elective services run efficiently and reliably. As well as investment in the clinical workforce, it is vital that there is investment in the operational and organisational capacity to deliver this.

- **In orthopaedics, the NI Orthopaedic Network will trial a regional booking system for one or two procedures by January 2022.**

- **All HSC Trusts will ensure the introduction of text or voice messaging services to reduce DNA rates for all elective services – by September 2022**

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

- **HSC Trusts will invest to increase capacity in patient booking teams to ensure that patients are contacted prior to surgery.**

LONGER TERM ACTIONS – JANUARY 2023 ONWARDS

INFRASTRUCTURE

The Department will develop a long term strategic plan for future capital investment, incorporating plans to maximise elective capacity and capability across the HSC. Consequently, when prioritising funding for elective care, due consideration should also be given to funding the associated infrastructure requirements.

TARGETS

In line with the commitment in New Decade New Approach, the HSCB will pilot referral to treatment targets across 5 procedure types.

The Department will oversee the development and introduction of new waiting times targets to reflect the entire patient journey, from referral to treatment.

7-DAY WORKING

In line with increasing HSC capacity, HSC Trusts will move to a 7-day working week for existing theatre infrastructure. There are, however, significant challenges to this. In addition to the necessary investment in the workforce, this will require significant engagement with staff. This is therefore a longer term aspiration and is subject to the delivery of additional recurrent investment.

DIGITAL

There are a number of major digital programmes that will deliver significant benefits to elective care services. These include:

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

- **Implementation of a Northern Ireland Picture Archiving and Communications (NIPACS+) Programme. The NIPACS+ Programme will provide a single enterprise imaging solution for HSCNI - to support clinical diagnosis, improve clinical pathway planning, improve patient safety and enhance patient care through continued and enhanced medical image sharing and collaborative working.**

- **The introduction of Encompass. Encompass is a HSC-wide programme, working to deliver the digitally enabled transformation of Health and Social Care in Northern Ireland. The Encompass vision is for a digital care record for every citizen in Northern Ireland that better informs and supports their health and wellbeing throughout their life.**

- **The implementation of electronic prescribing in primary care which will reduce workload associated with the management of prescriptions in general practices and community pharmacies.**

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

SECTION 1. INTRODUCTION

IMPACT OF THE PANDEMIC

The global Covid-19 pandemic has had a severe impact on Northern Ireland's Health and Care system (HSC). Even before taking into account the rising number of patients requiring hospitalisation and treatment, hospital capacity was reduced by the necessity to introduce strict infection prevention and control measures. At the same time, the need for self-isolation of staff testing positive for Covid-19 has exacerbated the existing workforce challenges and has put additional pressure on those staff working in hospital services.

Since March 2020, there have been three periods where demand for urgent and emergency (unscheduled) care has risen to the degree that it has been impossible to maintain planned care while also ensuring all unscheduled patients receive appropriate care and treatment; these are termed surge periods. The first surge period took place in April 2020. Since then, there have been further surges in November 2020 and January 2021.

During a surge period, the scale of the pressures on the HSC are so great that all resources must be deployed to deal with the urgent and emergency patients presenting at hospitals. HSC Trusts have put intense effort into maintaining as much elective work as possible. Regrettably, as the number of patients requiring admission and treatment rises, it becomes increasingly difficult to maintain planned services.

Staff across the system were redeployed to help manage the higher number of patients being admitted to hospitals on an emergency basis and also to allow the system to increase critical care capacity. The majority of routine elective work was also halted during each surge period. Furthermore, as the number of unscheduled patients requiring treatment in critical care increases, this also reduces the ability of critical care to provide dedicated support for the most complex elective surgery. It is extremely concerning that there has been a sustained impact on higher priority elective care during surge periods.

For the past year, rightly and unavoidably, our resources have been directed towards patients requiring urgent and emergency care. However, as the HSC recovers from

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

this unprecedentedly difficult start to the year, the immediate focus has now turned to how we restart elective activity and ensure that any time critical treatment that was delayed or otherwise impacted by the emergency response to the pandemic is rescheduled and carried out as quickly as possible. At this point we will also need to turn our attention to the growing backlog of patients waiting for assessment and treatment on our waiting lists.

WAITING TIMES PRE-PANDEMIC

Waiting times in Northern Ireland were at an unacceptable level before the pandemic and have been worsening steadily since 2014. Prior to the pandemic, waiting times for elective care were the worst in the UK and among the worst in Europe. Indeed, in March 2019 it was reported that a person in Northern Ireland is at least 48 times as likely as a person in Wales to wait more than a year for care. This is despite Wales being the worst performer otherwise in the UK. Covid-19 has exacerbated a situation that was already reaching a critical point.

This is not the first time that Northern Ireland has faced issues with waiting times. Prior to 2005, hospital waiting times here were the longest in the UK. By 2009, the situation had broadly stabilised and remained relatively stable until 2013. At this point, the wider national financial position led to a suspension of additional activity carried out within the HSC and in the independent sector. Since that time, the backlog of patients waiting longer than ministerial targets has continued to rise.

Waiting times are currently so long in Northern Ireland that Emergency Departments (EDs) and other urgent pathways have increasingly become the default entry point for patients requiring treatment, either due to patients waiting so long that their condition becomes urgent, or because EDs are seen as a faster way of accessing diagnosis and treatment. Fixing waiting times will therefore also help take some of the pressure away from EDs.

In 2017, the Department published an elective care plan setting out proposals for reform and transformation of elective care services. While there has been a great deal of good work carried out to improve how we provide elective care in Northern Ireland, there is still a significant gap between the demand for services and the

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

capacity of the HSC to meet it. As the experience of 2013 demonstrates, there are limitations to relying on short term funding models for these services. Short term funding will only ever produce short term solutions. Reducing waiting times and keeping them at acceptable levels will require long term investment and a radically new approach to planning and delivering elective care services.

There is no doubt that reform is necessary but, above all, there needs to be a commitment to significant and sustained investment both in the HSC and in the independent sector. Increasing capacity essentially means increasing the workforce. This is true for the independent sector as much as it is true for the HSC. Short term funding simply does not provide the stability necessary to attract and retain staff, or to plan services efficiently.

Ultimately, even if all of the reforms set out in the 2017 Elective Care Plan are to be introduced successfully, the scale of the backlog is so great that this is beyond the capacity of the HSC to resolve without help. There is no doubt that the HSC will need to access additional capacity through partners in the private and charitable sectors for the foreseeable future in order to bring waiting times down to acceptable levels.

TIMESCALE AND INVESTMENT

This Framework focuses on three key phases of this work:

- **Restart – Resumption of activity**
- **Recovery – Systematic backlog reduction**
- **Redesign – Enhance and protect elective capacity**

It is important to be realistic about the time and investment necessary to deliver the actions set out in this plan. Even with the necessary investment, it is expected that it will take at least 5 years to reduce the backlog to acceptable levels and to introduce the longer term reforms necessary to ensure that the HSC is equipped to meet the needs of the Northern Ireland population.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

The investment required to fix waiting times can be split into two distinct programmes:

- **Backlog reduction**: multi-year funding earmarked to tackle the backlog of patients waiting beyond ministerial standard – this is likely to be a combination of independent sector and HSC activity;
- **Closing the capacity gap**: additional recurrent investment to increase and reform HSC capacity to meet yearly demand now and projected for future years.

In the first years of the plan, investment will be skewed towards purchasing additional capacity in the IS and HSC. Over time, it is expected that this balance will change as we increase internal capacity to match annual demand. An analysis of the current gap between HSC capacity and demand for services is included at section 5. In total, it is estimated that the HSC will require more than £700m over 5 years to implement this plan. While it will take time to build up internal HSC capacity, it is estimated that the health service will eventually require an additional £121.5m of recurrent funding to close the gap between health service capacity and public demand.

CONCLUSION

The pandemic has cruelly exposed the fault lines in our system in terms of the inability to protect elective care during periods of surge. In spite of the massive efforts of HSC leaders, and the commitment of front line staff, Northern Ireland has had to turn off elective care sooner and for longer than other parts of the UK. This may not come as a surprise to many in our system. Northern Ireland waiting times were at crisis point long before Covid-19.

Many of the actions taken during the pandemic have shown that there is a better way to work. Trusts have collaborated more closely and staff have worked across administrative boundaries to make sure that as much care as possible could be provided to patients. We have learned a great deal about the weaknesses in our system and the obstacles to a better, more efficient way of working.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

The steps outlined in this plan represent a completely new approach to how elective care is planned and delivered in Northern Ireland. We will build on the good work that has already been carried out. We will learn from what worked, and from what didn't work. We cannot accept this level of service to patients in Northern Ireland.

This plan is based on the following six principles:

1. **Recurrent investment is required to ensure that the system can build capacity to meet the population's need.**
2. **Additional investment will be required to tackle the backlog of patients waiting for diagnosis and treatment.**
3. **Elective capacity should be fully resourced and protected from unscheduled pressures.**
4. **Elective performance and investment should be closely monitored to ensure productivity and value for money.**
5. **Patients should receive consistent levels of service and quality of care regardless of the centre they are treated in.**
6. **Above all, there must be recognition at local and national level that people in Northern Ireland cannot receive a lower standard of care than in other parts of the UK.**

There is no question that reform is necessary, but it must also be recognised that reform alone will not be enough to fix the problem. Without major sustained investment it will simply not be possible to return waiting times to an acceptable standard and to keep them there.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

SECTION 2. ELECTIVE CARE IN NORTHERN IRELAND DEMAND, CAPACITY, AND CURRENT WAITING TIMES

WHAT IS ELECTIVE CARE?

When we refer to elective care, we mean care that is planned in advance as opposed to emergency or unplanned treatment. Elective care normally involves specialist clinical assessment (generally following referral from a GP or other primary/community health professional), and subsequent care or treatment, including diagnostic tests, surgery, other medical treatments and therapies.

In Northern Ireland, performance against the individual elements of the patient journey for elective care (or stages of treatment) are measured and reported separately, i.e. the waiting time for a first outpatient appointment, a diagnostic test and inpatient or daycase admission is centrally monitored and official waiting time statistics are published on a quarterly basis.

The current waiting time targets are set out in a Commissioning Plan Direction. This Direction is issued by the Minister of Health and sets out the priorities, aims and improvement objectives for Health and Social Care (HSC). For 2020/21 these targets were:

<u>By March 2021:</u>

- 50% of patients should be waiting no longer than 9 weeks for an outpatient appointment and no patient waits longer than 52 weeks;

- 55% of patients should wait no longer than 13 weeks for inpatient/daycase treatment and no patient waits longer than 52 weeks.

- 75% of patients should wait no longer than 9 weeks for a diagnostic test and no patient waits longer than 26 weeks.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

CURRENT WAITING TIMES

Our official statistics show that at the end of December 2020, 323,174 patients were waiting for a first consultant-led outpatient appointment; 275,651 patients were waiting more than 9 weeks and 167,806 patients were waiting more than 52 weeks. 105,159 patients were waiting to be admitted to hospitals in Northern Ireland; 85,883 patients were waiting more than 13 weeks and 56,242 patients were waiting more than 52 weeks.

Pre Covid-19 there was already a significant shortfall in the capacity of the HSC in Northern Ireland to meet the demand for elective care services and this was reflected in the unacceptably long waiting times.

The spread of coronavirus has caused serious disruption to our Health and Social Care system and it was unavoidable that elective care activity would reduce due to the need to redeploy staff to address rising unscheduled demand. Unfortunately, our elective waiting times will be even worse after Covid-19.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

By March 2021, 50% of patients should wait no longer than 9 weeks for a first outpatient appointment, and no patient should wait longer than 52 weeks.

There were **323,174 patients** waiting for a first outpatient appointment in Northern Ireland

A **decrease** of **1.2%** on the previous quarter

An **increase** of **6.0%** on the same quarter last year

Source: DoH Outpatient Waiting Times Dataset

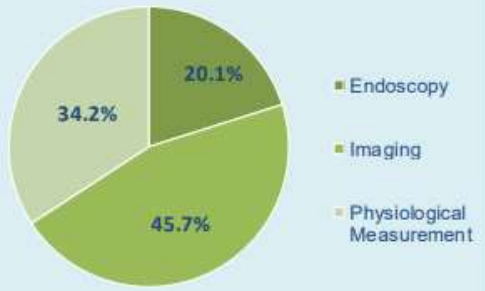
By March 2021, 75% of patients should wait no longer than 9 weeks for a diagnostic test, with no patient waiting longer than 26 weeks.

Total number of patients waiting at 31st December 2020

144,433 patients waiting for a diagnostic service at hospitals in Northern Ireland

decrease of **10.1%** on the previous quarter

increase of **2.2%** on the same quarter last year



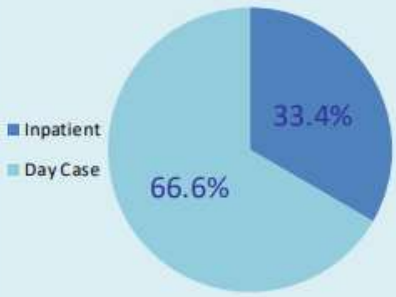
Source: SDR1

Total number of patients waiting at 31st December 2020

There were **105,159 patients** waiting to be admitted to hospitals in Northern Ireland

An increase of **5.5%** on the previous quarter

An **increase** of **16.2%** on the same quarter last year



Source: DoH Inpatient Waiting Times Dataset

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

HOW DOES THIS COMPARE WITH OTHER PARTS OF THE UK?

Direct comparison between waiting time statistics for Northern Ireland and the rest of the UK is not readily available because in the rest of the UK, waiting time data are no longer collected on separate outpatient and inpatient waits as is still the case in Northern Ireland. Other regions have moved to Referral to Treatment (RTT) time targets, which measure the total time the patient has to wait from referral to treatment. In Northern Ireland, the Department of Health do not measure complete patient journey time from GP referral to start of treatment. Once a referral for a first outpatient appointment has been made, the waiting time 'clock' starts and then stops once they have been seen by a Consultant / specialist. A separate waiting time 'clock' starts if the patient requires inpatient treatment on either a hospital admission or daycase basis, or if they require a diagnostic test.

However, if we look at pre Covid-19 figures for example, in England (total population around 55 million) at the end of November 2019 only 1,398 people were waiting more than 52 weeks on the Referral to Treatment (RTT) pathway to start treatment, whereas in NI (total population around 1.9 million), at the end of September 2019, 108,582 people were waiting more than 52 weeks for their first outpatient appointment[2].

As a relatively crude comparison, the Nuffield Trust has estimated that in March 2019, a person in Northern Ireland was at least 48 times as likely as a person in Wales to wait more than a year for care. This is despite Wales being the worst performer otherwise in the UK, and the Welsh method of measurement capturing more stages of the journey for patients who are admitted to hospital – effectively starting the clock slightly sooner[3].

[2] Waiting lists and waiting times for Elective Care in Northern Ireland: Taking stock - Research Matters (assemblyresearchmatters.org)
[3] nuffield-trust-change-or-collapse-web-final.pdf

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

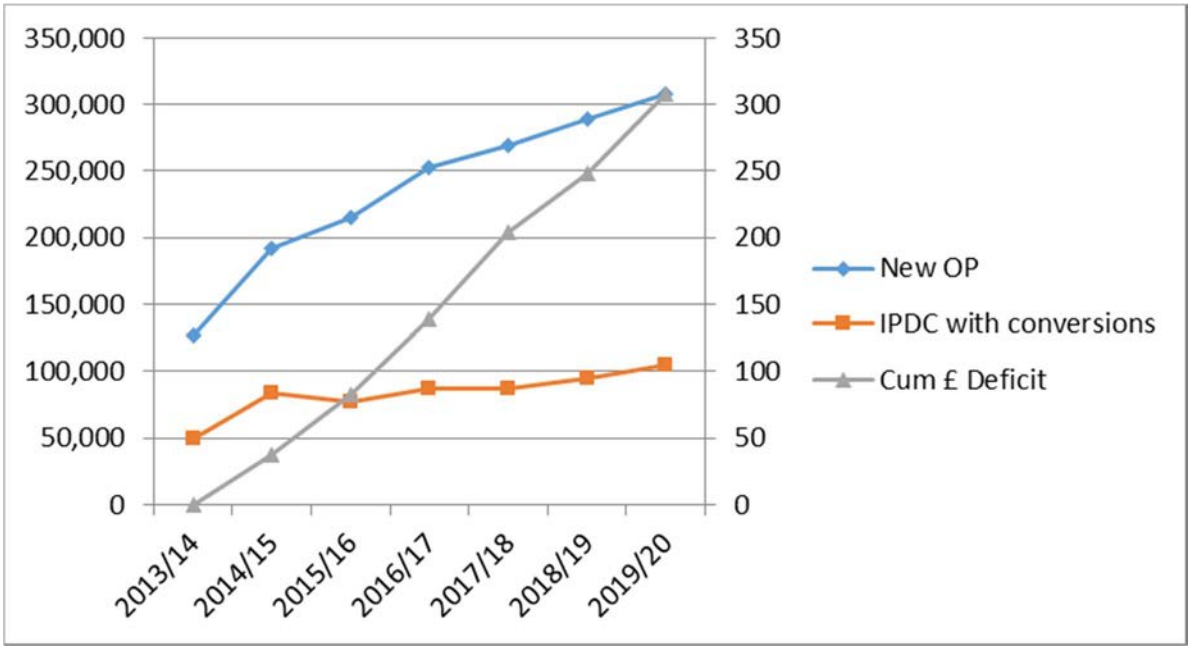
WHY ARE OUR WAITING TIMES SO HIGH?

There are several factors that have contributed to the current levels of waiting lists under-performance. Overall, demand for hospital based elective care services is increasing and this is influenced by demographic changes, particularly a growing, ageing population with more chronic health problems and complex health needs. In simple terms, the longer we live, the more likely we are to require hospital treatment at some point in our lives. Demand for care has been outstripping the ability of the system to meet it for many years. This trend will increase in the years ahead and will only be addressed by action to increase capacity, promote healthier lifestyles and tackle health inequalities.

Addressing the capacity gap is one of the most pressing challenges facing the HSC and, indeed, the Northern Ireland Executive. In practice, where the HSC is unable to deliver the required volumes of treatment, this leads to an over-reliance on buying additional activity, sometimes in-house through an overtime arrangement with HSC employed staff, or more commonly through use of the independent sector to deliver additional waiting list activity.

Since 2015 the annual budget allocated to the Department of Health has not been sufficient to keep waiting times to an acceptable level. The graph below shows how the number of patients waiting has increased as the health service deficit has increased. The fact that the number of patients waiting has not increased as steeply as the deficit clearly demonstrates that while doctors, nurses, other health professionals and managers have made every effort to ensure that any negative impact on patients has been kept to a minimum, waiting times have continued to grow. Waiting lists are now at a level where they will take years to stabilise and even longer to return to their pre-2015 levels. With the pressures of maintaining services in this period, allied to the impact of the pandemic, there is a real risk of burnout among staff. Significant additional investment and new ways of working to deliver services will be needed to achieve the necessary turnaround.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry



At the same time, our urgent and emergency services are continuing to face significant pressures and the number of acutely ill patients presenting to Emergency Departments and likely to require admission is also increasing. All too often, the result of these pressures is that planned elective procedures, or surgery, are cancelled because hospital theatres, beds or staff are needed for urgent and emergency cases.

Before a surgical procedure can be carried out a range of resources have to be brought together at the right time and the right place: surgical staff, nursing staff, anaesthetic staff, theatre time, beds. Remove any one of these components and the operation has to be cancelled. Where the same staff and resources are required to be available for both elective and emergency care, emergency treatment will always come first – because it is an emergency. The need for hospitals to quickly provide emergency treatment often results in the loss of one or more of these components for planned elective work resulting in the loss of theatre time for patients on elective waiting lists.

The way in which services are organised in Northern Ireland has also contributed to long term issues with efficiency. By attempting to provide 24/7 emergency surgery at multiple sites, we have become overly dependent on locum doctors and agency nurses in order to fill rotas and maintain unsustainable services. This approach combines inefficiency with expense and, above all, could lead to a lower standard of care for patients.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Taken together, these factors have led to a situation where demand continues to increase, while activity levels delivered by the HSC have largely remained static, or in some cases, have not maintained pace with this increase. The administrative and organisational structures we have created to deliver our health and care services can also serve to increase variation of approach. In practice, delivering elective care across five health and social care Trusts can mean that services and resources are not planned regionally, and that patients in different parts of Northern Ireland can experience different levels of service and significantly different waiting times.

Ultimately, if we persist with under-investment and our current outdated models of delivering elective and emergency care services, waiting times will continue to increase, elective capacity will not be able to keep up with demand, and the gap between what patients need and what the system can provide will continue to grow every year.

It also clear that if the system only receives short-term, non-recurrent investment, we will continue to rely on purchasing additional activity rather than investing in long term improvements. It is therefore critical that we balance short term funding to reduce waiting lists with long term investment in new ways of working to increase the in-house capacity within the HSC to meet the population's increasing demand for elective care services now and in the future.

THE IMPACT OF COVID-19

The impact of Covid-19 on the HSC has been profound and will undoubtedly be long lasting. Addressing the backlog will be challenging given the reduced operational capacity across the HSC. Indeed, separating Covid-19 and non-Covid-19 patients, maintaining physical distancing and implementing other infection control safeguards to reduce transmission of Covid-19 (e.g. isolation, use of PPE and environmental cleaning) have meant that hospitals are running at a significantly lower occupancy level than normal, with reduced theatre utilisation that is critical for urgent and elective

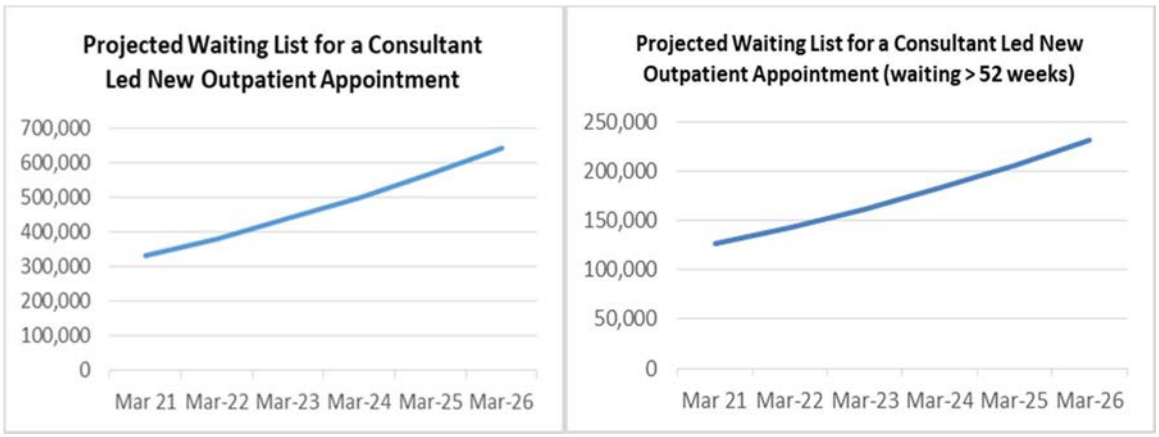
Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

work. This has restricted their capacity to deliver patient care and will constrain how quickly hospitals can begin to recommence non-Covid-19 services[4].

Primary care capacity has also been impacted and during the 20/21 year the number of GP referrals for a new Consultant Led Outpatient appointment reduced by approximately 30% from the previous year.

WHAT WILL BE THE LONG TERM IMPACT?

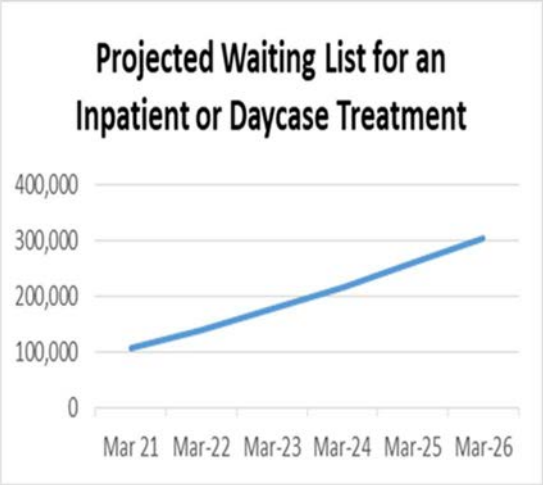
Prior to Covid-19, demand for Consultant Led New Outpatient appointments had been increasing year on year and if demand continues to rise in line with previous years, the waiting list for a New Outpatient appointment is forecast to rise to approximately 640,000 by March 2026, with 232,000 of these patients forecasted to be waiting more than 52 weeks. This reflects the impact of the current gap (approximately 50,000) and an assumed percentage increase in demand each year.

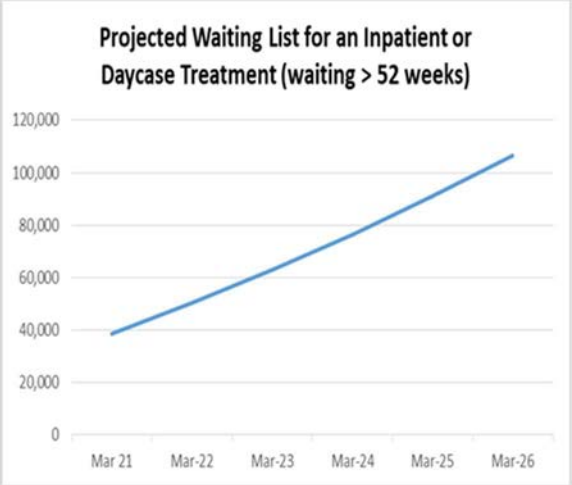


Similarly, by March 2026, the waiting list for Inpatient or Daycase treatment will rise to approximately 306,000, with 107,000 of these patients waiting > 52 weeks. This reflects the impact of the current annual gap (approximately 35,000).

[4] Preparing for a Challenging Winter – July 2020 – the Academy of Medical Sciences

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry





THE POLICY CONTEXT

In October 2016 the former Health Minister, Michelle O'Neill MLA, launched 'Health and Wellbeing 2026: Delivering Together', which seeks to radically reform the way health and social care services are designed and delivered in Northern Ireland, with a focus on person-centred care, rather than on buildings and structures. It is aligned with the aspirations set out within the Northern Ireland Executive's draft Programme for Government, and aims to improve the health of our people, improve the quality and experience of care, ensure the sustainability of our services, and to support and empower staff; but also recognises the challenges that need to be overcome if this is to be achieved.

The *Elective Care Plan* which was published in February 2017 is still a valid roadmap for change. The Plan set out the approach to redressing the waiting list crisis through major reform and transformation to sustainably improve elective care services and build capacity in the HSC. Many of the actions set out in this document were also included in the 2017 plan although the situation has deteriorated much further since then. The collapse of the Northern Ireland Executive was a significant contributory factor to the inability to implement the 2017 Elective Care Plan. While transformation funding was made available, this was only for a two year period, which did not allow for long-term, or even medium term planning.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

New Decade New Approach (NDNA) was published by the Northern Ireland Executive in January 2020. It sets out how the Executive plans to transform public services and restore public confidence in devolved government.

There are a number of specific actions relating to waiting times and the delivery of hospital services:

- Introduce a new action plan on waiting times.
- Reconfigure hospital provision to deliver better patient outcomes, more stable services and sustainable staffing. Improvements will be made in - stroke; breast assessment; urgent and emergency care; and daycase elective care - by the end of 2020.
- No one waiting over a year at 30 September 2019 for outpatient or inpatient assessment/treatment will still be on a waiting list by March 2021.
- Consider the scope for changing how waiting times are measured, to reflect the entire patient journey, from referral to treatment, with appropriate targets.

Work on these actions has largely been halted due to the impact of the pandemic and the position with regard to waiting lists has deteriorated. As the number of patients with Covid-19 continues to drop, HSC Trusts are putting in place 3-monthly plans to restart and rebuild elective care activity. Given existing pressures these plans can realistically achieve little more than reducing the rate of increase for waiting times.

DAYCASE ELECTIVE CARE

Much progress has been made on the establishment of Day Procedure Centres and work in this area can be regarded as a success story in terms of maintaining elective services throughout the pandemic.

Day Procedure Centres for cataracts and varicose veins have been operational since December 2018. A policy statement on The Establishment of a Regional Service

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Delivery Model for Daycase Elective Care Procedures in NI was published in July 2020 and a Clinical Network was established.

A Day Procedure Centre is currently operational at Lagan Valley Hospital and has been providing much needed support to the region for urgent and red flag daycase procedures in response to the downturn in elective activity in other hospitals during surge periods. A paediatric general surgery day procedure pilot is also underway at the Ulster Hospital to provide time critical surgery for children from across the region.

WHAT IS THE IMPACT ON PATIENTS?

The numbers waiting are shocking, but it is the experience of those patients waiting for care that is unacceptable. In 2018 the Patient Client Council (PCC) gathered information from approximately 700 people, nearly half of whom said their health had deteriorated while on a waiting list. Nearly a third of respondents highlighted worsening pain as a key issue. The negative impact on mental health was also described. Patients also referred to the wider adverse impact on their lifestyle and financial wellbeing.

PHYSICAL IMPACT

"I need my gallbladder removed. I have already had a scan to show stones blocking the neck. I am in constant pain. I live on anti-sickness tablets and painkillers and eat little."

MENTAL IMPACT

"The worry of what the outcome might have been had a knock on effect on my mental health, which resulted in me requiring further services."

SOCIAL IMPACT

"I am unable to make any arrangements or join in for family occasions, I feel bad letting people down which I find very disappointing and it leads to a lot of anxiety."

FINANCIAL IMPACT

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

I had more days off work with this than I have ever had in my whole life. I don't get sick pay at work only the statutory sick pay from the government and this has a huge impact on everything we do as a family. For example this year we won't be going on a summer holiday as I normally saved throughout the year to pay for this but couldn't this year. My son didn't get to go on a school trip because we really couldn't afford it."

When we describe the scale of the waiting lists in Northern Ireland, the numbers can appear so large that the impact on individuals is lost. In considering the major financial costs associated with implementing this plan, it essential not to allow this to obscure the human costs, not to mention the cost to society, of failing to address this.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

SECTION 3. RESTART: RESUMPTION OF ACTIVITY

The pandemic has caused unparalleled disruption to health and social care services and systems. The need to increase intensive care capacity to almost 200% of normal funded beds, allied to efforts to minimise nosocomial infections in health and care settings, have significantly reduced overall capacity. Staff have been redeployed to critical areas and new pathways of care due to testing requirements have resulted in slower flow of patients through the system. For large portions of the three surge periods experienced to date it has been impossible for HSC Trusts to maintain many routine services. At the height of the surges, there has even been an impact on some time critical services.

In practical terms, this has led to an increasing backlog of patients waiting to be seen on top of the existing backlogs pre-pandemic. Following the first surge period, staff in HSC Trusts made enormous efforts to resume elective services and succeeded in rapidly increasing activity over the summer months. Regrettably, from the point that unscheduled admissions began to rise significantly in October 2020, they remained stubbornly high until February 2021 and there has been a prolonged impact on some elective services.

To put this in perspective, Musgrave Park Hospital in Belfast, which provides the majority of the region's orthopaedic surgery, normally runs 10 daily lists for elective surgery. For much of the most recent surge period, this reduced to 1 list as staff were redeployed to deal with unscheduled pressures.

This section sets out the immediate actions that have been taken to restart and increase activity.

APRIL – SEPTEMBER 2021

The restart of elective services has been challenging. The following issues have been taken into consideration:

- A sustained drop in unscheduled occupancy and admissions was necessary before redeployed staff can return to their usual posts;
- Many staff are exhausted, physically and emotionally, and will require a break;

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

- Measures to prevent nosocomial infection will continue to be required. Capacity and flow will therefore continue to be impacted.
- With delays to treatment and diagnosis, it is likely that there will be an increase in referrals that will need to be treated quickly or as emergency presentations.
- In the restart phase, patients will need to be prioritised by clinical need rather than length of waiting time. Ongoing clinical review of patients on the waiting list will therefore need to be carefully managed.

RESTART: KEY ACTIONS

Since April, the HSC has been working to increase elective activity as rapidly as possible. In this period, the HSC has stood down additional surge capacity that was put in place to deal with the increased pressures on the system since November 2020 and restarted elective services. Some of the key actions have included:

DEMOBILISATION OF REDEPLOYED STAFF

The emphasis has been on ensuring a managed return of staff back to their usual roles and/or services, in particular returning theatre staff from intensive/critical care environments in order to allow high priority urgent elective surgery to recommence. This de-escalation has been carefully planned to ensure that these staff who have been involved in the peak demand period of the Covid surge also have some time to rest and recover.

CONTINUE REGIONAL PRIORITISATION OF THEATRE CAPACITY

Theatre capacity will continue to be constrained in this period across Northern Ireland as admission/inpatient numbers vary across sites in response to local demand. It is therefore essential that capacity is protected regionally for highest priority patients and that this is provided equitably across Northern Ireland.

The HSCB has established the Regional Prioritisation Oversight Group (RPOG) to ensure a clinically led network approach to agreeing relative clinical prioritisation of

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

cancer time critical/urgent cases across surgical specialties and Trusts. This approach offers a consistent and transparent means of ensuring the optimisation of all available theatre capacity (in-house and in the independent sector) during this period. The role of the RPOG will evolve as the rebuilding of elective services progresses but the overall aim is to ensure an agile and equitable regional approach to the allocation of capacity on the basis of clinical prioritisation.

The RPOG meets weekly to assess and align theatre capacity with agreed priorities. The RPOG provides the necessary oversight and governance to ensure the consistent classification of clinical priorities and this regional approach helps minimise the risk of a postcode lottery and ensures the allocation of theatre capacity on a clinically agreed prioritisation basis.

In order to support this approach, the performance management function within the HSCB will also be strengthened. This enhanced role will ensure that waiting lists are managed in line with the agreed regional clinical prioritisation standards/ process. Where necessary, the team will support Trusts to ensure the effective transfer of patients across Trust boundaries as required. The team will also look at theatre management data to assess utilisation and efficiency and identify examples of best practice that can be adopted across the region.

MAINTAIN 'GREEN' PATHWAYS FOR ELECTIVE SURGERY

The aim overall is to confirm and expand the implementation of green pathways. In this context, 'green' means that every effort will be made to keep these services entirely separate from any exposure to Covid-19 by ensuring complete separation of elective and unscheduled services.

For a site to be considered 'green' there must be complete separation of unscheduled and elective care services in and out of hours. For many sites, this will not be achievable based on current hospital configuration. Therefore, it is anticipated the establishment of 'green pathways' within hospital sites is more likely to be achievable during this period.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

All Trusts are currently delivering rebuilding plans for the period April – June 2021[5]. Within these plans, there are steps towards de-escalation of surge and development of new pathways to deliver 'green' theatre lists that are separate from unscheduled activity. Capacity to deliver these 'green' pathways should be increased in line with available theatre staff as more surge capacity is de-escalated and staff are able to return to their usual roles at the appropriate time. Scheduling theatre lists 2 - 3 weeks in advance will allow Trusts to remain agile in terms of how they respond to changing levels of unscheduled demand.

While accepting that there are still risks in the system, there is an onus on all organisations to manage this risk proportionally, giving the best opportunity to maximise theatre throughput and patient care. In this context, whilst acknowledging the negative impact on individuals affected, overall it is considered better to cancel patients at short notice, than to lose valuable theatre capacity.

One example of a green pathway is in the Western Trust where a team of orthopaedic surgeons has delivered elective orthopaedic surgery lists in the South West Acute Hospital (SWAH) in Enniskillen. This saw the successful treatment of low complex foot and ankle surgery on patients who had been waiting for years. It is hoped that the success of this pilot can be extended into the future on a regional basis and for the further development of elective orthopaedic, and other, services at the SWAH site.

Plans are also being developed in an area in the Royal Victoria Hospital to support regional flow and ensure equitable access and timely care for neurosurgery, vascular, thoracic and cardiac. The elective and unscheduled bed flow elements of these services will be managed separately.

GREEN SITES

The Lagan Valley Hospital is continuing to operate effectively as a green site for high priority daycase procedures. The unit has responded rapidly to changing regional

[5] https://www.health-ni.gov.uk/publications/rebuilding-health-and-social-care-services-phase-5-plans

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

priorities and is continuing to work with the HSCB and other HSC Trusts to expedite access to daycase theatre lists.

Northern Ireland's main elective site for complex surgery is the Belfast City Hospital (BCH) and it is important to protect regional specialist elective care at this hospital. The focus is on the development of green pathways within the site with a view to the BCH becoming a green site for complex surgery, serving the region.

HSC TRUST DELIVERY PLANS

As outlined in the Department's *Rebuilding Health and Social Care Services: Strategic Framework*[6], HSC Trusts prepare three-monthly plans setting out how core activity will be restarted, with Trusts currently delivering plans developed for April – June 2021. Following a review of activity projections for April against services actually delivered, Trust plans were revised to increase projected delivery, allowing more robust activity plans for June to be published[7]. The experience of delivering these plans will inform the development of plans that are more challenging and ambitious for the period July – August 2021, with a clear expectation of further increased activity. The intention is that plans from September onwards will have levels of activity matching and where possible exceeding pre-Covid levels. This, of course, will be subject to the future pattern of the pandemic. The position will be kept under review in light of the pandemic and other pressures as further Trust delivery plans are developed during the summer and into the autumn. The clear aim is that delivery of Trust activity will continue to be maximised in the prevailing Covid-19 context.

DEVELOP NEW UNSCHEDULED PATHWAYS

The long waiting times for elective care mean that there is likely to be an increase in the number of patients presenting to hospital later, and with greater acuity. It is therefore essential that there are effective pathways in place for these patients.

[6] https://www.health-ni.gov.uk/sites/default/files/publications/health/rebuilding-hsc.pdf
[7] https://www.health-ni.gov.uk/sites/default/files/publications/health/doh-rebuilding-hsc-services-phase-5-data-annexes-revised.pdf

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

In December, the Department published *No More Silos: COVID-19 Urgent and Emergency Care Action Plan*. Among a number of actions intended to support safe social distancing on acute hospital sites while receiving appropriate urgent and emergency treatment during the pandemic, this work has focused on the development of new pathways of care for patients requiring urgent care but who would not be defined as requiring emergency care.

HSC Trusts have already been working with the network to develop new pathways for cardiac, cancer, orthopaedic and imaging. This work will continue and expand in the coming months. There will be a specific focus on unscheduled and advanced cancer presentations through the Cancer Recovery Plan being developed by the HSCB.

INDEPENDENT SECTOR CAPACITY

Given the impact of Covid-19 on health service operating capacity, the Department has taken steps to secure theatre capacity from local independent sector hospitals. To date, this has allowed many hundreds of urgent and time critical patients to be treated. Provision for continued access to the three independent hospitals had been made to 31 March 2021 initially, however given the significant impact of the most recent surge, dialogue has resulted in a further 112 theatre sessions being made available for HSC cancer and time critical patients. During the period 1 April 2020 to 16 May 2021, approximately 5,500 patients have had their procedures undertaken by HSC consultants in the three local independent sector hospitals. In addition, capacity has been secured from private clinics in Ireland and discussions are ongoing with NHS England for additional capacity for Northern Ireland patients.

In addition to using independent sector hospital providers, there are a number of private healthcare providers providing in-sourcing services. In practice, this means privately recruited teams of clinicians providing services for HSC patients using available HSC infrastructure. This approach is currently being used successfully to deliver endoscopy and cataract procedures at weekends.

With the scale of the backlog of patients waiting for treatment, it is expected that this relationship with independent sector providers will be required for some time.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

SURGICAL TRAINING

With low levels of elective surgery taking place and the redeployment of staff to areas of unscheduled pressures during surge periods, the pandemic has had a devastating impact on elective surgical operations. In the most recent surge period, the majority of non-urgent elective operations were stood down in November and have not yet resumed to pre-Covid levels. Unsurprisingly, the suspension of surgical activity has also led to the suspension of surgical training.

The Department is working with the Royal College of Surgeons to identify actions to mitigate this impact as part of this plan to co-ordinate and rebuild services.

EMBED DIGITAL TRANSFORMATION

Throughout the pandemic Trusts have adopted use of technology such as use of telephone and virtual clinics to a much greater extent. Outpatient appointments have, where possible, moved to telephone/virtual appointments, consultations and essential communications. While there were many benefits to this, not least the ability to maintain services that would otherwise have been impossible to deliver, this also provided an opportunity to test the limitations of the virtual approach.

There are many benefits of these technology models, including: reduced travel time and easier access to services for patients; less time spent in hospital for patients; and more flexible working and timetabling for clinical staff. Alternatively, the feedback from clinical teams has also demonstrated that there are of course limitations to this approach, and many instances when a physical examination and assessment is necessary to inform clinical decision making in which a face to face appointment is more appropriate.

Technology will play a significant role in the delivery of elective care going forward and Trusts will continue to use technology where this is possible, appropriate, and where it offers the greatest benefit to patients.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

SECTION 4. RECOVERY: SYSTEMATIC WAITING LIST REDUCTION

APRIL 2021 – MARCH 2026

This section sets out two overarching strategic priorities:

- Tackling the backlog
- Closing the capacity gap

Public services in Northern Ireland are mainly funded through two distinct sources. Recurrent funding is funding that is made available to Departments to invest in services that are expected to be needed for the long term. Recurrent funding is required, for example, when recruiting additional staff into the health service. Non-recurrent funding, conversely, is funding that is made available for a specific, time-limited purpose, or which may be made available within the budget period due to underspend elsewhere. Importantly, non-recurrent funding cannot be used to invest in staff or services as there is no guarantee that it will be available after the budget cycle comes to an end.

There has been an acknowledgement for several years that there is an imbalance between patient demand for many elective specialties in Northern Ireland and the available recurrently funded capacity. For many years, the difficulties inherent to this situation were masked by the availability of additional non-recurrent funding in-year. In practice, this meant that the lack of capacity within the HSC to meet patient demand was balanced by the availability of short term funding to purchase additional activity either in the independent sector or within Trusts. This source of non-recurrent reduced dramatically in 2013 and waiting times have continued to rise since then.

HSC DEMAND AND CAPACITY

As mentioned above, the investment required to fix waiting times can be split into two distinct programmes:

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

- **Backlog reduction**: multi-year funding earmarked to tackle the backlog of patients waiting beyond ministerial standard – this will be a combination of independent sector and additional in-house activity;
- **Closing the capacity gap**: additional recurrent investment to increase and reform HSC capacity to meet yearly demand now and projected for future years.

In order to arrive at an assessment of how much recurrent investment is necessary to achieve a balanced 'steady state', it is essential that there is a clear understanding of the gap between HSC capacity and patient demand.

The following three tables set out details of the level of patient demand by specialty/modality and the corresponding funded HSC capacity for:

- New outpatient appointments;
- Inpatient/daycase treatment services;
- Diagnostic services.

These figures are based on broad planning assumptions at this time.

NEW OUTPATIENT APPOINTMENTS

	Demand Capacity Gap				
	2021/22	**2022/23**	**2023/24**	**2024/25**	**2025/26**
New Outpatient	49,640	55,540	61,868	68,669	75,872

Given that demand is expected to continue to increase, the capacity gap set out above is forecast to increase to approximately 75,900 by 2025/26.

INPATIENT/DAYCASE TREATMENT SERVICES

Intended Management	Demand Capacity Gap				
	2021/22	**2022/23**	**2023/24**	**2024/25**	**2025/26**

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Inpatient	7,429	7,962	8,524	9,115	9,738
Day case	30,528	32,537	34,653	36,880	39,232
Total	**37,957**	**40,499**	**43,177**	**45,995**	**48,970**
Excludes Cardiac Surgery and Cardiology					

Given that demand is expected to continue to increase, the capacity gap set out above (excluding cardiac surgery and cardiology and four Endoscopy procedures) is forecast to increase to approximately 49,000 by 2025/26.

DIAGNOSTIC SERVICES

Diagnostics	**Demand Capacity Gap**				
	2021/22	**2022/23**	**2023/24**	**2024/25**	**2025/26**
MRI	27,797	38,882	50,855	63,785	77,749
CT	54,784	74,939	96,707	120,216	145,606
NOUS	25,412	35,536	46,064	57,014	68,402
Plain Film	39,919	63,266	87,079	111,369	136,144
Endoscopy (4 Scopes)	4,761	5,571	6,432	7,347	8,318
Total	**152,673**	**218,194**	**287,137**	**359,731**	**436,219**

A range of reform and productivity initiatives have been factored into future modelling assumptions, but given that demand is expected to continue to increase, the overall capacity gap set out above is predicted to increase to approximately 436,500 by 2025/26.

BACKLOG

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Alongside the investment necessary to balance HSC capacity with annual population demand, it will be essential to tackle the cumulative impact of patients being added to waiting lists where the HSC does not have capacity to keep up with demand.

Where demand needs to be met over and above HSC capacity, this will need to be achieved through funding additional activity. Historically, additional activity has been provided through funding additional sessions above core capacity within HSC Trusts and by entering into contracts with independent providers to provide services to HSC patients either in private hospitals or using HSC facilities where these are not being used to deliver activity.

Working during the pandemic has had a clear impact on HSC staff, many of whom are exhausted after many months of managing the Covid-19 pandemic. It will also take time and sustained investment to train and recruit the staff required to increase HSC capacity. We will need to rely on both delivery methods.

Action is required now to address the growing number of patients waiting for diagnosis and treatment. It will require time and investment to close the capacity gap and eradicate the backlog of patients waiting for diagnosis and treatment.

At 31st March 2021, there were 189,753 (56.6%) and 68,309 (61.4%) patients waiting more than 52 weeks for a first outpatient appointment and inpatient/daycase treatment respectively, and 51,259 (37.4%) longer than 26 weeks for a diagnostic test.

ASSUMPTIONS

In order to estimate the funding requirements a number of assumptions have been made. These are:

- **Backlog** –the backlog will be cleared through funding additional in-house and independent sector activity, including inflationary uplifts.
- **Capacity gap** –
    - There will be an incremental increase in additional funded in-house capacity over the period. The assumed increase in capacity in that time has been costed at internal speciality cost rates.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

  - It will take time to increase HSC activity, and as a result there will be an ongoing reliance on funding additional activity to address the residual capacity gap, using a mixture of in-house, waiting list initiative and independent sector capacity.
- **Activity costs** – Historical average mix and cost data per specialty for additional activity and 70% of specialty cost for additional core capacity have been used for the cost model.
- **Existing core capacity** – It is assumed that HSC Trusts will deliver their existing funded core capacity. This may need to be revisited to establish the impact of Covid-19 measures on overall capacity.
- **Capital Costs** – capital costs associated with the installation of additional internal core capacity are not included with the cost model.

The number of patients waiting longer than the targets is several multiples greater than the annual capacity gap. Tackling a backlog of this scale will require ambition and innovation. If we continue to approach the problem as we have in previous years, we are likely to get the same results. Above all, we need to show the same urgency and creativity in tackling waiting times as we have shown in responding to the pandemic. It is clear that this will take many of us, clinicians, managers and elected representatives, out of our comfort zones, but this is where we need to be if we are going to fix the problem.

There has been debate in the past about whether or not the HSC should routinely use independent sector providers to deliver HSC care. We are beyond the point at which this debate is helpful, or even relevant. We are going to need all the additional capacity we can get, whether in-house or in the independent sector for the foreseeable future.

In total, it is expected that the HSC will require more than £700m over 5 years to implement the plan and address the existing backlog and the unfunded recurrent capacity gap.

While there is a clear intention to tackle waiting times as rapidly as possible, we must be realistic about the ability of both the HSC and the independent providers to deliver large amounts of activity without some time to build up services. It will be essential to invest carefully and to grow our capacity to deliver services both inside and outside

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

the HSC system. Funding requirements therefore will incrementally increase with the increase in both demand and capacity to deliver services.

This Framework sets out the investment required for the next five years. After this period, the position should be reviewed.

Additional Capacity

There will be multiple approaches to commissioning additional activity. These will include:

- In-house additionality – this will involve providing additional funding to Trusts to deliver extended days and weekend working.
- Insourcing independent sector contractors – there is a variety of providers who supply teams to carry out surgical and diagnostic procedures on HSC premises. Where existing theatre space is inactive or inefficient, these should be opened to contractors in priority specialties/services. It is proposed that uncommissioned or inactive theatre capacity will be leased to independent sector providers to deliver agreed activity.
- Outsourcing activity to the independent sector – the independent sector has repeatedly demonstrated its efficiency and productivity in delivering routine surgery. Where services can be provided at or below the cost of delivering these within the HSC, the Health and Social Care Board (HSCB) will develop multi-year contracts.

BACKLOG FUNDING REQUIREMENTS: 2021/22 – 2026/27

The amount of money made available for additional activity above commissioned healthcare services has been dropping steadily since 2013. Between 2009/10 and 2013/14, the HSC received roughly £70-80m per year of non-recurrent funding. By 2019/20, this had dropped to £37m.

While there is a clear intention to tackle waiting times as rapidly as possible, we must be realistic about the ability of both the HSC and independent providers to deliver large amounts of activity without some time to build up services and to ensure value for money. Unlike in previous years, the scale of the backlog in other jurisdictions

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

(while not comparable with the situation in NI) means that we are likely to be competing with other health services for additional capacity. Similarly, the level of the backlog means that there is already a great deal of activity in the independent sector, which may reduce their capacity to deliver lists on behalf of the HSC.

While none of the actions in this section require long term recurrent funding, they will certainly require a commitment to multi-year additional funding over at least the next five years.

Financial Year	Funding	Target
2021/22	£70m	By March 2022, we will deliver an additional 70,000 assessments and 24,500 treatments.
2022/23	£80m	By March 2023, we will deliver an additional 80,000 assessments and 28,000 treatments.
2023/24	£95m	By March 2024, we will deliver an additional 95,000 assessments and 33,250 treatments.
2024/25	£110m	By March 2025, we will deliver an additional 110,000 assessments and 38,500 treatments.
2025/26	£120m	By March 2026, we will deliver an additional 120,000 assessments and 42,000 treatments

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Total	£475m	

On the basis of a commitment from the NI Executive that the necessary backlog funding will be made available, the Department's clear aim is that, by March 2026, no-one should wait more than 52 weeks for a first outpatient appointment and inpatient/day case treatment; or, 26 weeks for a diagnostics appointment.

CLOSING THE CAPACITY GAP

In 2017, the Health and Social Care Board (HSCB) carried out a demand/capacity analysis of each of the 15 largest elective specialties, namely:

Orthopaedics	Ear, Nose and Throat	Plastic Surgery	General Medicine (including Gastroenterology)
Gynaecology	Oral Surgery	Pain Management	Rheumatology
Cardiology	Ophthalmology	Neurology	Cardiac Surgery
General Surgery	Dermatology	Urology	

Similar work has been carried out in diagnostics, focusing on the seven main modalities of:

MRI inc. CMR	CT	Non Obstetric Ultrasound	Plain Film

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Audiology	Cardiac Diagnostics	Endoscopy	

Although this work will need to be updated to reflect increasing demand and to reflect the impact of Covid-19 measures which may have reduced capacity overall, it remains a solid basis on which to plan and target new recurrent investment. The HSCB will lead on identifying immediate priorities and allocating available investment, with oversight from the Department of Health and in line with strategic reform priorities. In future years, recurrent investment will also be targeted towards the reforms identified in this framework.

Additional recurrent spend should be focused on incrementally increasing capacity. Costs will be cumulative as additional staff are recruited. Over time, recurrent investment in the HSC will allow the amount of non-recurrent funding to reduce.

There are a number of limiting factors, besides the availability of funding, to expanding health service capacity.

First and foremost, increasing capacity means increasing and investing in our workforce. Health workers are skilled professionals who require significant time to receive the necessary training and develop the skills needed to deliver these services. To support the delivery of sustainable improvements in waiting times, it will be necessary to ensure that the workforce is of sufficient size and has the necessary skills and support to carry out their roles effectively and productively.

The geographic separation of Northern Ireland from the rest of the UK, and possibly now allied to the implications of the UK's departure from the European Union, means that it can be harder to attract specialist staff to our services. Historically, there are greater benefits to training more staff locally, although there are limits to the number of training places that can be delivered. Recurrent investment is therefore likely to be limited by the number of training places that can be delivered or success in recruiting from elsewhere.

Recurrent investment will be targeted at increasing training numbers; recruiting new staff; sustainability of services; and, moving to seven day working for HSC services.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Financial Year	Funding	Cumulative Impact
2021/22	£1.5m	£1.5m
2022/23	£10m	£11.5m
2023/24	£20m	£31.5m
2024/25	£35m	£66.5m
2025/26	£55m	£121.5m

On the basis of a commitment from the NI Executive that the necessary capacity funding will be made available, the Department's clear aim is that, by March 2026, we will have eradicated the gap between demand and capacity for elective care.

Overall, this comes to a total of £232.5m over five years, with a recurrent requirement of £121.5m per year. This is a significant amount of investment but without additional funding on this scale, there is no realistic possibility of reducing waiting times to acceptable levels.

£707.5 million of additional investment should be made available over a five year period to reduce the backlog of patients and to build HSC capacity to meet annual demand for services. Without a commitment to additional investment on this scale, it will not be possible to reduce and sustain waiting times at acceptable levels.

PERFORMANCE MANAGEMENT

Service users have a growing expectation that the services we design and manage will result in the maximum health gain for the resources that we deploy. Reducing waste, increasing throughput and streamlining patient pathways are all actions which contribute to improved quality of care and delivering a more efficient and productive health service. Value for money and improved patient outcomes are not competing alternatives; they are one and the same thing.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

While the HSC has made steady progress in delivering improved productivity there still remains significant scope to release further gains. Service redesign is a key component of the reform and modernisation agenda and the HSC will continue to work closely with local Trusts, to progress this work. Through its performance management function the HSCB will also look at key productivity information to identify and challenge unwarranted variation.

It is important to be clear that the scale of the gap between demand and capacity in each of the areas described in the previous section means that the current ministerial targets for inpatient, daycase and diagnostic procedures are unlikely to be met for some years. The analysis carried out to develop this plan will allow the HSCB to identify and prioritise those specialties with the most significant backlog and the most significant capacity gaps. This will allow funding to be invested in areas where it will have the greatest impact but it will take time and investment to bring waiting times down to acceptable levels.

Alongside recurrent and non-recurrent investment to tackle the capacity gap and the backlog of patients waiting for care, a key element of this plan must be the reintroduction of robust performance management arrangements to ensure that organisations and individuals are held accountable for the delivery of agreed outcomes and funded activity.

In the interim, and in addition to new funding models, the HSCB will bring a renewed focus to performance, quality and productivity, both in the HSC and in the independent sector. This will include an assessment of gaps in existing management information, consideration of new approaches to performance management, and the establishment of new, realistic performance targets until we are in a position to meet the current ministerial standards.

As part of this work, the HSCB will also work to introduce the Referral to Treatment (RTT) waiting times reflecting the entire patient journey, from GP referral up to the point where the patient is actually treated.

The primary objective of an RTT target is to measure and ultimately help reduce patient waiting time over the whole journey of care and not just for discrete stages of

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

treatment. Any waiting by patients along the 'patient journey' should be as a consequence of a decision by the clinical team, and through discussion with the patient, rather than as a consequence of the need to queue for access to clinical services. Such pathways are therefore about improving the patient's experience and ensuring all patients receive high quality elective care without any unnecessary delay.

Introduction of the RTT would be challenging while the backlog of patients waiting for diagnosis and treatment remains so extensive. Introducing RTT waiting times is likely to be a long term project and will need to be aligned to the introduction of Encompass across the HSC. If it is decided to proceed with the creation of a single delivery body to manage dedicated elective care sites, this could provide an ideal opportunity to test this approach across a number of pathways.

In order to ensure additional investment is used as effectively as possible, the performance management function within the HSCB will be enhanced and strengthened to ensure that it is fully equipped to:

- **Measure and monitor accurate and timely data on theatre utilisation, productivity and efficiency;**
- **Identify underperformance and put measures in place to support improvement;**
- **Learn from international experience to identify best practice and promote adoption and spread of learning;**
- **Identify and invest in high performing services;**
- **Provide monthly performance updates including:**
    - **levels of activity delivered in the HSC and the independent sector;**
    - **Theatre utilisation and productivity for lists delivered through the HSC and productivity in the independent sector, benchmarked against NHS good practice.**

A new Waiting List Management Unit will be in place at the HSCB Care Board by summer 2021

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Subject to confirmation of the available budget, the HSCB will produce an annual Elective Care Delivery Plan setting out:

- **Performance in the previous year;**
- **Realistic annual activity targets;**
- **Projected activity for independent sector contracts and in-house additionality;**
- **Overall demand/capacity information for each specialty.**

Performance and productivity gains will only be fully exploited if there is early confirmation of the available budget. Effective advance planning of elective capacity in the HSC and the independent sector requires advance notice of the level of funding to be made available.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

SECTION 5. REDESIGN: ENHANCE AND PROTECT ELECTIVE CAPACITY

PROTECTING ELECTIVE SERVICES AND ENSURING EQUITY OF ACCESS

It is too early to state definitively that Northern Ireland has performed less well than other UK countries in maintaining elective services. There are, however, indications that, in order to manage the unprecedented levels of unscheduled care pressures at hospitals, the Northern Ireland HSC has found it necessary to turn down elective services earlier, and for longer, than other parts of these islands.

Nevertheless, the pandemic has also demonstrated what can be achieved within our system when it is required. The incredible commitment shown by clinical staff and managers in the HSC has allowed everyone requiring unscheduled care to receive it. Critical care capacity has been doubled and clinicians and managers have found new ways of working that would not have been thought possible even 18 months before.

However, it is fair to say that the impact on elective services here is reflective of the longstanding vulnerability of our hospital services. Similarly the incapacity of the HSC in Northern Ireland to create truly 'green' sites is at least partly due to the systemic problems identified as far back as the Hayes report in 2000 and, subsequently, in *Transforming Your Care*, and *Systems, Not Structures*.

Elective care services in Northern Ireland are under significant pressure; there are long waiting times and large numbers of patients waiting for treatment. As with many services, as a relatively small region we are currently spreading our resources far too thinly across multiple sites. Day procedures, for example, are currently being delivered across five HSC Trusts and around 19 different hospital sites.

As a result of this fragmented system, there is a persistent inequity of service provision. Waiting times vary significantly across Northern Ireland depending on demand, capacity and performance in different Trust areas. In practice this creates a postcode lottery in terms of access to treatment with patients in one area waiting years for treatment while in another area they may be able to access the same treatment within weeks. Moreover, the pressures on services are expected to

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

increase in future due to a number of factors, including demographic change, new technological developments, and new medical advances.

In addition to the expected clinical benefits of delivering high volumes of treatments on a small number of specialist sites, there are likely to be significant organisational and administrative benefits to delivering day procedures as a single regional service. In a region the size of Northern Ireland, it is not acceptable that people should have such widely different experiences of accessing healthcare based purely on where they live.

It should also be noted that the reforms proposed in this section will only work to their full impact if action is taken to address the capacity gap outlined in the previous section, which will require significant investment. Without this, there will always be pressures and gaps in services and redesign of any scale would have to be carefully managed in order to ensure that it did not destabilise services of higher clinical priority.

SEPARATION OF SCHEDULED AND UNSCHEDULED CARE

The nature of the most complex elective surgery means that it can never be separated entirely from unscheduled care services. However, for the less complex surgery to be as efficient as possible, there is a strong case for attempting to insulate it from unscheduled care pressures. Before a surgical procedure can be carried out, a range of resources have to be brought together at the right time and the right place: surgical staff, nursing staff, anaesthetic staff, theatre time, beds. Remove any one of these components and the operation has to be cancelled. Where the same staff and resources are required to be available for both emergency and elective care, emergency treatment will always come first and will inevitably result in cancellation of elective.

Locally, nationally, and internationally, there are multiple working examples of how efficiently elective care can be provided where there is no competition from unscheduled pressures. From an HSC perspective, it is perhaps unfortunate that in Northern Ireland these are largely in the independent sector. It has been known for some time that clinicians working in independent clinics can deliver 12-13 cataract procedures per list. In recent months, it has also become clear that clinicians working

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

as an in-sourced team in an HSC hospital can deliver the same levels of productivity. By comparison, clinicians working in their HSC capacity, deliver an average of 7 procedures per list. The experience has also been reflected in current endoscopy services being delivered on an in-sourcing basis in one Trust where productivity rates have also been significantly higher than the HSC average. In many cases, the clinicians working in the independent sector are also employed within the HSC. In view of this, it can only be concluded that there must be other, systemic, factors at play which prevent teams working within the HSC from achieving the levels of productivity they produce when working with independent providers. While some of these, such as the need to provide training to junior staff, may be unavoidable, it is likely that clear delineation of and investment in elective care services that are completely protected from unscheduled pressures would lead to increased productivity.

The approach of improving elective efficiency by separating it entirely from unscheduled can also be replicated within the public sector. The Golden Jubilee hospital in Glasgow has been established as a provider delivering only elective care. Established in 2002, the Golden Jubilee National Hospital is NHS Scotland's original national elective and diagnostic centre. The Golden Jubilee model has been considered a success story by the Scottish Government and the same approach is now being expanded across the country in order to allow patients to be treated more quickly for planned surgery, taking pressure off hospitals dealing with unplanned and emergency treatment. As well as providing services to patients from the surrounding area, patients from any part of Scotland can opt to be treated in the hospital, for example where they may have to wait longer for treatment locally.

A dedicated elective care body, similar to the Golden Jubilee model, would offer streamlined planning, delivery and accountability, as well as facilitating the separation of elective and unscheduled care administratively as well as physically. The establishment of such a body would require legislation and there would be costs associated in terms of staffing, overheads, boardroom costs etc. although over time this may be offset by higher efficiency and more effective performance management.

While we continue to rebuild services that have been impacted by the pandemic response, this may not be the most appropriate time to create new structures,

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

although this may be an option that could be revisited as work on regional elective care centres continues to develop. In the sections below we describe how we propose to establish a separate and regional Management Team responsible for overseeing the delivery of Elective Care Centres. In the first instance, this will be taken forward within the existing HSC governance and accountability structures.

Decisions around the future of elective care should also be taken in the context of the vulnerability of General Surgery across the region. General Surgery is a wide ranging specialty with many subspecialties. As one of the largest surgical specialties in the UK, General Surgery plays a key role in the provision of elective and emergency surgery.

Unfortunately, as with other areas of care, the current General Surgery service is struggling as a result of increasing demands for services, increasing surgical specialisation and capacity gaps within the current structure. There is significant variation in practice and in waiting times across the region and, allied to this, there are specific issues relating to the requirement to maintain multiple 24/7 rotas for emergency surgery for adults and children and the difficulties this creates in terms of staffing and meeting professionally mandated standards of care. It is also important to note that some elements of general surgery delivered as planned elective procedures have been particularly impacted by the pandemic.

A new approach is needed to ensure that General Surgery, both unscheduled and elective, can be provided safely and sustainably across Northern Ireland.

The Department will therefore lead a review of General Surgery in Northern Ireland. The first phase of this review should include a rapid assessment of the actions required to stabilise General Surgery in the short to medium term. This is likely to have implications for how elective and emergency surgical services are planned and delivered.

ESTABLISHING ELECTIVE CARE CENTRES IN NORTHERN IRELAND

Last summer it was decided that Lagan Valley Hospital in the South Eastern Trust would become a dedicated elective care centre for the region. While the nature of

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

the site means that it is most suitable for daycase surgery and procedures rather than more complex work, the complete separation of elective and unscheduled services at the site has enabled services to continue be delivered throughout the pandemic on a 'covid-light' pathway. In recent months, the site has delivered red flag and other high priority lists on behalf of the region where these could not be accommodated at the hospital of origin due to pandemic pressures.

The Day Procedure Centre at Lagan Valley has treated 1,588 patients since October 2020 across a range of specialties including plastic surgery, Ear Nose & Throat, General Surgery, Breast surgery, Urology, Ophthalmology.

The success of the model is also dependent on the host Trust protecting the available staff and beds for regional patients. In establishing Northern Ireland's first regional elective care centre, the South Eastern Trust has proved that this can be done.

Within the same Trust area a regional paediatric general surgery pilot is underway at the Ulster Hospital and clinical teams are also continuing to deliver some cataract operations on a regional basis at the Downe Hospital. Prior to the pandemic, there were also similar initiatives for cataracts and varicose veins in Omagh, South Tyrone and the Mid-Ulster Hospital.

While the overall model for Lagan Valley Hospital is still developing, it has already demonstrated the benefits of having dedicated elective care capacity. Alongside the work to finalise the model at Lagan Valley, it is therefore proposed that consideration should be given to expanding this approach to further sites in a managed process.

These sites will become 'green sites' in that every effort will be made to keep them entirely separate from any exposure to Covid-19 by ensuring complete separation of elective and unscheduled services.

As more elective capacity becomes available as pressures at hospitals decrease, it is proposed that we will develop a plan to expand the number of sites providing regional daycase facilities for adults and children as part of a managed process.

With the scale of the backlog of patients waiting for assessment and treatment, and the expectation that this will continue in light of forecast demographic changes and

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

the increasing population, it is proposed to now move beyond daycase procedure capacity in the next phase of developing elective care centres to include consideration of how a similar model could work in relation to some short stay inpatient procedures.

In the initial phases of this work, the HSC will continue to operate within existing systems and organisations. While it is acknowledged that the system is unlikely to be able to deliver the full efficiency and productivity gains within these structures, they will provide invaluable learning as the system moves to the new model described below.

The development of regionally managed elective care centres for daycase procedures and short stay inpatient procedures will be taken forward on a phased basis. We aim to identify the next suitable centre (Phase 2) by October 2021 and further centre/s (Phase 3) by March 2022.

ELECTIVE CARE CENTRES – REGIONAL MANAGEMENT

In establishing a regional Daycase Procedure Centre at the Lagan Valley Hospital, it was decided to place the governance and management of the centre under the responsibility of the South Eastern HSC Trust. On the whole, this has worked well. While there continue to be some persistent difficulties around the transfer of patients across Trust boundaries, the work at the site has been driven and managed by a small team of committed individuals who have engaged openly and equitably with other HSC organisations.

Nevertheless, as the model is expanded to further sites, it is possible that establishing and managing a new model of elective care centres within existing Trusts would result in all five Trusts being providers of elective services to all other Trusts. This is likely to present a degree of complexity that will be confusing for staff and, above all, for patients. Furthermore, the scarcest and most valuable resources (our staff) would have employment and management processes to overlay on this. In practice it is likely that, under a 5 Trust model of elective care, providers would be dependent on one or two other Trusts for critical resources to deliver services to all Trusts. On this basis, it is not difficult to see how staffing shortages in one Trust

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

could result in those staff being withheld from Elective Care Centres in another Trust, perpetuating the problems that HSC is facing today.

Performance issues, especially in terms of cancellations or underutilisation of sessions, will impact the delivery of the entire Elective Care Centre plan. Under the arrangement described above, meaningful accountability processes would require a framework involving all Trusts in assessing and addressing underperformance.

In order to deliver this, it is proposed that the Department will establish an Elective Care Centre Management Team. In its initial form, the Management Team will exist as part of a collaborative model, ensuring regional planning and delivery of Elective Care Centre capacity, including the identification of potential new spoke sites. Working within the current governance and accountability structures, it is clear that Elective Care Centres must operate under the accountability of the host Trust. The role and functions of the Management Team may change in response to the closure of the HSCB and as the new HSC planning model develops.

While the Management Team would operate on a regional basis and would have responsibility for allocation of the budget associated with elective care centres, it will work in partnership with HSC leaders and established Clinical Networks to ensure a collaborative approach to the delivery of elective care. The Management Team would be accountable to the HSCB and, ultimately, the Department.

In carrying out its role, the Management Team will ensure that the network of regional Elective Care Centres:

- Responds to changes in demand through effectively managing regional capacity;
- Has local performance management arrangements embedded;
- Meets current and future quality and regulatory requirements;
- Is supported by modern information systems and infrastructure;
- Promotes best practice and standardisation;
- Adopts new ways of working and innovative technologies;
- Has a focus on positive patient outcomes and experience and has systems in place to gather such information;
- Makes efficient use of available resources; and,
- Provides training and teaching opportunities for staff and medical students.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

The creation of a new regional elective care Management Team will take 3 months to deliver. In addition to taking on oversight of the delivery of regional elective care services at Lagan Valley, the new Management Team will assume a lead role in planning for future elective care centre hubs across Northern Ireland.

While only applying to a subset of elective care procedures, this proposed approach represents a significant change in the way in which elective care services are currently planned and delivered. It would require a commitment from all Trusts that in sites identified as regional elective care centres, beds and staff would be ring fenced for the delivery of regional elective care with operational oversight granted to the Management Team alongside local operational leads.

The benefits and risks of a regional approach to the operational planning and delivery of Elective Care Centres must therefore be considered alongside the implications of this new approach in terms of accountability, staffing and culture.

Preparation for this will require detailed work on: accountability; governance; staffing models; funding and performance management metrics; structures; case mix; and, ministerial targets.

ORTHOPAEDIC SURGERY

Elective orthopaedic services have been severely impacted by the pandemic. Orthopaedic conditions are rarely life threatening and, as a result, orthopaedic services have been downturned earlier and for longer than many other specialties. However, while they may not be life threatening, the impact of these conditions can be severely life limiting and can have a very serious impact on people's quality of life, their ability to work, or their ability to live independently. As the British Orthopaedic Association has stated, "patients suffer major effects on their physical and mental health as their bones deteriorate and they struggle to undertake everyday activities. These delays really matter. Patients suffer before and after treatment."

Furthermore, waiting times for orthopaedic services were already the longest in the UK prior to the onset of the pandemic and demand for these services continues to increase in line with ageing demographics. Musgrave Park Hospital carries out

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

approximately two thirds of the surgery in Northern Ireland and plans are already in place for it to operate as an elective care centre. In practice, however, the site is often required to deal with unscheduled pressures which impact on overall elective orthopaedic capacity. It will be a priority to re-establish and protect Musgrave Park Hospital as a regional green site for orthopaedic surgery. At the same time, it will be important that orthopaedic capacity is increased and protected as far as possible at each of the hub sites of Craigavon, Altnagelvin and Musgrave Park in line with the orthopaedic recovery blueprint.

Plans must also be put in place to ensure that orthopaedic surgery can be protected through any future surges. This means that staff and theatres should be protected from unscheduled pressures to ensure that services can be maintained at times of pressure.

Where it is not possible to guarantee the protection of HSC delivered services, we will need to consider whether medium term contracts with independent sector providers – either on an insourcing or outsourcing basis – would provide a more reliable service model in the medium term.

As an immediate next step plans will be put in place to a similar regional model for ring fenced elective orthopaedic services at Musgrave Park Hospital. The Northern Ireland Orthopaedic Network will work closely with the three Health and Social Care Trusts providing orthopaedic services to develop plans for the protection of orthopaedic capacity at sites serving the region.

WORKFORCE PLANNING

Perhaps the most critical aspect of delivering sustainable reform in elective care is the workforce. To support the delivery of long term improvements in waiting times it is clear that the system needs to be fully resourced in terms of having the right number of staff with the necessary skills and support.

It is therefore important that we look at the skills mix required to deliver services. This involves designing the roles and responsibilities of a team, around the needs of

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

the patient, to ensure staff have got the right skills at the right level to meet those needs. During the pandemic, certain parts of the HSC system, by necessity, radically changed the way they were staffed to ensure sufficient capacity was available to manage demand for essential services. There is much we can learn from this approach to ensure that we have the appropriate skills mix in the workforce to deliver both high quality care and also value for money. For the system to function as efficiently as possible, all parts of the patient journey need to be able to fulfil their role.

- An increase in GP numbers will be necessary to maintain existing primary care services and support the expansion of elective demand that can be managed in a primary care setting, thereby reducing the need for a referral to secondary care services in a hospital setting.

- The response to the pandemic has underlined the essential role played by the nursing workforce in maintaining elective care services, and also the vulnerability of these services due to the current level of vacancies. Substantial expansion of the nursing workforce is essential.

- A significant increase will also be required to the consultant workforce across a range of specialty areas to ensure appropriate staffing levels to respond to both elective and unscheduled care demand and to provide appropriate specialist support to GPs and other staff in primary and community care settings.

- We must also continue to grow and develop new, multidisciplinary roles that will help to support and increase elective care provision. These will include advanced and specialist nursing roles, Allied Health Professionals, operating department practitioners, physicians' associates, and other key roles that are essential to maintain and expand these services in line with appropriate professional regulation and standards.

A key element of any plan will be increasing the number of training places. Recognising the time taken to develop and train individuals, it is likely international recruitment will continue to play an important role in the reduction of HSC vacancy rates. To the extent that these training places and/or other measures to expand the workforce cannot be funded and delivered, it will be necessary to maintain on an

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

ongoing basis arrangements with independent providers to address any shortfall in HSC capacity relative to patient demand.

REGIONAL WORKFORCE PLANNING

Beyond this, however, as a region we also need to work smarter with regard to recruitment to specialist acute services.

In the past decade, there have been numerous examples of one Trust recruiting to fill medical vacancies, only for the successful candidate to come from a neighbouring Trust, thereby creating another vacancy in the service. In practice, this simply serves to move the problem around Northern Ireland, rather than offering any additional capacity.

In future, there needs to be a greater level of regional planning in terms of the available workforce and recruitment to such posts. Where possible, this should also include a move to a regional waiting list for some specialist services in order to ensure that demand is spread equally and patients have an equitable level of access to services. This would also help to mitigate the impact of any changes to the service profile as described above. The move to a single HSC employer as described in the Health & Social Care Workforce Strategy 2026 will be a key enabler for these changes.

Once established, the new Elective Care Delivery Management Team will support the Department in the development of a multi-disciplinary workforce plan to ensure each centre can deliver its full capacity using the most appropriate skills mix.

Investment in the Elective Care Centre workforce plan must be considered alongside competing workforce priorities to maintain capacity for complex elective and unscheduled care services.

WORKING ACROSS TRUST BOUNDARIES

In establishing the prototype daycase elective care centres for cataracts and varicose veins, perhaps the most important lesson derived from these projects was

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

the difficulty of planning such services across Trust boundaries. In both cases, there were significant difficulties around issues such as: the transfer of patient notes; workforce governance, pharmacy governance; and, technical or administrative difficulties in terms of setting up and managing regional waiting lists.

While some of the governance issues will only be fully addressed with the creation of a single HSC employer, the prototypes have developed a number of temporary workarounds to tackle these challenges. These are however sub-optimal and add a significant administrative burden to the process. The development of effective governance, administrative and technical solutions is absolutely essential to enable greater consistency, standardisation, and cross-Trust collaboration.

Interim digital solutions will need to be put in place to facilitate regional management of waiting lists in elective care centres and support the development of standardised clinical pathways. These solutions should be designed to inform and complement the delivery of the Encompass programme

COMMISSIONING MODEL AND PERFORMANCE MANAGEMENT

COMMISSIONING ELECTIVE CARE

Commissioning in the context of health and social care can be defined as the process of securing the provision of services to meet the needs of a population. This is a complex process. In practice, it requires the assessment of the population's health and social care needs; the planning of services to meet those needs; the procurement of those services; monitoring of the delivery of services against agreed standards; and an evaluation of the impact of the services that have been commissioned.

The Department's policy statement on the establishment of daycase elective care centres set out the most common approaches to commissioning elective care. These include:

- Capitation: Broadly speaking capitation means paying a provider or group of providers to cover the majority (or all) of the care provided to a specified

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

population across different care settings. The regular payments are calculated as a lump sum per patient.

- Block Contracts: These are effectively pre-payments that are made by commissioners to healthcare providers to deliver a pre-agreed number of procedures or operations. For example, a hospital could be given a block contract to undertake acute care in a particular geographical area. Generally, the value of the contract is independent of the actual number of patients treated or the amount of activity undertaken.
- Tariff/ Activity Based Funding: This is a system of paying hospitals and other providers for the number of patients that they treat. The idea is that providers will receive a fixed payment – the national tariff – for each type of patient treated. Termed 'payment by results', the policy rewards providers for volumes of work adjusted for differences in case mix.

Historically, commissioning in Northern Ireland has generally focused on a combination of capitation and block contracts. Several reviews carried out in Northern Ireland have made comment on the methods of commissioning and have drawn out the benefits of a tariff model in transparently driving efficiency and productivity.

The policy statement 'A regional Model for Daycase Elective Care Centre in Northern Ireland' published in July 2020 recognised that a tariff based commissioning model would be an appropriate mechanism for daycase elective care to ensure that high productivity is rewarded and also that poor performance is rapidly identified and corrective action taken. The risk of perverse incentives is low as referrals into the service will be driven by clinical decisions. Conversely, increased productivity and efficiency would bring great benefits to patients, and to the wider health and care system in terms of the most effective use of resources.

The introduction of a tariff based funding model will make it simpler to monitor activity, tackle underperformance and reward productivity. Under a tariff model, organisations are only funded for the activity they deliver. Underperformance is therefore reflected in the overall investment in the service. However, this model will take time to implement and may only be appropriate for a subset of the overall elective programme.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

The Health and Social Care Board (HSCB) is working to pilot a shadow tariff model in a number of high volume specialties, including cataracts and hernias.

Following evaluation of this approach, consideration may be given to the expansion of tariffs into other aspects of elective care, including appropriate inpatient activity. This should also take into account the experience of the commissioning/payment model in England and best practice in other jurisdictions.

PRIMARY CARE – EXPAND CAPACITY AND CAPABILITY

In addition to the move from inpatient to daycase surgery, this trend has also been apparent in the increasing number of procedures that are being carried out in an outpatient setting or in primary care.

For example this year 1,000 vasectomies will be treated in primary care settings. If carried out in hospitals, these would have required up to 130 theatre sessions as well as a significant commitment from surgical teams across general surgery and urology.

General practitioners and hospital clinicians are currently working together to deliver similar approaches in relation to dermatology, musculoskeletal, and gynaecology patients. These new ways of delivering non-complex elective procedures in primary care have benefits in terms of efficiency and also in terms of patient comfort and convenience. They can also provide opportunities for other health care professionals to broaden their skills and the scope of their relationship with their patients.

There are significant opportunities to better manage patient demand in primary care avoiding the need for a referral to secondary care for a specialist opinion. Through GP Federations and other arrangements, it should be possible in a range of specialties for GPs to work individually and collectively in a way which maximises the skills and expertise within primary care and significantly reduce demand for secondary care services. There are particular opportunities in non-surgical specialties such as rheumatology and dermatology. To secure these opportunities

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

will require an expansion in primary care capacity and the development of wider skills and capabilities, supported as required through appropriate education.

By taking these procedures out of hospitals, we can free up capacity for the delivery of more complex elective care either in dedicated regional elective care centres treating in-patients or on major acute hospital sites.

Where care can be provided appropriately in a primary care setting, this has benefits for patients who may be able to receive their treatment faster, in a more convenient setting, and for our system in preventing unnecessary attendance at our hospitals. It is recommended that the HSCB should continue to develop and expand the delivery of appropriate elective procedures in a primary care setting.

OUTPATIENTS

Transformation of our outpatient services is key to improving the productivity and sustainability of our elective services. The aim is to ensure that patients are seen by the right person, with the right information, at the right time, in the right place.

One-stop clinics have been implemented in a number of specialties and have contributed to a significant reduction in the number of outpatient appointments required. This has freed up consultant capacity and improved patient experience.

Work continues to change review practice across specialties to ensure those patients who have had treatment and need to be reviewed by the hospital team are seen in a timely manner. This involves no planned specialist follow-up after routine surgery as standard and has already been introduced for a number of pathways. Where a review appointment is necessary consideration should be given to developing non-consultant led outpatient services including nurse specialist, enhanced Allied Health Professional (AHP) services.

We have also developed new and innovative ways to see patients in appropriate settings for example through our enhanced GP services and our Day Procedure Centres. Through these initiatives we are standardising and streamlining patient pathways.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Throughout the pandemic Trusts have adopted use of technology such as telephone and virtual clinics to a much greater extent and this transformation will now be embedded with technology continuing to play a significant role in the delivery of elective care, where possible and appropriate.

Going forward the HSC will also focus on expansion of the e-triage model which allows hospital consultants to electronically triage primary care referrals and either, (i) provide direct advice to the GP on the next steps, (ii) refer directly for investigations, or (iii) invite the patient to attend an outpatient clinic. Direct access for specific tests can be a cost effective way of reducing the time for diagnosis and improving patient access.

The HSC will also take forward the development of 'hot clinics' and 'megaclinics' which will facilitate rapid access for patients and avoid attendance in ED.

The establishment of Rapid Diagnostic Centres is being considered as part of work on the forthcoming Cancer Strategy. There is a high level of clinical support for the development of Rapid Diagnostic Centres as a means of increasing diagnostic capacity. Implementation of Rapid Diagnostic Centres will however require additional investment in the staff and infrastructure required to deliver them.

The Department, HSCB and Trusts will continue to develop opportunities to consolidate and transform our outpatient services to reduce waiting times and improve patient experience.

INFRASTRUCTURE

One of the key principles underpinning this Framework is that existing HSC infrastructure should be used optimally before recommending a new development.

The analysis carried out through the daycase elective care project suggested that there are opportunities to increase efficiency and throughput in the existing theatre capacity. However, it is also expected that the scale of the gap that has grown

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

between capacity and demand is likely to require capital investment in additional theatres and, on some sites, additional bed capacity.

Drawing on our understanding of the capacity and capability of each hospital site to deliver the required volumes activity will shape the development of capital plans to maximise the delivery of elective care in line with the recommendations of this framework.

The Department will therefore develop a long term strategic plan for future capital investment to maximise elective capacity and capability across the HSC.

As a principle we aim to maximise the use of our existing theatre capacity. To the extent that additional infrastructure cannot be funded, staffed and delivered, it will be necessary to use Waiting List Initiatives to address any shortfall in HSC capacity relative to patient demand. Waiting List Initiatives include extra clinics in hospitals at nights and at weekends, use of independent sector hospitals and in-sourcing arrangements whereby privately recruited teams of clinicians providing services for HSC patients use available HSC infrastructure.

In order to increase capacity in the medium term, where it is demonstrated that independent providers can provide value for money and the same standard of service as the HSC, the system should consider the viability of longer term contracts to commission services from independent providers alongside those provided within the HSC.

HEALTH INEQUALITIES & PREVENTION

It is recognised that health inequalities and differences in health status are experienced by certain population groups. In particular, people in lower socio-economic groups are more likely to experience chronic ill-health and may die earlier than those who are more advantaged.

Good access to health and social care services has long been recognised as fundamental to people's health and wellbeing. It is important to have a prompt diagnosis and subsequent treatment. It is also important to be able to obtain quality

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

preventative care early enough to avoid illness or complications. In a health service such as ours, which is free at the point of delivery to all citizens, it is important that there is equality of access to these services.

Recent work to introduce regional prioritisation of theatre capacity has helped to ensure that there is at least equity of access to high priority services based on clinical need. While this has been a positive step, it does not resolve the issue of access to more routine elective care services. It is also important to bear in mind that while an individual's requirement may not be urgent, this does not mean that it is not extremely important. Routine surgery may be just as life changing as interventions deemed to be more urgent.

With the current scale of the waiting times to access diagnosis and treatment, there are indications that many people are choosing to pay to access these services rather than spend many months or years waiting for them. Under a universal healthcare system, it is not right that anyone should have to pay to access services that should be available through the public system. Furthermore, the very fact that some can choose to do so creates an obvious inequality for those in society who are unable to do so. There is therefore a very real risk that long waiting times could exacerbate, and perpetuate, existing health inequalities.

There is also a potential cumulative impact on wider society. Those who must wait longer for diagnosis or treatment may be more likely to become economically inactive or to have reduced quality of life. In addition to the impact on individuals, it is also very likely that delays to diagnosis and treatment will ultimately lead to higher costs for the health service as patients present with more advanced conditions.

There is already some anecdotal evidence from Emergency Departments that they are seeing an increase in the number of patients arriving at hospital and requiring admission for conditions that should have been dealt with through elective pathways.

The Department will therefore commission work to analyse the impact of long waiting times on health inequalities. Based on the findings of this work, additional interventions may be required to mitigate the impact of this.

The Making Life Better strategy published in 2014 seeks to create the conditions for individuals and communities to take control of their own lives and move towards a

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

vision for Northern Ireland where all people are enabled and supported in achieving their full health and wellbeing potential.

It details that to achieve better health and wellbeing for everyone and reduce inequalities in health, strengthened co-ordination and partnership working in a whole system approach is required.

Delivering Together reaffirmed this, noting that economic, social and environmental factors, and experiences early in life, play a major role in determining not just the health outcomes at an individual and community level, but also their social, educational, economic and other outcomes.

Partnerships and cross-sector collaboration are essential. New services or interventions created, or existing ones that are transformed, will not always be HSC-owned.

As we develop our new integrated care planning model and building on the work taken forward to date, we will ensure that this is underpinned by a population health approach that looks to deliver improved health and wellbeing outcomes for the whole population and reduce the health inequalities which continue to persist in our society.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

CONCLUSION

With the experience of Covid-19, health and social care in Northern Ireland has been through a once in a generation crisis. However, as we emerge from the pandemic, it is clear that we face a different kind of crisis.

Waiting times for patients in Northern Ireland are disproportionally worse than in other parts of these islands and this brings with it a serious social and economic cost. There are people on waiting lists who are living in continuous pain. There are people whose condition makes them unable to carry out their jobs, resulting in loss of income. There are people whose overall physical health deteriorates because they wait too long for a simple operation. There are people whose mental health suffers from the anxiety and uncertainty of a long wait for diagnosis or treatment. Even without the context of a pandemic, the waiting lists have been increasing steadily for a number of years. There is already effectively a two tier system in place. Those who can afford to pay for private treatment do so, and those who can't afford it continue to wait.

There are structural issues in the Northern Ireland HSC system that need to be resolved. We need more sites providing dedicated elective services that are entirely separate from unscheduled care. We need to make better use of our theatre capacity on a regional basis. We need to bring a stronger focus to productivity and efficiency. There is still a tendency in Northern Ireland towards professional silos. We need to challenge conservatism in relation to the skills mix of health professionals providing care.

However, it must also be accepted that there are capacity issues that need to be addressed. The HSC does not currently have the capacity to simultaneously provide scheduled and unscheduled services to match the population's needs over the course of the year.

This plan sets out an ambitious, but achievable, plan to bring waiting lists down and to keep them at that level. It requires investment and it requires time. If the investment that is required to deliver this plan is made available, it is important that we resist the temptation to put all of this into buying additional activity. It is clear that

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

we also need to plan for the future by training and recruiting large numbers of health professionals in key specialties, and by designing the best possible environment to allow them to carry out their jobs effectively. Above all, this plan is about creating better services for two groups of people - those who require treatment and those who deliver it. It is essential that we invest in the future and, while investment in our staff will take longer to bear fruit, in the end it will lead to more lasting change.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

From: Corporate.Governance
To: DoH Early Alert
Subject: Early Alert
Date: 31 July 2020 12:01:41
Attachments: 31072020 EA JULY 2020 20.pdf

Good Afternoon,

Please find attached Early Alert from Southern Health and Social Care Trust.

Kind Regards

Diane

Corporate Clinical & Social Care Governance Office
Corporate Governance Assistant
Beechfield House
Craigavon Area Hospital Site
Telephone Personal Information redacted by the USI

The Information and the Material transmitted is intended only for the person or entity to which it is addressed and may be Confidential/Privileged
Information and/or copyright material.

Any review, transmission, dissemination or other use of, or taking of any action in reliance upon this information by persons or entities other than the intended recipient is prohibited. If you receive this in error,
please contact the sender and delete the material from any computer.

Southern Health & Social Care Trust archive all Email (sent & received) for the purpose of ensuring compliance with the Trust 'IT Security Policy',
Corporate Governance and to facilitate FOI requests.

Southern Health & Social Care Trust IT Department Personal Information redacted by the USI

ANNEX A

Initial call made to CMO Office **(DoH) on** 31.07.2020 **DATE**

Follow-up Pro-forma for Early Alert Communication:

Details of Person making Notification:

Name	Dr Maria O'Kane	Organisation	Southern Health and Social Care Trust
Position	Medical Director	Telephone	Personal Information redacted by the USI

Criteria (from paragraph 1.3) under which event is being notified (tick as appropriate)

1. ***Urgent regional action***
2. ***Contacting patients/clients about possible harm***
3. ***Press release about harm***
4. ***Regional media interest***
5. ***Police involvement in investigation***
6. ***Events involving children***
7. ***Suspension of staff or breach of statutory duty***

Brief summary of event being communicated: ****If this relates to a child please specify DOB, legal status, placement address if in RCC. If there have been previous events reported of a similar nature please state dates and reference number. In the event of the death or serious injury to a child - Looked After or on CPR - Please confirm report has been forwarded to Chair of Regional CPC.***

On 7th June 2020 the Trust became aware of potential concerns regarding delays of treatment of surgery patients who were under the care of a Trust employed Consultant Urologist. As a result of these potential patient safety concerns a lookback exercise of the Consultants work was conducted to ascertain if there were wider service impacts. The lookback which considered cases over a 17 month period (period 1st January 2019 - 31st May 2020), the following was found:

- The emergency lookback concentrated on whether the patients had a stent inserted during procedure and if this had been removed. 147 patients taken to theatre that was listed as being under the care of the Consultant during the lookback period with concerns identified in 46 of these cases.
- There were 334 elective-in patients reviewed where 120 of cases were found to have experienced a delay in dictation ranging from 2 weeks to 41 weeks, a further 36 patients who had no record of care noted on the regional NIECR system. To date one of the elective in-patient cases has been identified for screening for Serious Adverse Incident review.

In addition two recent cases managed by this consultant have been identified which are being screened as Serious Adverse Incidents involving two prostatic cancer patients that indicate potential deficiencies in care provided by the consultant in question where these deficiencies potentially had an impact on patient prognosis. The following actions have been taken:

- Discussions with the GMC employer liaison service have been conducted
- This case has been discussed with NHS Resolutions who have recommended restrictions of clinical practice including a request to the Consultant not to undertake private practice in his own home or other premises pending further exploration
- Restrictions have been placed by the Trust that they no longer to undertake clinical work and that they do not access or process patient information either in person or through others either in hard copy or electronically. A request has also been made they voluntarily undertake to refrain from seeing any private patients at their home or any other setting and confirm the same in writing.
- A preliminary discussion has been undertaken with the Royal College of Surgeons invited Review Service regarding the consultants practice and potential scope and scale of any lookback exercise

Appropriate contact within the organisation should further detail be required:

Name of appropriate contact: Stephen Wallace / Zoe Parks

Contact details:

Email address (work or home) Personal Information redacted by the USI ; Personal Information redacted by the USI

Mobile (work or home) Telephone (work or home) Personal Information redacted by the USI

Forward pro-forma to the Department at: Personal Information redacted by USI and the HSC Board at: Personal Information redacted by USI

FOR COMPLETION BY DoH:

Early Alert Communication received by: ……..... Office: ……..……..

Forwarded for consideration and appropriate action to: ……..……. Date: ….....

Detail of follow-up action (if applicable) ……..……

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

From:	Adams, James (DoH)
To:	Dermot Parsons
Cc:	Jeffrey, Karen
Subject:	Early Alert - EA 182/20
Date:	31 July 2020 14:25:00
Attachments:	EA 18220.pdf

Dermot,
Please see attached Early Alert – EA 182/20.

Can you please confirm receipt by return e-mail.

Regards,
Jim Adams
Safety Strategy Unit

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

ANNEX A

Initial call made to CMO Office **(DoH) on** 31.07.2020 **DATE**

Follow-up Pro-forma for Early Alert Communication:

Details of Person making Notification:

Name	Dr Maria O'Kane	Organisation	Southern Health and Social Care Trust
Position	Medical Director	Telephone	Personal Information redacted by the USI

Criteria (from paragraph 1.3) under which event is being notified (tick as appropriate)

1. ***Urgent regional action***
2. ***Contacting patients/clients about possible harm***
3. ***Press release about harm***
4. ***Regional media interest***
5. ***Police involvement in investigation***
6. ***Events involving children***
7. ***Suspension of staff or breach of statutory duty***

Brief summary of event being communicated: ****If this relates to a child please specify DOB, legal status, placement address if in RCC. If there have been previous events reported of a similar nature please state dates and reference number. In the event of the death or serious injury to a child - Looked After or on CPR - Please confirm report has been forwarded to Chair of Regional CPC.***

On 7th June 2020 the Trust became aware of potential concerns regarding delays of treatment of surgery patients who were under the care of a Trust employed Consultant Urologist. As a result of these potential patient safety concerns a lookback exercise of the Consultants work was conducted to ascertain if there were wider service impacts. The lookback which considered cases over a 17 month period (period 1st January 2019 - 31st May 2020), the following was found:

- The emergency lookback concentrated on whether the patients had a stent inserted during procedure and if this had been removed. 147 patients taken to theatre that was listed as being under the care of the Consultant during the lookback period with concerns identified in 46 of these cases.
- There were 334 elective-in patients reviewed where 120 of cases were found to have experienced a delay in dictation ranging from 2 weeks to 41 weeks, a further 36 patients who had no record of care noted on the regional NIECR system. To date one of the elective in-patient cases has been identified for screening for Serious Adverse Incident review.

In addition two recent cases managed by this consultant have been identified which are being screened as Serious Adverse Incidents involving two prostatic cancer patients that indicate potential deficiencies in care provided by the consultant in question where these deficiencies potentially had an impact on patient prognosis. The following actions have been taken:

- Discussions with the GMC employer liaison service have been conducted
- This case has been discussed with NHS Resolutions who have recommended restrictions of clinical practice including a request to the Consultant not to undertake private practice in his own home or other premises pending further exploration
- Restrictions have been placed by the Trust that they no longer to undertake clinical work and that they do not access or process patient information either in person or through others either in hard copy or electronically. A request has also been made they voluntarily undertake to refrain from seeing any private patients at their home or any other setting and confirm the same in writing.
- A preliminary discussion has been undertaken with the Royal College of Surgeons invited Review Service regarding the consultants practice and potential scope and scale of any lookback exercise

Appropriate contact within the organisation should further detail be required:

Name of appropriate contact: Personal Information redacted by the USI

Contact details:

Email address (work or home) Personal Information redacted by the USI ; Personal Information redacted by the USI

Mobile (work or home) Telephone (work or home) Personal Information redacted by the USI

Forward pro-forma to the Department at: Personal Information redacted by USI and the HSC Board at: Personal Information redacted by USI

FOR COMPLETION BY DoH:

Early Alert Communication received by: …….... Office: ……..……..

Forwarded for consideration and appropriate action to: ……..…… Date: ….....

Detail of follow-up action (if applicable) ……..……

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

From:	Johnston, Jackie (DoH)
To:	Wilson, Ryan (DoH)
Cc:	Pengelly, Richard; McBride, Michael; Chada, Naresh; Geoghegan, Lourda; Johnston, Jackie (DoH); Adams, James (DoH); DoH Early Alert; DoH Private Office; DoH CMO Office; Colgan, Elaine; Gordon, David
Subject:	HPRM: FW: Early Alert - Urology July 2020
Date:	03 August 2020 12:36:10
Attachments:	Early Alert - Urology July 2020.docx image001.png

Ryan

Could you:

(1) Ask the Southern Trust whether they have notified this incident to the HSCB/PHA;
(2) Advise the HSCB/PHA that we have received this Early Alert and look to them to assess this incident and decide whether it needs to be escalated to the Department; and,
(3) Send a note to the Minister informing him of this incident.

Regards

Jackie

From: Gordon, Lesley **On Behalf Of** Carson, Jane
Sent: 03 August 2020 12:13
To: Pengelly, Richard [redacted]; McBride, Michael <[redacted]>; Chada, Naresh <[redacted]>; Geoghegan, Lourda <[redacted]>; Johnston, Jackie (DoH) <[redacted]>; Adams, James (DoH) <[redacted]>; DoH Early Alert <[redacted]>; DoH Private Office <[redacted]>
Cc: DoH CMO Office <[redacted]>; Colgan, Elaine <[redacted]>
Subject: FW: Early Alert - Urology July 2020

Please see attached.
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]

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry



Stay Home Stay Safe

From: DoH CMO Office
Sent: 03 August 2020 12:09
To: Colgan, Elaine [redacted]; Carson, Jane [redacted]
Subject: FW: Early Alert - Urology July 2020

Hi both

Do we know what needs to be done with this…..?

Wendy

From: OKane, Maria [redacted]
Sent: 31 July 2020 11:42
To: DoH CMO Office [redacted]
Cc: Wallace, Stephen [redacted]; Parks, Zoe [redacted]; Campbell, Emma [redacted]
Subject: Early Alert - Urology July 2020

As per phonecall. Thank you

The Information and the Material transmitted is intended only for the person or entity to which it is addressed and may be Confidential/Privileged
Information and/or copyright material.

Any review, transmission, dissemination or other use of, or taking of any action in reliance upon this information by persons or entities other than the intended recipient is prohibited. If you receive this in error,
please contact the sender and delete the material from any computer.

Southern Health & Social Care Trust archive all Email (sent & received) for the purpose of ensuring compliance with the Trust 'IT Security Policy',
Corporate Governance and to facilitate FOI requests.

Southern Health & Social Care Trust IT Department [redacted]

ANNEX A

Initial call made to CMO OFFICE **(DoH) on** 01.08. 20 **DATE**

Follow-up Pro-forma for Early Alert Communication:

Details of Person making Notification:

Name	Dr Maria O'Kane	Organisation	Southern Health and Social Care Trust
Position	Medical Director	Telephone	Personal Information redacted by the USI

Criteria (from paragraph 1.3) under which event is being notified (tick as appropriate)

1. ***Urgent regional action***
2. ***Contacting patients/clients about possible harm***
3. ***Press release about harm***
4. ***Regional media interest***
5. ***Police involvement in investigation***
6. ***Events involving children***
7. ***Suspension of staff or breach of statutory duty***

Brief summary of event being communicated: ****If this relates to a child please specify DOB, legal status, placement address if in RCC. If there have been previous events reported of a similar nature please state dates and reference number. In the event of the death or serious injury to a child - Looked After or on CPR - Please confirm report has been forwarded to Chair of Regional CPC.***

On 7th June 2020 the Trust became aware of potential concerns regarding delays of treatment of surgery patients who were under the care of a Trust employed Consultant Urologist. As a result of these potential patient safety concerns a lookback exercise of the Consultants work was conducted to ascertain if there were wider service impacts. The lookback which considered cases over a 17 month period (period 1st January 2019 - 31st May 2020), the following was found:

- The emergency lookback concentrated on whether the patients had a stent inserted during procedure and if this had been removed. 147 patients taken to theatre that was listed as being under the care of the Consultant during the lookback period with concerns identified in 46 of these cases.
- There were 334 elective-in patients reviewed where 120 of cases were found to have experienced a delay in dictation ranging from 2 weeks to 41 weeks, a further 36 patients who had no record of care noted on the regional NIECR system. To date one of the elective in-patient cases has been identified for screening for Serious Adverse Incident review.

In addition two recent cases managed by this consultant have been identified which are being screened as Serious Adverse Incidents involving two prostatic cancer patients that indicate potential deficiencies in care provided by the consultant in question where these deficiencies potentially had an impact on patient prognosis. The following actions have been taken:

- Discussions with the GMC employer liaison service have been conducted
- This case has been discussed with NHS Resolutions who have recommended restrictions of clinical practice including a request to the Consultant not to undertake private practice in his own home or other premises pending further exploration
- Restrictions have been placed by the Trust that they no longer to undertake clinical work and that they do not access or process patient information either in person or through others either in hard copy or electronically. A request has also been made they voluntarily undertake to refrain from seeing any private patients at their home or any other setting and confirm the same in writing.
- A preliminary discussion has been undertaken with the Royal College of Surgeons invited Review Service regarding the consultants practice and potential scope and scale of any lookback exercise

Appropriate contact within the organisation should further detail be required:

Name of appropriate contact: Personal Information redacted by the USI

Contact details:

Email address (work or home) Personal Information redacted by the USI ; Personal Information redacted by the USI

Mobile (work or home) Telephone (work or home) Personal Information redacted by the USI

Forward pro-forma to the Department at: Personal Information redacted by USI and the HSC Board at: Personal Information redacted by USI

FOR COMPLETION BY DoH:

Early Alert Communication received by: ……..... Office: ……..……..

Forwarded for consideration and appropriate action to: ……..……. Date: ….....

INVESTORS IN PEOPLE

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Detail of follow-up action (if applicable) ……

INVESTORS IN PEOPLE

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

From:	DoH Private Office
To:	Wilson, Ryan (DoH)
Cc:	Hardy, Joan; Pengelly, Richard; Johnston, Jackie (DoH); DoH Private Office; DoH Press Office; Burns, Kim; Jeffrey, Karen; DoH SpAd; DoH CMO Office; DoH CNO
Subject:	Submission Decision SUB-1740-2020 : EARLY ALERT (182/20) - CONSULTANT UROLOGIST RESTRICTED FROM CLINICAL PRACTICE
Date:	24 September 2020 16:01:07
Attachments:	SUB-1740-2020 COVER NOTE.pdf SUB-1740-2020 Submission on SHSCT Early Alert - Urology - EA 18220.msg

Classification: Official
Timing: Desk Immediate
Reference: SUB-1740-2020

Subject: SUB-1740-2020 : EARLY ALERT (182/20) - CONSULTANT UROLOGIST RESTRICTED FROM CLINICAL PRACTICE

To: RYAN WILSON
Date: 24/09/2020

The following comment has been made to your submission of 06/08/2020:

Noted.

For further information etc. contact:
Suzanne Ferris
Private Office and Coordination
Personal Information redacted by

Copied To For Information:
Hardy, Joan; Pengelly, Richard; Johnston, Jackie (DoH); DoH Private Office; DoH Press Office; Burns, Kim; Jeffrey, Karen; DoH SpAd; DoH CMO Office; DoH CNO

PO Cover Sheet

Approved	
Noted	✓
Meeting with Officials	
Further Information Required	

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

Deadline: .....

Title: GP Earnings & Expenses Report 2018/19 for England, Wales, Northern Ireland & Scotland.

Ref: SUB-1740-2020

To PS/Minister: SF 10/9/20

Comments from Special Adviser:

SPAD Signed: Personal Information redacted by the USI

Date: 10.09.20

Comments from Minister:

Minister Signed: Personal Information redacted by the USI

Date: 10/9

PTO for further comments

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

From:	Johnston, Jackie (DoH)
To:	Olive MacLeod; Paul Cavanagh
Cc:	McBride, Michael; Wilson, Ryan (DoH)
Subject:	RE: HPRM: MM/0121/2020 - Email from Maria O"Kane - CONFIDENTIAL EARLY ALERT - Urology
Date:	24 August 2020 15:54:26
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

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

SUB/xxxx/2020

FROM: Ryan Wilson
Director of Secondary Care

DATE: 26 October 2020

TO: Robin Swann MLA, Minister

WRITTEN STATEMENT IN RELATION TO CONFIDENTIAL EARLY ALERT (182/20) – SOUTHERN TRUST CONSULTANT UROLOGIST RESTRICTED FROM CLINICAL PRACTICE

ISSUE:	Update and draft written statement in relation to Southern Trust Early Alert (EA 182/20) about concerns regarding the practice of a retired consultant urologist.
TIMING:	Desk immediate.
PRESENTATIONAL ISSUES	This issue has begun to attract media attention which is likely to escalate as details of the ongoing scoping exercise by the Southern Trust emerge. A holding line has been provided to the Irish News on 25 October. DoH Press Office will continue to liaise with colleagues in SHSCT on agreed lines. **Cleared by Press Office 26/10/2020.**
FOI IMPLICATIONS	Consideration should be given to Section 30 – investigations and proceedings conducted by public authorities.
FINANCIAL IMPLICATIONS	None
LEGISLATION IMPLICATIONS	None
SPECIAL ADVISOR COMMENTS:	
RECOMMENDATION:	It is recommended that you: • Note the updated position as reported by the Southern Trust on 15 October including the summary of historic concerns regarding this consultant which were under investigation from 2016, and the recently identified serious concerns about his prescribing practice; • Note the establishment of a Department-led Urology Assurance Group to oversee the ongoing Trust scoping exercise and future management plan; and,

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

	• Publish the brief draft written statement at **Annex D** indicating your intention to provide a more detailed oral statement to the Assembly next week.

Introduction

1. Further to my submission of 6 August 2020 and verbal update on 7 October 2020, this is to:
   - update you on the Southern HSC Trust's ongoing internal scoping exercise in relation to concerns raised through Early Alert 182/20 about a retired consultant urologist;
   - bring your attention to historic concerns regarding this consultant's practice as detailed in a recent update report to the Department from the Southern Trust;
   - advise you of the establishment of a Departmental Urology Assurance Group to oversee this exercise and management plan; and,
   - provide a draft written statement for your consideration.

Background

2. The Southern Trust submitted confidential Early Alert EA 182/20 on 31 July 2020 regarding potential safety concerns that were initially raised on 7 June 2020 about a consultant urologist, Mr Aidan O'Brien, who was employed by the Trust from 6 July 1992 until his retirement on 17 July 2020. The Early Alert was updated on 15 October 2020 to include new concerns arising from the scoping work about the consultant's prescribing practice. A copy of both Early Alert forms is attached at **Annex A**.

3. At that time, following a review of the consultant's work from January 2019, the Trust had identified concerns in a cohort of approximately 230 patients. They advised that their concerns mainly related to inconsistencies in maintaining patient case notes which indicated the potential for delay in follow up care of some patients. These included surgical cases for the insertion of stents, elective in-patients with delays in the dictation of clinical notes (with potential impact on their

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

cancer diagnosis and prognosis) and patients with no record of care noted on the regional NIECR system. Three cases were being screened as potential SAIs.

4. The Trust had also initiated the following actions:
   - prior to retirement, restricted the consultant's clinical practice and access to patient information;
   - wrote to the consultant's solicitor to seek assurance that they refrain from private practice pending further investigation;
   - notified the General Medical Council; and,
   - held preliminary discussions with the Royal College of Surgeons (RCS) Invited Review Service to understand the scope and scale of any further independent review.

5. At a meeting with Department officials on 3 September 2020, the Trust advised that the RCS Invited Review Service was unlikely to provide the appropriate investigative vehicle to comprehensively address all potential concerns as it would be based on a sample of 80 cases (approx. 1%) drawn from across all of the Trust's urology service. The Department advised that the serious nature of the concerns would necessitate a Ministerial statement to the Assembly once the Trust had determined the number of patients impacted and made the necessary arrangements to establish patient and GP helplines.

6. It was therefore agreed that in order to inform the terms of reference for a more targeted independent review and patient recall, the Trust should continue with a scoping exercise to determine the number of patients under the care of the consultant whose case notes provided any cause for concern. The Trust advised that this approach would also minimise any undue concern amongst the wider community of urology patients, and their families, whose notes did not give rise to concerns when reviewed. Officials from the Department, HSCB and PHA have participated in weekly update calls with the Trust since 10 September 2020 about this exercise.

7. It was initially envisaged that this work could be completed to facilitate an oral statement by you to the Assembly by mid-late September, however this has been

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

deferred at the Trust's request a number of times in order to be as precise as possible about the quantum of the review to date as the scoping exercise has identified further concerns about the consultant's clinical and prescribing practices, as well as additional SAIs.

SHSCT Report

8. At the meeting on 8 October 2020 the Department requested a comprehensive report about the Trust's scoping exercise to date in order to inform Ministerial briefing and possible next steps. This report was received via the HSCB on 15 October and is attached at **Annex B** below. It includes a total of **nine confirmed SAIs to date**, including two in respect of deceased patients.

9. An SAI panel has been established with a Chair and Subject Matter Experts identified. Patients/families of the nine confirmed SAIs have been notified, however at this stage it is our understanding that each patient/family has not been advised of the related cases and wider issues.

10. A summary of the Trust exercise to date and SAIs is as follows:

- <u>Emergency stent procedures (Jan 2019 – June 2020)</u>
  Three out of 160 emergency stent patients had not had their stent management plans enacted. Clinical Management has been subsequently arranged for these three patients.
- <u>Elective-in patients taken to theatre (Jan 2019 – June 2020)</u>
  343 patients reviewed leading to **two confirmed SAIs.**
- <u>Pathology and Cytology results (Jan 2019 – June 2020)</u>
  Exercise completed by clinical nurse specialists. 168 results identified; of which 50 required review, leading to **three confirmed SAIs** with further 5 requiring a review follow-up.
- <u>Radiology results (Jan 2019 – June 2020)</u>
  Ongoing consultant-led exercise to review 1536 patients whose electronic care records do not confirm sign-off or action – as this may have been done manually these cases need to be reviewed for confirmation and follow-up if required. **One confirmed SAI** to date.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

- Cancer Multi-disciplinary Meeting (MDM) discussions (Jan 2019 – June 2020)
  Ongoing consultant-led exercise to review 271 patients who were discussed at MDM, leading to **two confirmed SAIs** with a further 2 needing a review follow-up.
- Oncology Review Backlog (Jan 2019 – June 2020)
  236 review oncology outpatients will be seen face to face by a retired Urologist in the independent sector. This consultant will either discharge or make appropriate plans for ongoing management and referral back the Southern Trust Urology Team MDM for further review/management. **One confirmed SAI** to date.

11. **Appendix 1 of the Trust report** (below) also provides a summary of previous governance and patient safety concerns in relation to this consultant. These were initially raised by Trust management in a letter to the consultant in March 2016 and included:
    - 253 Un-triaged outpatient referral letters dating back to December 2014.
    - 679 patients on the consultant's review backlog dating back to 2013, with a separate oncology waiting list of 286 patients.
    - Concerns/frustrations of consultant colleagues at lack of records of consultations / discharges on Patient Centre system or on patient notes.
    - Concerns that a number of patients' hospital charts (as yet not quantified) had been kept at Consultant A's home.

12. **Appendix 1** also gives a timeline of events since then, including an SAI commencing in the autumn of 2016 about a patient with a poor clinical outcome as their GP referral had not been triaged as red-flag by the consultant. The resultant SAI investigation identified:
    - 783 un-triaged GP referrals from June 2015, of which 24 were subsequently deemed to need upgraded and a further four with confirmed diagnoses of cancer (i.e. four further SAIs in addition to the initial SAI patient);
    - Over 60 undictated clinics (668 patients) over 18 months with unclear clinical management plans;
    - 288 patients' clinical notes which had been taken to the consultant's home and thus not readily available on Trust systems.

13. From December 2016 formal action was initiated by the Trust and the consultant was managed within the Maintaining High Professional Standards (MHPS) framework, including a 4-week immediate exclusion. In summary, this process including several investigation meetings, delays and prevarications, continued through 2017-2018, culminating in the submission of a grievance by the consultant in November 2018. The grievance process through the General Medical Council (GMC) is ongoing. As the consultant is no longer employed, the Conduct Hearing under MHPS cannot be concluded. The GMC processes will continue regarding Consultant A's fitness to practise in light of both the previous concerns and the most recent concerns.

Prescribing of Bicalutamide

14. The report (and Early Alert update also received on 15 October) also outlined further serious concerns that had come to light around 14 October in relation to the consultant's prescribing of Bicalutamide, an anti-androgen that has a number of recognised short term uses in the management of prostate cancer, which should only be prescribed over a short timeframe due to potential serious side effects. The scoping exercise had at that stage identified a number of patients who appeared to have been on this medication for significant periods and therefore, the Trust advised, an exercise had immediately been initiated to identify and assess all patients whose prescriptions indicated usage beyond the normal range. In light of this discovery the Trust advised the Department that this would severely impact the time required to complete the overall scoping exercise.

15. At the update meeting on 22 October, the Southern Trust further advised that the Subject Matter Expert appointed to the SAI panel was recommending a 5-year lookback on patients who were prescribed Bicalutamide, estimated at 800 patients in total. The Trust therefore recommended further deferral of any announcement in order to facilitate a desktop review of these 800 records. It advised that the opening of public advice helplines prior to this would have an enormous detrimental impact on consultants' ability to contact and assess the relevant patients from that cohort, and was therefore described as a potential patient safety concern which ought to be considered.

Alert Letters

16. Under Departmental guidance circular HSS(TC8) 6/98, the Chief Medical Officer has issued alert letters to the HSC Board, HSC Trusts, PHA, CMO Scotland, CMO Wales and NHS England. [Personal Information redacted by USI]. These letters provide the consultant's name and GMC number and advise organisations to contact the Southern Trust Medical Director if an application for permanent or temporary employment is made. They do not provide any information about the reason for the alert. The HSCB is required to advise all independent sector providers in NI likewise.

Urology Assurance Group

17. On consideration of the Trust's report, and in light of parallels with the ongoing recall of Belfast Trust neurology patients, the Department wrote to the Southern Trust Chief Executive on 22 October to advise that a Department-led Urology Assurance Group would be established from w/c 26 October to provide the necessary oversight to the ongoing review process and the management of issues arising from it given the seriousness of the findings to date. A copy of the Permanent Secretary's letter and terms of reference for the Urology Assurance Group are attached below at **Annex C**.

Advice

18. Subject to your agreement an oral statement to the Assembly had been envisaged for w/c 2 November, following an initial meeting of the Assurance Group this week to consider the latest Trust position and confirm that preparations were in place to open patient and GP helplines. Whilst the Trust's clear preference would be further deferral of a statement by several weeks to complete the review and assessment of Becalutamide patients, the Department has advised that this would not be tenable.

19. In light of media attention making this issue public from 26 October, it is recommended that you issue a brief written statement to the Assembly tomorrow (Tuesday 27 October 2020) stating your intention to provide a more detailed oral

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

statement to the Assembly next week. Delaying this until tomorrow will allow us to notify the consultant's legal representatives of the Department's proposed action.

Recommendation

20. It is recommended that you:

- Note the updated position as reported by the Southern Trust on 15 October including the summary of historic concerns regarding this consultant which were under investigation from 2016, and the recently identified serious concerns about his prescribing practice;
- Note the establishment of a Department-led Urology Assurance Group to oversee the ongoing Trust scoping exercise and future management plan; and,
- Publish the brief draft written statement at **Annex D** indicating your intention to provide a more detailed oral statement to the Assembly next week.

Ryan Wilson

Ext no. Personal information redacted by USI

Copied to:
Richard Pengelly
CMO
CNO
Jackie Johnston
Sharon Gallagher
Lourda Geoghegan
Naresh Chada
David Gordon
Michael O'Neill
Anne Marie Bovill
Kim Burns
SpAd

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Annex A

Initial call made to (DoH) on
DATE CMO OFFICE 01.08. 20

Follow-up Pro-forma for Early Alert Communication:

Details of Person making Notification:

Name: Dr Maria O'Kane
Organisation: Southern Health and Social Care Trust
Position: Medical Director
Telephone: Personal Information redacted by USI

Criteria (from paragraph 1.3) under which event is being notified (tick as appropriate)

1. ***Urgent regional action***
2. ***Contacting patients/clients about possible harm***
3. ***Press release about harm***
4. ***Regional media interest***
5. ***Police involvement in investigation***
6. ***Events involving children***
7. ***Suspension of staff or breach of statutory duty***

Brief summary of event being communicated: ****If this relates to a child please specify DOB, legal status, placement address if in RCC. If there have been previous events reported of a similar nature please state dates and reference number. In the event of the death or serious injury to a child - Looked After or on CPR - Please confirm report has been forwarded to Chair of Regional CPC.***

On 7th June 2020 the Trust became aware of potential concerns regarding delays of treatment of surgery patients who were under the care of a Trust employed Consultant Urologist. As a result of these potential patient safety concerns a lookback exercise of the Consultants work was conducted to ascertain if there were wider service impacts. The lookback which considered cases over a 17 month period (period 1st January 2019 - 31st May 2020), the following was found:

- The emergency lookback concentrated on whether the patients had a stent inserted during procedure and if this had been removed. 147 patients taken to theatre that was listed as being under the care of the Consultant during the lookback period with concerns identified in 46 of these cases.
- There were 334 elective-in patients reviewed where 120 of cases were found to have experienced a delay in dictation ranging from 2 weeks to 41 weeks, a further 36 patients who had no record of care noted on the regional NIECR system. To date one of the elective in-patient cases has been identified for screening for Serious Adverse Incident review.

In addition two recent cases managed by this consultant have been identified which are being screened as Serious Adverse Incidents involving two prostatic cancer patients that indicate potential deficiencies in care provided by the consultant in question where these deficiencies potentially had an impact on patient prognosis. The following actions have been taken:

- Discussions with the GMC employer liaison service have been conducted
- This case has been discussed with NHS Resolutions who have recommended restrictions of clinical practice including a request to the Consultant not to undertake private practice in his own home or other premises pending further exploration
- Restrictions have been placed by the Trust that they no longer to undertake clinical work and that they do not access or process patient information either in person or through others either in hard copy or electronically. A request has also been made they voluntarily undertake to refrain from seeing any private patients at their home or any other setting and confirm the same in writing.
- A preliminary discussion has been undertaken with the Royal College of Surgeons invited Review Service regarding the consultants practice and potential scope and scale of any lookback exercise

Appropriate contact within the organisation should further detail be required:

Name of appropriate contact: Stephen Wallace / Zoe Parks

Contact details:

Email address (work or home) Personal Information redacted by the USI ; Personal Information redacted by the USI

Mobile (work or home) Telephone (work or home) Personal Information redacted by the USI

Forward pro-forma to the Department at: Personal Information redacted by USI and the HSC Board at: Personal Information redacted by USI

FOR COMPLETION BY DoH:

Early Alert Communication received by: ……..... Office: ……..……...

Forwarded for consideration and appropriate action to: ……..…… Date: ….....

Detail of follow-up action (if applicable) ……..……

ANNEX A

Initial call made to Ryan Wilson (DoH) on 15th October 2020 DATE

Follow-up Pro-forma for Early Alert Communication:

Details of Person making Notification:

Name	Dr Maria O'Kane	Organisation	Southern Health and Social Care Trust
Position	Medical Director	Telephone	Personal Information redacted by the USI

Criteria (from paragraph 1.3) under which event is being notified (tick as appropriate)

1. ***Urgent regional action***
2. ***Contacting patients/clients about possible harm***
3. ***Press release about harm***
4. ***Regional media interest***
5. ***Police involvement in investigation***
6. ***Events involving children***
7. ***Suspension of staff or breach of statutory duty***

Brief summary of event being communicated: **If this relates to a child please specify DOB, legal status, placement address if in RCC. If there have been previous events reported of a similar nature please state dates and reference number. In the event of the death or serious injury to a child - Looked After or on CPR - Please confirm report has been forwarded to Chair of Regional CPC.*

Further to Early Alert dated 31st July 2020 (attached for ease of reference) relating to the provision of Trust Urology Services additional significant concerns have been brought to the attention of the Trust regarding prescribing practices regarding the medication Bicalutamide by the individual consultant who is no longer employed by Health and Social Care Services.

These additional concerns have been identified following an initial meeting of the Serious Adverse Incident review team which occurred this week. Concerns have been raised regarding the subject's prescribing practices which include use of unlicensed and sub-therapeutic dosages of Bicalutamide which we consider a significant and potentially wide patient safety risk requiring immediate action. Trust staff are working with the HSCB medications team to gain a better understanding of the implications of this latest development in terms of scale and scope and to identify patient groups that may be at risk. It is recognised that this prescribing issue involves medicines that are prescribed by primary care providers on advice from the secondary care team.

In addition to this early alert senior staff at HSCB, PHA and Department of Health have been briefed directly of this development. The Trust is continuing to liaise directly with colleagues in each organisation in order to take appropriate action.

Appropriate contact within the organisation should further detail be required:

Name of appropriate contact: Dr Maria O'Kane

Contact details:

Email address (work or home) Personal Information redacted by the USI

Mobile (work or home) Personal Information redacted by the USI Telephone (work or home)

Forward pro-forma to the Department at: [redacted] and the HSC Board at: [redacted]

FOR COMPLETION BY DoH:

Early Alert Communication received by: ..... Office: .....

Forwarded for consideration and appropriate action to: ..... Date: .....

Detail of follow-up action (if applicable) .....

Working for a Healthier People

INVESTORS IN PEOPLE

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Annex B

Southern Health and Social Care Trust

Report to Department of Health on Consultant A

Date:	14 October 2020
Title:	Clinical Concerns within Urology – Southern Trust
Lead Directors:	Mrs Melanie McClements – Director of Acute Services Dr Maria O'Kane – Medical Director

Key Strategic aims:

Delivery of safe, high quality effective care

Key Issues/risks:

This report outlines a summary of the clinical concerns relating to Consultant A, the actions taken to review aspects of his practice and the development of appropriate management plans to minimise risk or harm to patients.

Consultant A is no longer employed as of 17th July 2020, having given his notice of his intention to retire from his substantive post. The Trust declined his request to return given outstanding employment matters relating to a previous MHPS case commenced on 30th December 2016.

Any patients identified where clinical concerns have been raised will be reviewed and followed-up. Due to capacity issues there is likely to be impact on other patients who are awaiting urological appointments/follow up.

Plans have been put in place to respond to primary care colleagues and to establish a targeted help line for patient concerns.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Background

On 7th June 2020, the Trust became aware that 2 out of 10 patients listed for surgery under the care of Consultant A were not on the hospital's Patient Administration System at this time. As a result of these potential patient safety concerns a review of Consultant A's work was conducted to ascertain if there could be wider service impacts.

As a result of these potential patient safety concerns a review of Consultant A's work was conducted to ascertain if there were wider patient safety concerns and service impacts. The internal reviews, which considered cases over an 18 month period (period 1st January 2019 – 30 June 2020), identified the following:

- The first internal review concentrated on whether the patients who had been admitted as an emergency had had a stent inserted during procedure and if this had been removed. There were 160 emergency patients listed as being taken to theatre. 3 patients had not had their stent management plans enacted. Clinical Management has been subsequently arranged for these 3 patients.

- The second internal review was for 343 elective-in patients taken to theatre. Out of the 343 patients reviewed there have been **2 of these patients who have been identified as meeting the threshold of needing a Serious Adverse Incident Review**.

The following areas have been identified that immediately need to be reviewed and actions taken on these patients to mitigate against potentially preventable harm

1. **Jan 2019- June 2020** - Pathology and Cytology results: 168 patients with 50 patients needing reviewed. From this there has been **3 confirmed SAI with a further 5 requiring a review follow-up** to determine if they have come to harm.

2. This exercise has also now identified concerns of clinical practice in the prescribing of Bicalutamide drug has revealed examples of poor practice, delay in following up the recommendations from results/MDM's and delay in dictation to other health care professionals in the ongoing care and treatment of the patients. The full extent of this is not yet clear.

3. **Jan 2019- June2020** - Radiology results –1536 patients listed on NIECR. These patients may have had the results manually signed off and actioned but as we have identified cases where this hasn't happened we need to review all of these records to reassure ourselves that these have all been actioned. This exercise is ongoing.

4. **Jan 2019-July 2020** - MDM discussions – there are 271 patients who were patients of Consultant A and who were discussed at MDM, a review of these patient records is being undertaken. There are currently **2 confirmed SAI's and a further 2 needing a review follow-up** to determine if they have come to harm. This exercise is ongoing.
5. **Oncology Review Backlog** – 236 review oncology outpatients will be seen face to face by a retired Urologist in the independent sector. This consultant will either discharge or make appropriate plans for ongoing management and referral back the Southern Trust Urology Team MDM for further review/management. (Note

to date there has been **one SAI confirmed** from this backlog as the patient presented to Emergency Department and he has been followed up as a result of this attendance).

6. **Patients on Drug "Bicalutamide" (raised in point 2 above) -** *this is an Anti-androgen that has a number of recognised short term uses in the management of prostate cancer. In men with metastatic prostate cancer NICE Guidance states;*

'1.5.9 For people with metastatic prostate cancer who are willing to accept the adverse impact on overall survival and gynaecomastia with the aim of retaining sexual function, offer anti-androgen monotherapy with bicalutamide[6] (150 mg). ***[2008]***

1.5.10 Begin androgen deprivation therapy and stop bicalutamide treatment in people with metastatic prostate cancer who are taking bicalutamide monotherapy and who do not maintain satisfactory sexual function. ***[2008]'***

All patients currently receiving this treatment are being identified by a number of parallel processes utilising Trust and HSC / Primary Care systems in order to provide a review to ascertain if the ongoing treatment with this agent is indicated or if an alternative treatment / management plan should be offered.

Summary table of Serious Adverse Incidents

Element of Concern
MDM *RIP ** was diagnosed with locally advanced prostate cancer in August 2019. An MDT discussion on 31 October 2019 recommended androgen deprivation therapy (ADT) and external beam radiation therapy (EBRT). ** was not referred for ERBT and his hormone treatment was not as per guidance. In March 2020 ** PSA was rising and when restaged in June 2020 ** had developed metastatic disease
Review Op Backlog In May 2019 ** had an assessment which indicated he had a malignant prostrate. ** was commenced on androgen deprivation therapy (ADT). Reviewed in July 2019 in outpatients and planned for repeat PSA and further review. Patient lost to review and attended Emergency Department in May 2020. Rectal mass investigated and diagnosed as locally advanced prostate cancer
Elective Exercise ** had a follow up CT scan of chest abdomen and pelvis performed on 17 December 2019 which was reported on 11 January 2020. The indicate for this was restaging of current renal cell carcinoma. ** had a right radical nephrectomy March 2019.The report noted possible sclerotic metastasis in L1 vertebral body. Result was not actioned. Patient contacted with result on 28 July 2020 and further assessment required
Elective Exercise Patient underwent TURP on 29/1/20. Pathology reported incidental prostate cancer. No follow-up or action from pathology result until picked up from elective exercise
MDM

CT renal report of 13/11/2019 unsigned on NIECR. No record of action taken recorded in NIECR. Case identified at urology MDM of 3/9/2020 following review of backlog
Pathology Patient diagnosed with prostate cancer Gleason 7. MDM 08/08/19- Significant Lower urinary tract symptoms but declined investigations. On maximum androgen blockade - No onward oncology referral was made.
Pathology Diagnosed with penile cancer, recommended by caner MDM for CT scan of Chest, Pelvis and Abdomen to complete staging. Same delayed by 3 months.
Pathology Patient diagnosed with a slow growing testicular cancer (Seminoma) had delayed referral to oncology and therefore delay in commencing chemotherapy.
MDM/ Bicalutamide (RIP)** MDM outcome not followed and inadequate treatment given. MDM outcome = commence LHRHa. Started on low dose of bicalutamide (unlicensed and sub-therapeutic dosage), subsequently represented with local progression January 2020 and appropriate treatment (Degeralex) was given along with TUR and stent / nephrostomy. The evidence for LHRHa in context of metastatic disease is that it reduces the risk of local progression (renal failure and spinal cord compression). This man had inadequate treatment and experienced a complication likely as a result of this.

Immediate actions following discovery of concerns in June 2020

- Advice sought from NHS Resolutions (formerly NCAS) who recommended restrictions of clinical practice.
- Referral of these concerns in respect of Consultant A was made to the GMC. This doctor is already known to the GMC.
- In consultation with NHS Resolutions and the GMC, from discovery until the date of termination of contract, restrictions were placed by the Trust on the Consultant's practice. Consultant A was to no longer undertake clinical work and could not access or process patient information either in person or through others either in hard copy or electronically. A request was also made that he voluntarily undertake to refrain from seeing any private patients at his home or any other setting and same was confirmed in writing via Consultant A's solicitor.
- Given that Consultant A is no longer employed by the Southern Trust since the 29th July 2020, the Responsible Officer authority has now passed to the GMC. Consultant A has asked for all correspondence through his solicitor, Tughan and Company, Belfast. In keeping with the Regional Guidance, Health and Social Care Board, Procedure for the Reporting and Follow up of Serious Adverse Incidents (November 2016),the Trust together with the PHA and the Board has facilitated the establishment of a panel to undertake the Serious Adverse Incident Reviews identified in the course of reviewing Consultant A's patients. This is chaired by an independent Chair, with a Urology Consultant

recommended by the Royal College of Surgeons as a Urology Subject Expert (from England).

- Early Alerts have been submitted to the Department of Health advising them of the professional performance and patient safety concerns.
- Two separate weekly meetings have been established since 11 August 2020
    i. Internal oversight meeting - chaired by Director of Acute Services and Medical Director as Deputy Chair;
    ii. External – Chaired by Director of HSCB with representatives from Trust, PHA, HSCB and Department of Health.

Preliminary discussions have been undertaken with the Royal College of Surgeons Invited Review Service regarding Consultant A's practice and potential scope and scale of any independent external reviews

Timescales

Initial scoping exercises as outlined have been completed and initial reviews of aspects of Consultant A's work from January 2019 are underway as described. The Royal College of Surgeons has advised that any look backs required should be undertaken using a chronological and incremental approach, beginning with most recent first has been implemented. A resource plan is in development to identify clinical capacity for patient assessment and clinical management, information and communication; this will present significant challenges given the current workforce issues within the Urology speciality and in the context of an ongoing Covid 19 Pandemic

Previous concerns relating to Consultant A

Previous concerns relating to Consultant A were being addressed since March 2016, and under Maintaining High Professional Standards from December 2016. The timeline for these previous concerns is included in Appendix One.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Southern Health and Social Care Trust

Appendix One

Detail on Previous Concerns with timeline details

Previous concerns relating to Consultant A

Previous concerns were raised in relation to Consultant A in March 2016, and managed within the Maintaining High Professional Standards framework from December 2016. The timeline for these previous concerns is detailed below:

March 2016

On 23 March 2016, Mr EM, the then Associate Medical Director (Consultant A's clinical manager) and Mrs HT, Assistant Director (Consultant A's operational manager) met with Consultant A to outline their concerns in respect of his clinical practice. In particular, they highlighted governance and patient safety concerns. Consultant A was provided with a letter dated 23 March 2016 detailing their concerns and asking him to respond with an immediate plan to address the concerns. Four broad concerns were identified:

- **Un-triaged outpatient referral letters**
  It was identified at that time that there were 253 un-triaged referrals dating back to December 2014.

- **Current Review Backlog up to 29 February 2016**
  It was identified at that time that there were 679 patients on Consultant A's review backlog dating back to 2013, with a separate oncology waiting list of 286 patients.

- **Patient Centre letters and recorded outcomes from clinics**
  The letter noted reports of frustrated Consultant colleagues concerned that there was often no record of consultations / discharges made by Consultant A on Patient Centre or on patient notes.

- **Patients' hospital charts at Consultant A's home**
  The letter indicated the issue of concern dated back many years. No numbers were identified within the letter.

April to October 2016

During the period April to October 2016, discussions were on-going between the then Director of Acute Services Acute Directorate and the previous Interim Medical Director about how best to manage the concerns raised with Consultant A in the letter of 23 March 2016. It was determined that formal action would not be considered as it was anticipated that the concerns could be resolved informally. Consultant A advised the review team he did not reply to the letter but did respond to the concerns raised in the letter by making changes to his practice.

November 2016

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Consultant A was off work on sick leave from 16 November 2016 following surgery and was due to return to work on 2 January 2017. An on-going Serious Adverse Incident (SAI) review within the Trust identified a Urology patient (Patient 10) who with a poor clinical outcome because the GP referral was not triaged by Consultant A.

An SAI review was commenced in autumn 2016. Through the SAI it was identified that the referral for patient Patient 10 had not been triaged by Consultant A. An initial review exercise was undertaken and a number of other patients were identified as not having been triaged by Consultant A. Further assessment of the issue identified a significant number of patient's letters (783 letters dating back to June 2015) who had not been triaged by Consultant A.

It should be noted that the issues of concern relating to patient Patient 10 were wider than the referral delay. It was considered that the symptoms recorded by the patient's GP on the initial referral should have resulted in the referral being upgraded to a 'red-flag' referral and prioritised as such.

December 2016

The professional concerns arising from the SAI were notified to the Trust's Medical Director, Dr RW in late December 2016. As a result of the concerns raised with Consultant A on 23 March 2016 and the serious concern arising from the SAI review by late December 2016, the Trust's Medical Director determined that it was necessary to take formal action to address the concerns.

The information initially collated from the on-going SAI of Consultant A's administrative practices identified the following:

- from June 2015, 318 GP referrals had not been triaged in line with the agreed / known process for such referrals. Further tracking and review was required to ascertain the status of all referrals.
- there was a backlog of 60+ undictated clinics dating back over 18 months amounting to approximately 600 patients, who may not have had their clinic outcomes dictated. It was unclear what the clinical management plan was for these patients, and if the plan had been actioned
- there was concern that some of the patients seen by Consultant A had their clinical notes taken back to his home As such these were then not readily available within the Trust secure systems. The clinical management plan for these patients was unclear, and may have been delayed.

As a result of these concerns, work was undertaken to scope the full extent of the issues and to put a management plan in place to review the status of each patient. The management plan put in place aimed to provide the necessary assurances in respect of the safety of patients involved.

28 December 2016

Advice was sought from the National Clinical Assessment Service (NCAS) on 28 December 2016 and it was indicated that a formal process under the Maintaining High Professional Standards Framework was warranted.

30 December 2016

Consultant A was requested to attend a meeting on 30 December 2016 with Dr RW, Medical Director and Ms LH, HR Manager during which he was advised of a decision by the Trust to place him on a 4 week immediate exclusion in line with the Maintaining High Professional Standards (MHPS) Framework to allow for further preliminary enquiries to be undertaken. A letter was issued to Consultant A in a follow up to the meeting detailing the decision of immediate exclusion and a request for the return of all case notes and dictation from his home. The letter also advised Consultant A that Dr AK had been appointed as Case Manager for the case and Mr CW was identified as the Case Investigator under the terms of MHPS..

03 January 2017

Consultant A met with Mrs MC, Head of Service for Urology to return all case notes which he had at home and all undictated outcomes from clinics in line with the request made to him by Dr RW on 30 December 2017. (There were a total of 288 casenotes returned and 668 patients identified as having had no dictation done following their clinical episode).

20 January 2017

During the period of the 4 week immediate exclusion period notified to Consultant A on 30 December 2016, Mr CW Clinical Director wrote to Consultant A to request a meeting with him on 24 January 2017 to discuss the concerns identified and to provide an opportunity for Consultant A to state his case and propose alternatives to formal exclusion.

23 January 2017

On 23 January 2017, Mr CW wrote to Consultant A seeking information from him in respect of 13 sets of case-notes that were traced out on PAS to him but could not be located in his office and which had not been returned to the Trust with the other case-notes on 3 January 2017.

24 January 2017

The meeting between Mr CW and Consultant A took place on 24 January 2017 with Mrs SH, Head of Employee Relations present.

26 January 2017

In line with the MHPS Framework, prior to the end of the 4 week immediate exclusion period, a case conference meeting was held within the Trust to review Consultant A's immediate exclusion and to determine if, from the initial preliminary enquiries, Consultant A had a case to answer in respect of the concerns identified.

A preliminary report was provided for the purposes of this meeting. At the case conference meeting, it was determined by the Case Manager, Dr AK that Consultant A had a case to answer in respect of the 4 concerns previously notified to him and that a formal investigation would be undertaken into the concerns.

The matter of his immediate exclusion was also considered and a decision taken to lift the immediate exclusion with effect from 27 January 2017 as formal exclusion was not deemed to be required. Instead, Consultant A's return to work would be managed in line with a clear management plan for supervision and monitoring of key aspects of his work.

These decisions were communicated to Consultant A verbally by telephone following the case conference meeting on 26 January 2017.

6 February 2017

A letter was sent to Consultant A on 6 February 2017 confirming the decisions from the case conference meeting on 26 January 2017 and notifying him of a meeting on 9 February 2017 to discuss the detail of the management plan and monitoring arrangements to be put in place on his return to work.

9 February 2017

Consultant A attended a meeting with the Case Manager, Dr AK on 9 February to discuss the management arrangements that were to be put in place on his return to work following the immediate exclusion period. Mrs SH and Consultant A's son were in attendance at the meeting. The action plan was accepted and agreed with Consultant A at the meeting.

20 February 2017

Between 27 January 2017 when the immediate exclusion was lifted and 17 February 2017, Consultant A was unable to return to work due to ill health. He returned to work on 20 February 2017 in line with action plan agreed at the meeting on 9 February 2017.

As part of the action plan agreed, monitoring mechanisms were put in place to continuously assess his administrative processes to safeguard against a recurrence of the concerns raised with regards to his outpatient work. This monitoring arrangement was in place up until Consultant A's date of leaving. There were 3 occasions when there were deviations from the agreed actions, and on two occasions Consultant A offered acceptable explanations. On the third occasion, Consultant A had no acceptable explanation for the delay in dictation, however all dictation was completed at the point of retirement.

January and February 2017

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

During January and February 2017, Consultant A made a number of representations to Dr RW, Medical Director and Mr JW, Non-Executive Director in respect of process and timescale. In considering the representations made, it was decided that Mr CW should step down as Case Investigator prior to the commencement of the formal investigation. Dr NC, Associate Medical Director and Consultant Psychiatrist was appointed as Case Investigator.

16 March 2017

The terms of reference for the formal investigation were shared with Consultant A along with an initial witness list.

April, May and June 2017

During April, May and June 2017 the Case investigator met with all witnesses relevant to the investigation. Witness statements were prepared and issued for agreement.

14 June 2017

Dr NC, Case Investigator wrote to Consultant A requesting to meet with him on 28 June 2017 for the purpose of taking a full response in respect of the concerns identified.

19 June 2017

Consultant A requested to reschedule the meeting to secure his preferred accompaniment to the meeting. This was facilitated. A meeting on 29 June, 30 June and 1st July was offered. Consultant A requested to defer the meeting until later in July until after a period of planned annual leave, and a meeting was confirmed for 31 July 2017.

05 July 2017

Consultant A advised the date of 31 July was not suitable and a date of 3 August 2017 was agreed.

03 August 2017

A first investigation meeting was held with Consultant A in order to seek his response to the issues of concern.

At the meeting on 3 August 2017 it was agreed that a response would not be taken in respect of term of reference number 4 in respect of private patients until patient information requested by Consultant A had been furnished to him. It was agreed that a further meeting date would be arranged for this purpose once all information had been provided. Consultant A's responses to the remaining terms of reference were gathered.

16 October 2017

A meeting date for the second investigation meeting was agreed for 06 November 2017.

06 November 2017

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

A second investigation meeting was held with Consultant A in order to seek his response to the issues of concern in respect of term of reference 4. At the meeting of 6 November 2017, Consultant A advised Dr NC that he wished to make comment on both his first statement and also the witness statements provided to him. He further advised that his priority for November and December was completion of his appraisal and that he would not be able to provide his comments during this period. It was agreed his timescales would be facilitated.

15 February 2018

By 15 February 2018, Consultant A had not provided the comments he had previously advised he wished to make and therefore this was queried with Consultant A and an update sought.

22 February 2018

No response was received and a further email reminder was sent to Consultant A on 22 February 2018. On the same day, Consultant A responded to advise that he had not had time to attend to the process since the meeting in November 2017. He requested a copy of the statement from the November meeting and indicated he would provide commentary on all documents by 31 March 2018. Consultant A was asked to provide comments by 9 March 2018 rather than 31 March 2018.

16 March 2018

Comments on the documents were not received on 9 March 2018 and a further reminder was sent to Consultant A requesting his comments no later than 26 March 2018. It was advised that the investigation report would be concluded thereafter if comments were not provided by 26 March 2018.

26 March 2018

No comments were received from Consultant A.

29 March 2018

A final opportunity was provided to Consultant A to provide comments by 12 noon on 30 March 2018. It was advised that the investigation report would be thereafter drafted.

30 March 2018

No comments were received from Consultant A.

2 April 2018

Comments on the statements from the meetings of 3 August and 6 November were received from Consultant A. Consultant A also queried requested amendments to notes of meeting on 30 December 2016 and 24 January 2017.

21 June 2018

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

In the interests of concluding the investigation report without further delay, all comments from Consultant A were considered and a finalised report was provided to Consultant A on 21 June 2018 for comment.

14 August 2018

The Case Manager, Dr AK wrote to Consultant A acknowledging receipt of his comments and advising he would consider these along with the final report and reach his determination in terms of next steps.

1 October 2018

Dr AK, Case Manager met with Consultant A to outline outcome of his determination that the case should be forwarded to a Conduct Panel under MHPS.

The Findings from the investigation

There were 783 un-triaged referrals by Consultant A of which 24 were subsequently deemed to need upgraded and a further 4 with confirmed diagnoses of cancer (plus the original SAI patient.) There was therefore potential for harm of 783 patients.

Consultant A stored excessive numbers of case notes at his home for lengthy periods. 288 charts were brought by him from his home and returned in January 2017. This is outside normal acceptable practice. There were 13 case notes missing but the review team is satisfied with Consultant A's account that he does not have these.

There were 66 clinics (668 patients) undictated and 68 with no outcome sheets, some going back a few years. Consultant A gave an explanation of doing a summary account of each episode at the end. He indicated patients were added to waiting lists at the point they should have been in any event.

Some of Consultant A's private patients were added to the HSC waiting list ahead of HSC patients without greater clinical need by these private patients.

27 November 2018

Consultant A submitted a lengthy and detailed grievance of 40 pages, with 49 Appendices. It was lodged along with a request for information. The grievance was held in abeyance pending completion of the information requests.

9 April 2019

Consultant A was advised by Dr AK, Case Manager that a GMC referral was to be submitted following a discussion regarding the case with the GMC Liaison Officer.

Timeline for grievance process – November 2018 to June 2020:

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

The requested information relating to the information request was provided to Consultant A in 2 returns – one on 21 December 2018 and one on 11 January 2019. Consultant A wrote to the Trust again on 12 March 2019, and advised that he had sought the advice of the Medical Protection Society and also Legal Counsel, and that he was therefore submitting a request for further information. Consultant A advised that following its receipt, the Trust would be advised whether any further information was to be requested, and /or whether the Formal Grievance was to be amended.

HR Director wrote to Consultant A on 3 June 2019, seeking further clarity on information requested in his 12 March 2019 letter. The Trust advised him that the information request was extensive in nature and would require significant time and resources within the Trust to compile. The Trust advised him that all reasonable efforts were being made to gather the requested information, however within his request there were elements which were much too wide and not properly defined. Consultant A was therefore asked to refine and clarify the specifics of his request in respect of a number of points.

Consultant A responded on 24th June 2019, clarifying the information plus seeking 2 additional items. The request for information was still significant in nature, and took significant time and resources for the Trust to compile. The requested information was delivered to Consultant A's Secretary for his attention on 30th October 2019.

Since Consultant A had indicated that, following receipt of the requested information, he would advise whether or not his formal grievance was to be amended, the Trust awaited hearing from him in this regard. However, no further correspondence was received from Consultant A in respect of his grievance, or any amendments to it.

At this stage, from November 2019 through to end of January 2020, the Trust suffered significant disruption to its services and its HR function by reason of widespread Industrial Action by health service trade unions. Furthermore, work was ongoing to finalise the SAI (Serious Adverse Incident) processes in respect of the patients affected by the original concerns in respect of Consultant A's practise.

In recent months the Trust's services and normal HR processes has been very severely impacted by the Covid – 19 pandemic. This prevented any employee relations work, including the hearing of grievances, being taken forward for a 3 month period from March to start of June.

On 26th April 2020, Consultant A wrote to the Trust's HR Director again, highlighting that a number of pieces of information from original requests had not been provided, and he requested these by 15th May 2020. On 15th, 22nd May and also on 8th June the Director of HR wrote to Consultant A with responses to these requests. The Trust believes that all substantial and detailed information requests have now been responded to.

June 2020 – September 2020

Grievance process ongoing. The grievance panel is due to conclude by mid October 2020.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

As Consultant A is no longer employed, the Conduct Hearing under MHPS cannot be concluded. The GMC processes will continue regarding Consultant A's fitness to practise in light of both the previous concerns and the most recent concerns.

Summary of previous Serious Adverse Incidents – from 2016 onwards

Following the SAI Index Case Patient 10 which triggered the first MHPS case, the Trust identified a number of GP Urology referrals who were not triaged by Consultant A. 30 patients should have been red-flag referrals and of these 4 had cancer. A fifth patient, discovered during an outpatient clinic, was included as he was also not triaged and subsequently had a cancer confirmed. These five cases were subject to a further SAI review process.

Lessons Learned from the 5 SAI's

1. The clinical urgency category allocated by GPs to 30 patients referred to Urology were incorrect. The referrals using NICaN guidance should have been referred as a Red Flag. Four (plus 1) of these patients were subsequently shown to have cancer.

2. The process of triaging Urology cancer referrals from Primary Care to Secondary Care, under the direction of the HSCB, appears to be less efficient than it could be, bearing in mind that NICE NG12 guidance has not been adopted and electronic referral using CCG is not being used as efficiently as it could.

3. GP's are not mandated to provide HSCB with an assurance that they comply with the most up to date NICE or other guidelines. Therefore, HSCB are unaware of any risks consequent upon the non-compliance with NICE and other guidance within GP practices.

4. GP's are not mandated to refer patients using CCG clinical criteria banners; this can lead to error and delay.

5. There is no Regional or Trust guidance or policy on what is expected of clinicians when triaging referral letters. Triage of patient referrals is obviously viewed as extremely important but does not seem to be at an equivalent level of importance when ranked alongside other clinical governance issues. Despite being an evident problem for decades and requiring considerable time and effort to find a solution, it only really surfaced within the Trust after an Index case forced the situation out into the open.

6. Despite it being absolutely clear to Consultant A (based upon his close proximity to the development and signing off of regional guidance) of the consequences of non-triage, he did not routinely triage referral letters. The Review Team consider that Consultant A's refusal to triage to a level similar to other clinicians, led to patients not being triaged, and this resulted in delays in assessment and treatment. This may have harmed one patient.

7. Consultant A confirmed that despite the Trust reminding him of the requirement to triage, he did not consistently triage referrals. He argued that, due to time pressures, he felt he was unable to perform the duties of the Consultant of the

Week and his triaging duties. He has highlighted those views to Trust operational and management teams over a number of years.

8. The Trust made efforts to address Consultant A's non-triage over time. However, the Trust failed to put systems, processes and fail safes in place to ensure Consultant A consistently triaged patient referrals until 2017. However, this safeguarding process is heavily dependent on the Head of Service checking triage is completed when Consultant A is Consultant of the Week.

9. The Informal Default Triage process allows patients who should be red flagged to **remain on a waiting list of routine or urgent cases.**

Annex C

From the Permanent Secretary and HSC Chief Executive

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

Castle Buildings
Upper Newtownards Road
BELFAST, BT4 3SQ

Tel: Personal Information redacted by the USI
Fax:
Email: Personal Information redacted by the USI

Shane Devlin
Chief Executive
Southern HSC Trust

Personal Information redacted by the USI

Our ref: RP5593

Date: 22 October 2020

Dear Shane

CONFIDENTIAL EARLY ALERT 182/2020 – SOUTHERN TRUST CONSULTANT UROLOGIST

I refer to the above Early Alert which was notified to the Department on 31 July 2020, and the subsequent report submitted to the Department via the HSCB on 15 October 2020, summarising the Trust's ongoing scoping and management of the issues arising from it.

Whilst I fully appreciate the complexity of this task and the intensive efforts by Trust colleagues to date to quantify these issues and to ensure that no patients come to harm as a consequence, the Department's view is that this process will benefit at this stage from a commensurate level of external oversight and assurance. Further to our discussion today I have therefore attached at **Annex A** draft terms of reference for a Department-led assurance group which I will chair in order to review progress and guide the way forward in terms of the Trust's management plan. It is my intention that the Urology Assurance Group will begin to meet from next week in order to agree the terms of reference and discuss the immediate next steps. Michael O'Neill, Acting Director of General Healthcare Policy, will lead on this in the Department and provide secretariat for the group.

Yours sincerely

Personal Information redacted by the USI

RICHARD PENGELLY
ACCOUNTING OFFICER

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

cc.
CMO
CNO
Lourda Geoghegan
Naresh Chada
Jackie Johnston
David Gordon
Michael O'Neill
Ryan Wilson
Maria O'Kane, SHSCT
Sharon Gallagher, HSCB
Paul Cavanagh, HSCB
Olive MacLeod, PHA
Brid Farrell, PHA
Tony Stevens, RQIA
Emer Hopkins, RQIA

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

ANNEX A

UROLOGY ASSURANCE GROUP
DRAFT TERMS OF REFERENCE

Background

The Department received a confidential Early Alert (EA 182/20) from the Southern Health and Social Care Trust on 31 July 2020 regarding potential safety concerns that were initially raised on 7 June 2020 about a consultant urologist who retired at the end of June 2020.

The Trust took a number of initial actions relating to these concerns, including restricting the consultant's clinical practice and access to patient information, notifying the GMC and discussing the matters with the Royal College of Surgeons Invited Review Service to understand the scope and scale of any further independent review.

In order to fully define the areas for concern and quantify the number of patients potentially impacted, the Trust has undertaken an internal scoping exercise of all patients who were under the care of the consultant, initially for an 18 month period. This involves a review of all case notes to identify those which provide any cause for concern.

Officials from the Department, HSCB and PHA have participated in weekly progress update calls with the Trust since 10 September 2020. Upon request a report was provided to the Department on 15 October 2020 summarising the current position, including the quantity of patient case notes that need to be reviewed and progress so far, confirmed SAIs to date, and advising of additional patient safety concerns identified in the course of this exercise.

Objectives

In light of the concerns identified a Department-led Urology Assurance Group will provide external oversight of the various work streams arising from the ongoing scoping exercise Trust. Specifically the Group will:

- review the progress of the initial scoping exercise;
- consider emerging strategic issues;
- commission and direct further work as necessary;
- monitor the impact on urology and related services;
- ensure coordination with other associated reviews / investigations; and
- oversee communication across all stakeholder groups.

Membership

The Group will be chaired by the Permanent Secretary. Membership will include:

- Dr Michael McBride, Chief Medical Officer, DoH
- Sharon Gallagher, Interim Chief Executive, HSCB/PHA
- Jackie Johnston, Deputy Secretary Healthcare Policy Group, DoH
- Olive Macleod, Interim Chief Executive, PHA
- Paul Cavanagh, Director of Commissioning, HSCB
- Dr Brid Farrell, AD Service Development, Safety and Quality, PHA
- Dr Tony Stevens, Interim Chief Executive, RQIA
- Emer Hopkins, Interim Director of Improvement, RQIA
- Shane Devlin, Chief Executive, Southern Trust
- Maria O'Kane, Medical Director, Southern Trust

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

- Lourda Geoghegan, Deputy Chief Medical Officer, DoH
- David Gordon, Director of Communications, DoH
- Ryan Wilson, Acting Director of Secondary Care, DoH
- Michael O'Neill, Acting Director of General Healthcare Policy, DoH,
- Anne Marie Bovill, General Healthcare Policy

Support
Secretariat will be provided by General Healthcare Policy Directorate and meetings will initially be held fortnightly, but will be subject to review.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Annex D

DRAFT WRITTEN STATEMENT –
CLINICAL CONCERNS WITHIN UROLOGY AT SOUTHERN HEALTH AND SOCIAL CARE TRUST

The Southern Health and Social Care Trust notified my Department on 31 July 2020 that it had identified clinical concerns in relation to the work of a consultant urologist who no longer works in the health service.

An internal exercise was immediately initiated by the Trust and is ongoing in order to ascertain the number of patients whose care may need to be reviewed. At this stage, a small number of patients have been contacted in this regard.

As Health Minister, I am extremely concerned about any issue that involves the potential for patients to come to harm within our Health and Social Care system. However, it is important to stress that the vast majority of urology patients in the Southern Trust will be unaffected by the issues that have come to light. I want to assure all patients and their families that the investigation into these matters will be comprehensive, and that anyone whose care needs to be reviewed will be contacted as quickly as possible.

My Department has been kept updated by the Southern Trust regarding progress with this exercise, and I intend to make an oral statement in the Assembly next week in order to provide further details about this matter.

My Department's immediate priority is to ensure that the Southern Trust completes this initial phase of work in the weeks ahead in order to minimise and prevent any potential risk or harm to patients.

My Department has therefore established a Urology Assurance Group to provide external oversight to the Southern Trust's ongoing process, and the future management plan for the issues arising from it. The Assurance Group comprises senior officials from the Department of Health, Health and Social Care Board, Public Health Agency, Regulation and Quality Improvement Authority, as well as the Southern Trust. I will publish final terms of reference for the Assurance Group alongside my Assembly statement.

If any urology patient or their carer has concerns about their treatment and would like information they should contact the Southern Trust on 0800 4148520.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

ANNEX A

Initial call made to Ryan Wilson **(DoH) on** 15th October 2020 **DATE**

Follow-up Pro-forma for Early Alert Communication:

Details of Person making Notification:

Name	Dr Maria O'Kane	Organisation	Southern Health and Social Care Trust
Position	Medical Director	Telephone	Personal Information redacted by the USI

Criteria (from paragraph 1.3) under which event is being notified (tick as appropriate)

1. Urgent regional action
2. Contacting patients/clients about possible harm
3. Press release about harm
4. Regional media interest
5. Police involvement in investigation
6. Events involving children
7. Suspension of staff or breach of statutory duty

Brief summary of event being communicated: ****If this relates to a child please specify DOB, legal status, placement address if in RCC. If there have been previous events reported of a similar nature please state dates and reference number. In the event of the death or serious injury to a child - Looked After or on CPR - Please confirm report has been forwarded to Chair of Regional CPC.***

Further to Early Alert dated 31st July 2020 (attached for ease of reference) relating to the provision of Trust Urology Services additional significant concerns have been brought to the attention of the Trust regarding prescribing practices regarding the medication Bicalutamide by the individual consultant who is no longer employed by Health and Social Care Services.

These additional concerns have been identified following an initial meeting of the Serious Adverse Incident review team which occurred this week. Concerns have been raised regarding the subject's prescribing practices which include use of unlicensed and sub-therapeutic dosages of Bicalutamide which we consider a significant and potentially wide patient safety risk requiring immediate action. Trust staff are working with the HSCB medications team to gain a better understanding of the implications of this latest development in terms of scale and scope and to identify patient groups that may be at risk. It is recognised that this prescribing issue involves medicines that are prescribed by primary care providers on advice from the secondary care team.

In addition to this early alert senior staff at HSCB, PHA and Department of Health have been briefed directly of this development. The Trust is continuing to liaise directly with colleagues in each organisation in order to take appropriate action.

Appropriate contact within the organisation should further detail be required:

Name of appropriate contact: Dr Maria O'Kane

Contact details:

Email address (work or home) Personal Information redacted by the USI

Mobile (work or home) Personal Information redacted by the USI Telephone (work or home)

Forward pro-forma to the Department at: Personal Information redacted by USI and the HSC Board at: Personal Information redacted by USI

FOR COMPLETION BY DoH:

Early Alert Communication received by: …….... Office: ……..……..

Forwarded for consideration and appropriate action to: ……..…… Date: ….....

Detail of follow-up action (if applicable) ……..……

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

UROLOGY ASSURANCE GROUP
TERMS OF REFERENCE

Background

The Department received a confidential Early Alert (EA 182/20) from the Southern Health and Social Care Trust on 31 July 2020 regarding potential safety concerns that were initially raised on 7 June 2020 about a consultant urologist who retired at the end of June 2020.

The Trust took a number of initial actions relating to these concerns, including restricting the consultant's clinical practice and access to patient information, notifying the GMC and discussing the matters with the Royal College of Surgeons Invited Review Service to understand the scope and scale of any further independent review.

In order to fully define the areas for concern and quantify the number of patients potentially impacted, the Trust has undertaken an internal scoping exercise of all patients who were under the care of the consultant, initially for an 18 month period. This involves a review of all case notes to identify those which provide any cause for concern.

From 10 September 2020, officials from the Department, SPPG and PHA participated in weekly progress update calls with the Trust. Upon request a report was provided to the Department on 15 October 2020 summarising the current position, including the quantity of patient case notes that need to be reviewed and progress so far, confirmed SAIs to date, and advising of additional patient safety concerns identified in the course of this exercise.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Objectives

In light of the concerns identified the Permanent Secretary ledUrology Assurance Group (UAG) will provide external oversight of the various work streams arising from the ongoing scoping exercise Trust. Specifically the Group will:

- review the progress of the initial scoping exercise;
- consider emerging strategic issues;
- commission and direct further work as necessary;
- monitor the impact on urology and related services;
- ensure coordination with other associated reviews / investigations; and
- oversee communication across all stakeholder groups.

The UAG will receive updates from the Southern Urology Oversight Steering Group as appropriate. The Steering Group will continue to review the findings of the initial lookback exercise and scope the potential need for a further lookback exercise.

Membership

The UAG will be chaired by the Permanent Secretary. Membership will include:

- Chief Medical Officer, DoH
- Deputy Secretary Strategic Planning and Performance Group, DoH
- Deputy Secretary Healthcare Policy Group, DoH
- Chief Executive, PHA

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

- Director of Commissioning, Strategic Planning and Performance Group, DoH
- Assistant Director of Service Development, Safety and Quality, PHA
- Chief Executive, Southern Trust
- Medical Director, Southern Trust
- Director Acute Services, Southern Trust
- Deputy Chief Medical Officer, DoH
- Director of Communications, DoH
- Director of Secondary Care, DoH
- Director of General Healthcare Policy, DoH,
- Head of General Healthcare Review, DoH

Support

Secretariat will be provided by General Healthcare Policy Directorate andmeetings will be held every 4-6 weeks, or at longer intervals as determined by the Chair.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Ministerial Statement

Urology: Southern Health and Social Care Trust

Mr Speaker: I have received notice from the Minister of Health that he wishes to make a statement. Before I call the Minister, I remind Members that, in light of social distancing being observed by the parties, the Speaker's ruling that Members must be in the Chamber to hear a statement if they wish to ask a question has been relaxed. Members still have to make sure that their name is on the speaking list if they wish to be called, but they can do this by rising in their places as well as notifying the Business Office or the Speaker's Table directly. I remind Members to be concise in asking their questions. This is not a debate per se, and long introductions should not be entered into.

Mr Swann (The Minister of Health): Mr Speaker, it is with deep regret that I inform the House of a further occurrence of serious concerns about the clinical practice of a hospital consultant notified to my Department by one of our health and social care trusts. The incident concerns the clinical practice of a urology consultant, Mr Aidan O'Brien, who retired from the Southern Trust earlier this year.

On 31 July 2020, the Southern Trust contacted my Department to report an early alert concerning the clinical practice of the consultant. The trust informed my Department that, on 7 June, it became aware of potential concerns regarding delays in the treatment of surgery patients who were under the care of the consultant urologist employed by the trust. The trust became aware that two out of 10 patients listed for surgery under the care of the consultant were not on the hospital's patient administration system at that time. As a result of those potential patient safety concerns, an initial look-back exercise in relation to the consultant's work was conducted to ascertain whether there were other areas of potential concern.

The initial look back, which considered cases over an 18-month period of the consultant's work in the Southern Trust from 1 January 2019 to 30 June 2020, concentrated on whether patients had had a stent inserted during a particular procedure and if the stent had been removed within the clinically recommended time frame. The initial look back identified concerns with 46 cases out of a total of 147 patients who had the procedure and were listed as being under the care of the consultant during the period addressed by the initial look-back exercise.

When my Department was contacted on 31 July, the trust confirmed that the following actions had already been taken: discussions with the GMC's employer liaison service had been conducted; the case had been discussed with NHS Resolution, which recommended restrictions of clinical practice; restrictions were put in place by the trust preventing the consultant from undertaking clinical work in the trust and denying him the access or ability to process patient information; the trust requested that the consultant voluntarily undertake to refrain from seeing any private patients at their home or any other setting and that he confirm the same in writing; and a preliminary discussion was undertaken with the Royal College of Surgeons' invited review service regarding the consultant's practice and the potential scope and scale of any further look-back exercise that may be required.

The trust also established a review group to assess the further findings of the initial look-back exercise and to explore the potential need for a further look-back exercise in the context of the

emerging concerns. That group has been working diligently since August, and I am now in a position to inform the Assembly of its most recent findings. Whilst Mr O'Brien has worked in the Southern Trust for 28 years, in consultation with the Royal College of Surgeons, the review group has looked at the time frame from 1 January 2019 until 30 June 2020. During that time, 2,327 patients were under his care. The review group identified the most vulnerable group of urology patients in that cohort and concentrated on those 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 the safe prescribing of an anti-androgen drug outside established NICE guidance in the management of prostate cancer. Across those areas, to date, 1,159 patients' records have been reviewed, and 271 patients or families have been contacted by the trust. The group's work continues across those areas of concern. Further details of the various review strands are appended to the statement.

So far, nine cases have been identified that meet the threshold for a serious adverse incident (SAI) review, and all nine patients and/or their families have been contacted by the trust to inform them of the position of their respective cases. A further six cases are being reviewed in more detail to establish whether those patients have come to harm.

The consultant also had a significant amount of private practice. Much of that was carried out in private domestic premises and, therefore, sat outside the regulatory framework that requires the registration and external assurance of facilities in the independent sector in which clinicians may undertake private practice. That is also of significant concern to me, as many of those patients may be unknown to the Southern Trust or the wider Health and Social Care (HSC) system.

Following a recent media report about the developing situation, the trust has issued a statement and has advised patients that, if they are concerned about aspects of their urology care and require further advice, they should contact the Southern Trust by email or through its urology information phone line. That information line is available from Monday to Friday between 10.00 am and 3.00 pm, and the number is 0800 4148520.

I am sure that the House will agree that the issues identified by the trust's review group are of the gravest concern. The impact of the concerns will be felt most severely by the patients and families affected, and, unfortunately, we are only at the start of what is likely to become a long and detailed investigation of the matter. As Health Minister, I want first to unreservedly apologise to the patients and their families for any upset and distress that has been caused. I wish to reassure them that I will endeavour to ensure that they obtain appropriate treatment and support and the care that they need over the coming weeks and months.

I propose to take a number of actions to uncover how the situation developed over a number of years without any apparent action being taken by the trust to deal with the practice of the consultant before now. I need to determine quickly whether a further look-back exercise is required that might necessitate a significant review and recall of a larger group of patients, other than those identified to date, who require a review of their clinical care and treatment. In addition to that, given the large number of cases that have been identified as meeting the threshold for an SAI review, particular action will be required to ensure that matters relating to those patients and their care and treatment are dealt with in an effective and timely way.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

I have therefore taken the following actions. First, I have established a urology assurance group, chaired by the permanent secretary of my Department, to provide external oversight of the various work streams arising from the initial look-back exercise initiated by the Southern Trust. Specifically, that group will review the progress of the initial look-back exercise; consider emerging strategic issues; commission and direct further work as necessary; monitor the impact on urology and related services in the Southern Trust; ensure coordination with other associated reviews or investigations; and oversee communication across all stakeholder groups, with patient care being the central focus throughout. I have published the terms of reference for the group alongside the statement. Secondly, the Royal College of Surgeons has been commissioned to carry out an independent review of a sample of the clinical cases included in the initial look-back exercise to determine whether a further, more extensive look-back or patient recall by the trust is required. Thirdly, in relation to the consultant's private patients who are not known to the Southern Trust, I have requested that Mr O'Brien's solicitors outline how he intends to provide a similar independent process to ensure that those private patients are alerted to issues arising and that their immediate healthcare needs are being met. While the Department has no explicit duty to take this particular matter forward, as part of our wider healthcare responsibilities, I want to do all that I can to safeguard patients who may have received care or treatment in a private capacity from the consultant.

The remaining issues to be addressed relate to the management of all past, present and future cases that would meet the threshold for an SAI review, as well as establishing why this happened and whether action could have been taken by the Southern Trust to identify and address the apparent deficiencies in the consultant’s clinical practice. Given the large number of cases already identified as meeting the threshold for an SAI review and my concerns that there may be more to come, a different and specific approach is required. The fourth action, therefore, that I intend to take is to establish a statutory public inquiry under the Inquiries Act 2005. I believe that that is the best way to ensure that the full extent of the concerns is identified and for the patients and families affected to see that those and all relevant issues are pursued in a transparent and independent way. My officials are preparing the way to get the inquiry up and running as soon as possible. That will take some time, and I would expect that the respective families and patients will have the opportunity to influence the inquiry's terms of reference. I must also be mindful of the statutory duties placed on me to discuss the issues with the appointed chair in advance of establishing the inquiry. Further details will be provided in that regard when they are available.

Inevitably, this type of work leads to a range of statistics relating to patient numbers, records reviewed, patient contacts and so on. Members will know that, behind every statistic, there is a patient, a family and their story and experience. These types of exercise can cause upset, distress and anxiety.

A significant element in all this work, therefore, will be to communicate with and support patients and their families as much as possible in the coming weeks and months. To help with that, the Southern Trust is developing a patient support package to include any counselling and psychological support that is needed, alongside the provision of family liaison and related support services.

10.45 am

Members will be all too aware that these significant concerns come hard on the heels of the recall of neurology patients by the Belfast Trust, and I am sure that Members will be keen to see the outcomes

of that inquiry in due course. I recently met patients and families affected by the neurology recall and reiterated my apology to them for how they had been let down by the Health and Social Care system. To address those cases, as Members will know, an independent inquiry was initiated by the Department. That inquiry was established in the absence of Ministers, when it was not possible to constitute the inquiry under the Inquiries Act. To date, the work of that independent inquiry has been largely unaffected by that non-statutory approach, and I take the opportunity to thank Brett Lockhart QC and his team for their immense efforts in recent months. However, to ensure that, in the closing stages of the neurology inquiry, Mr Lockhart and his team have timely and unfettered access to all relevant information, I also announce that I intend to convert the Independent Neurology Inquiry to a statutory public inquiry under the Inquiries Act 2005. It is important to note that the inquiry team is at a very advanced stage of its evidence-gathering process, and I want to be clear that I do not intend this decision to add to or alter the work or timescales of the neurology inquiry team, nor do I expect to see changes in the way that evidence has been gathered or public access has been provided. That would not be in the interests of the patients and families affected. They have already waited too long for answers. My officials will be in contact with Mr Lockhart as soon as possible to ensure that the transition is as seamless as it can be.

The emerging situation in the Southern Trust causes me and my Department the gravest of concerns. While I remain convinced that the experience of patients who use our health service is overwhelmingly that of a safe and quality service, these incidents, regrettably, dent the confidence of service users. I fully acknowledge that, and I will do all that I can to ensure that lessons are learned to prevent situations such as these occurring again. I trust that Members will agree that what I have announced today constitutes robust and timely action in a deeply concerning situation. I commend my statement to the Assembly.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

From: Dawson, Andrew
To: Briege Donaghy; Emer Hopkins; Davis, Robbie
Cc: Ruddy, Donna; Wright, Sharon (DoH)
Subject: RE: Sent on Behalf of Dr Maria O"Kane - Urology Structured Clinical Record Review Process
Date: 22 February 2022 14:06:06
Attachments: 20220220_ltr RQIA SCRR Review.pdf

Briege – many thanks.

Robbie – are you content from Dept/PSNRAG perspective?

Copying to Donna and Sharon to note iro sponsor branch and SAI policy.

Andrew

From: Briege Donaghy <Personal Information redacted by the USI>
Sent: 21 February 2022 14:24
To: Emer Hopkins <Personal Information redacted by the USI>
Cc: Dawson, Andrew <Personal Information redacted by the USI>
Subject: FW: Sent on Behalf of Dr Maria O'Kane - Urology Structured Clinical Record Review Process

"This email is covered by the disclaimer found at the end of the message."

Hi Emer- please see attached a formal request now from SHSCT to undertake this review of process and assurance re same re Urology Review.
Will wait to discuss with you before acknowledging request to us.

With thanks

Briege

Andrew – take it this is agreed approach with DoH under Urology assurance arrangements. Much appreciated

From: Montgomery, Ruth [Personal Information redacted by the USI]
Sent: 21 February 2022 10:13
To: Briege Donaghy
Cc: Robbie.Davis Personal Information redacted by the USI; OKane, Maria; Wallace, Stephen
Subject: Sent on Behalf of Dr Maria O'Kane - Urology Structured Clinical Record Review Process

Sent on behalf of Dr Maria O'Kane

Dear Briege,

Please see attached correspondence sent on behalf of Dr Maria O'Kane regarding the Urology Structured Clinical Record Review.

Kind Regards,

Ruth

Ruth Montgomery
Project Manager
Beechfield House
Craigavon Area Hospital

☎ Please note my new contact number – External - Personal Information redacted by the USI / Internal ext: Personal Information redacted by

Personal Information redacted by the USI

"The information contained in this email and any attachments is confidential and intended solely for the attention and use of the named addressee(s). No confidentiality or privilege is waived or lost by any mistransmission. If you are not the intended recipient of this email, please inform the sender by return email and destroy all copies. Any views or opinions presented are solely those of the author and do not necessarily represent the views of HSCNI. The content of emails sent and received via the HSC network may be monitored for the purposes of ensuring compliance with HSC policies and procedures. While HSCNI takes precautions in scanning outgoing emails for computer viruses, no responsibility will be accepted by HSCNI in the event that the email is infected by a computer virus. Recipients are therefore encouraged to take their own precautions in relation to virus scanning. All emails held by HSCNI may be subject to public disclosure under the Freedom of Information Act 2000."

Southern Health and Social Care Trust

Quality Care - for you, with you

20th February 2022 Ref: MOK/ec

Via email [redacted]

Briege Donaghy
Chief Executive
Regulation and Quality Improvement Agency
9th Floor BT Tower
Belfast

Dear Briege,

RE: UROLOGY STRUCTURED CLINICAL RECORD REVIEW PROCESS

As you will be aware, the Southern Trust is conducting a lookback exercise regarding our Urology services. The purpose of the lookback exercise is to review patients who were under the care of an individual consultant no longer employed by the Trust.

Following the completion of an initial nine Serious Adverse Incident (SAI) reviews in 2021 and as advised by the Department of Health, the SAI process will not be used to review subsequent potential issues in care identified as a result of the lookback process. However remaining cognisant of regional parameters and requirements for the identification, review and learning from Adverse and Serious Adverse Incidents (SAI) as set out in the HSCB *Procedure for the Reporting and Follow up of Serious Adverse Incidents (November 2016,)* the Trust has sought to provide an alternative, proportionate and robust review structure that can be utilised to review these incidents in a timely manner.

As a result of this the Trust has developed a *'Structured Clinical Record Review'* (SCRR) process founded on Structured Judgement Review methodology as developed by the

Southern Trust Headquarters, Craigavon Area Hospital, 68 Lurgan Road, Portadown, BT63 5QQ
Tel: [redacted] Email: [redacted]

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Royal College of Physicians. The SCRR process has been designed to allow the Southern Trust to identify if there is any learning or areas where patient safety can be improved.

I understand the Department of Health Sponsor Branch has made contact with you regarding support to the Trust through conducting a review relating to the SCRR process. Specifically we are asking for RQIA to undertake the following please:

- A review of the choice of SJR methodology to underpin the SCRR process
- A review of the SCRR process in relation to its effectiveness in identifying learning

In terms of output from this, it would be useful to have a statement to assure the Urology Assurance Group on the effectiveness of the SCRR process please. If in the event that the SCRR process is not found to be satisfactory, I would be grateful if you could recommend an alternative approach please.

I look forward to hearing from you.

Yours sincerely

Personal Information redacted by the USI

Dr Maria O'Kane
Medical Director

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

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

From: Dawson, Andrew
To: Ruddy, Donna; Rocks, Dennis
Subject: FW: Urology Structured Clinical Record Review Process
Date: 03 March 2022 09:16:58
Attachments: Reply to_ltr RQIA SCRR Review 020322.pdf

FYI

From: Katrina Andrews <Personal Information redacted by the USI>
Sent: 02 March 2022 10:22
To: OKane, Maria <Personal Information redacted by the USI>
Cc: Emer Hopkins <Personal Information redacted by the USI>; Dawson, Andrew <Personal Information redacted by the USI>; Leanne Morgan <Personal Information redacted by the USI>; Briege Donaghy <Personal Information redacted by the USI>
Subject: Urology Structured Clinical Record Review Process

"This email is covered by the disclaimer found at the end of the message."

Sent on behalf of RQIA Chief Executive

Dear Dr O'Kane

Please see attached response correspondence sent on behalf of Briege Donaghy regarding the Urology Structured Clinical Record Review Process.

Kind Regards,

Katrina

Katrina Andrews
PA to Briege Donaghy, RQIA's Chief Executive,
PA to Dr Julie-Ann Walkden, Deputy Director of Assurance

The Regulation and Quality Improvement Authority
7th Floor,
Victoria House
15-27 Gloucester Street
Belfast
BT1 4LS

Tel: Personal Information redacted by the USI
Email: Personal Information redacted by the USI

Web: www.rqia.org.uk
Twitter: @RQIANews

Assurance Challenge and Improvement in Health and Social Care

“The information contained in this email and any attachments is confidential and intended solely for the attention and use of the named addressee(s). No confidentiality or privilege is waived or lost by any mistransmission. If you are not the intended recipient of this email, please inform the sender by return email and destroy all copies. Any views or opinions presented are solely those of the author and do not necessarily represent the views of HSCNI. The content of emails sent and received via the HSC network may be monitored for the purposes of ensuring compliance with HSC policies and procedures. While HSCNI takes precautions in scanning outgoing emails for computer viruses, no responsibility will be accepted by HSCNI in the event that the email is infected by a computer virus. Recipients are therefore encouraged to take their own precautions in relation to virus scanning. All emails held by HSCNI may be subject to public disclosure under the Freedom of Information Act 2000.”

The Regulation and Quality Improvement Authority

Our Ref: 845

2 March 2022

Dr Maria O'Kane
Medical Director
SHSCT

Email only: [redacted]
Personal Information redacted by the USI

Dear Dr O'Kane

Urology Structured Clinical Record Review Process

Thank you for your letter of the 20 February and the detail provided about the work undertaken so far by the Trust in relation to the Urology Structured Clinical Record Review Process. I note also the specific request you are making of RQIA.

We have considered this and agree that providing external independent assurance of your approach in respect of these cases would be an appropriate task for us to undertake.

I have requested that our Director of Hospital Services, Independent Health Care, Audit and Reviews, Mrs Emer Hopkins take forward this piece of work with the support of our Clinical Lead for Medicine, Dr Leanne Morgan, and other members of our review programme as required. Emer will be in touch over the next few days and it is likely she will ask for a meeting with your team, to discuss the scope, your approach to the record review and how it fits in the overall context of the Urology Inquiry. She can also discuss possible methodologies and timescales and have a first sight of the SCRR tools you have produced.

In the meantime, we will develop a methodology for this work and prepare confidential information request for relevant documents under Article 41 of The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003. This means that these documents can be prepared in good time for consideration by any panel/team we may appoint to assist us with our review and in advance of meeting with appropriate members of the Trust team undertaking this work if required.

RQIA, 7th Floor
Victoria House
15-27 Gloucester Street
Belfast BT1 4LS

Tel 028 9536 1111
Email info@rqia.org.uk
Web www.rqia.org.uk
Twitter @RQIANews

INVESTORS IN PEOPLE
We invest in people Silver

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

The Regulation and Quality Improvement Authority

If you would wish to discuss any of this further, please do not hesitate to contact Emer Hopkins at Personal Information redacted by the USI

Yours sincerely

Personal Information redacted by the USI

Briege Donaghy
Chief Executive

cc Emer Hopkins, Director of Hospital Services, Independent Health Care, Audit and Reviews, RQIA
Andrew Dawson, Director of Quality Safety and Improvement, DoH
Dr Leanne Morgan, Clinical Lead, RQIA

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

UROLOGY ASSURANCE GROUP (UAG)

Wednesday 23rd May 2022 at 11.00am, by Zoom

Draft Minutes

FOI Implications: May not be disclosed Section 22 Information intended for future publication, Section 33 audit functions, Section 35 formulation of Government policy refers.

Jim Wilkinson, DoH (Chair)	Maria O'Kane, Southern Trust
Robbie Davis, DoH	Melanie McClements, Southern Trust
Ryan Wilson, DoH	Margaret O'Hagan, Southern Trust
Paula Ferguson, DoH	Damian Gormley, Southern Trust
Sharon Gallagher, SPGG	Jane McKimm, Southern Trust
Sophie Lusby, SPGG	Martina Corrigan, Southern Trust
Aidan Dawson, PHA	Brid Farrell, PHA

Apologies: Peter May (DoH), Michael McBride (DoH), Lourda Geoghegan (DoH), David Gordon (DoH), Anne-Marie Bovill (DoH), Stephen Wallace (Southern Trust), Paul Cavanagh (SPGG)

Welcome and apologies

1. The group was welcomed and apologies noted.

Minutes of previous meeting

2. The draft minutes of the previous meeting were agreed.

Actions from previous meeting

3. Any actions arising from the previous meeting were addressed during the course of the meeting.

Terms of Reference

4. The revised Urology Assurance Group (UAG) Terms of Reference, circulated in advance of the meeting, were agreed by the group.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Trust Update (Southern Trust)

5. Melanie McClements apologised the Trust update report had not been available prior to the meeting and advised it would be circulated after the meeting. Melanie provided the group with a verbal update and the following matters were discussed by the group:

USI

6. The Group noted evidence gathering for the Urology Services Inquiry is continuing. The Trust advised, as at May 18th 2022, there are 46 active individual S21 notices requiring response. The Trust highlighted the importance of the notices and confirmed they are liaising with DLS in response to USI requests. Melanie advised that the Trust are actively looking for additional resources in order address resource issues.

SAI Recommendations

7. Melanie advised the Trust continue to meet monthly with service users to work through the SAI recommendations. The group noted a targeted project in relation to Recommendation 1 (the SHSCT must provide high quality urological cancer care for patients) has commenced. A questionnaire has been developed, with input from service users, to focus on post diagnosis clinic experience, an area service users felt needed improved. The aim is to have a questionnaire for the relative/supportive person to compliment the patient feedback and allow the Trust to review experience for all involved. The Trust intends to roll out the questionnaire to other cancer services following this pilot.

8. Melanie confirmed the Task & Finish group to review the SAI recommendations continues to meet on a monthly basis. It was noted the Trust is in the process of appointing a Cancer Information and Audit Officer to support the auditing of MDTs as an action coming out of the SAI recommendations.

9. The group noted of the 11 SAI recommendations, 7 have been categorised “completed” and 4 have been categorised “actioned, nearing completion”.

Lookback Review

10. Melanie confirmed the current cohort stands at 2,112 patients and outlined that originally the review consisted of 4 questions, however on reflection it was felt that the previously suggested 10 questions, to include historic care was more appropriate. The group noted that a total of 1,605 patients have had the 10 question review. 124 patients have had the 4 question review and these patients will now be reviewed against the 10 question review. Melanie advised this is due for completion by the end of May 2022.

11. Melanie confirmed of the 503 patients identified as requiring face to face reviews, 41 patients remain to be seen.

Structured Clinical Record Review (SCRR)

12. Melanie advised 77 records were previously identified as requiring an SCRR. An internal screening process has now confirmed that 22 records do not require a SCRR, 2 remain under consideration and 53 patients have been confirmed as requiring an SCRR.

13. The Proposal for SCRR and SCRR Progression to date papers provided by the Southern Trust and circulated to UAG members prior to the meeting were noted by the group. Maria O'Kane advised the Trust requested that the RQIA undertake a review of the SCRR process to provide quality assurance and recommendations for any improvements. This review commenced in May 2022 and has a target completion date for late June / early July 2022. Maria advised the number of SCRRs could potentially increase to 100.

14. The group discussed the options for the continuation of the SCRR process:
    - Option 1 - Continue with current SCRR Process by utilising in-house Trust expertise;
    - Option 2 – Continue with current SCRR Process with British Association of Urology Surgeons (BAUS) identified Subject Matter Expert's;
    - Option 3 – Continue with current SCRR Process with support from an Independent Sector Provider; and

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

- Option 4 – Pause the current SCRR Process at the existing number of identified cases, with no further action.

The group agreed with the Urology SPPG Oversight Group to discount Option 1 due to the impact on the delivery of core patient facing services. The group also discounted Option 4, as it was agreed that there is a duty of care to patients and an expectation that a SCCR process will be completed. The group agreed the two viable options were Option 2 and Option 3. The Trust will explore both of these options further and provide an update at the next UAG meeting.

Action: Southern Trust agreed to explore Option 2 and Option 3 further and provide an update at the next meeting.

Preparations for extending the Urology Review

15. Jim Wilkinson updated the group on recent concerns raised by the Chair of the USI to the Minister, which included need for a further lookback review period. Maria confirmed that initial thoughts were for the 18 months with the potential to extend to 5 years and highlighted the potential that some patients within the extended timeframes, may have been assessed in the current lookback review cohort.

16. The group noted the Trusts considerations for extending the lookback and agreed a paper is required to be presented at the next UAG meeting for consideration.

Action: Southern Trust agreed to prepare a proposal paper for extending the lookback review period, for consideration by UAG at next meeting.

Urology Lookback Outcomes Report

17. Melanie advised the Trust is working with SPGG on developing the lookback Review Outcomes Report, following a similar approach to the Neurology Recall Reports, with an initial draft to be submitted to SPGG early June 2022. The group noted the Trust is responsible for the production of the report, with SPGG

providing quality assurance and UAG providing final sign off, prior to publication.

18. Jim highlighted the importance that the report demonstrates the work completed by the Trust and lesson learned, to ensure public confidence in the process completed.

Private Patients

19. The group discussed the options paper to address the difficulty in accessing private patient records, provided by the DoH and circulated to UAG members prior to the meeting. The group discussed the options and the following noted:

- Primary care – Margaret O'Hagan suggested an option would be to reach out through GPs. [redacted]
- Option 1 – no further action – the group agreed this is not a viable option;
- Option 2 - The Trust to write to Mr O'Brien's legal representative – [redacted]
- The group agreed Options 5, 6 and 7 will be considered following the outcome of Option 2;

Action: Southern Trust agreed to action Option 2, (to write to Mr O'Brien's legal representative to seek agreement to access private patients records.)

Communications

20. Jim referred to the recent letter from Christine Smith, Chair of the USI, to the Minister raising concerns in relation to the Urology Lookback Review and patient safety issues. The group noted the Department is considering the concerns raised and how these issues will be addressed moving forward.

Any other business

21. No other business was raised by the group.

Date of next meeting

22. The group agreed the next meeting should be arranged by the end June 2022 and a date will be confirmed in due course.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Annex 1

Action Log

Action	Date of Meeting	Owner	Actioned
Trust to prepare proposal paper for extending the lookback for consideration by UAG at next meeting.	23/5/2022	Southern Trust	
Trust to write to Mr O'Briens legal representative to seeks agreement to access his private patients records.	23/5/2022	Southern Trust	
Trust to arrange meeting with Paul Cavanagh, Brid Farrell and Lourda Geoghegan to assess the SCRR process and learnings to date	23/2/2022	Southern Trust	Closed
Trust to produce summary report on the SCRR process, including learnings to date and recommendations for continuing the process;	23/2/2022	Southern Trust	Completed
Maria O'Kane to liaise with the Chief Executive of the GMC Northern Ireland to discuss the	23/2/2022	Maria O'Kane	Completed

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

concerns regarding Mr O'Brien's private practice further.			
DoH to engage with the Minister to explore a formal request to the GMC along with a public statement regarding Mr O'Brien's private practice.	23/2/2022	DoH	Closed
DoH to confirm terminology with USI team.	1/11/2021	DoH (Robbie Davis)	Completed
SHSCT to contact all patients involved in the lookback.	1/11/2021	Southern Trust	Ongoing
HSCB and SHSCT to reconsider lookback questions and agree final methodology.	1/11/2021	HSCB / Southern Trust	Completed
Public Inquiry to be removed as agenda item.	1/11/2021	DoH	Completed
Jim Wilkinson to ask the Permanent Secretary to request RQIA quality assure the Trust SJR process.	1/11/2021	DoH (Jim Wilkinson)	Ongoing
To continue to engage with RQIA regarding possible assistance in gaining accessing Mr O'Brien's Private patients.	6/9/2021	Southern Trust (Shane Devlin / Stephen Wallace)	Ongoing – DoH issued paper to DSO November 2021

To liaise further with DLS, to provide clarity on presentational concerns and to ensure that the letter to Mr O'Brien issues in early course.	6/9/2021	Southern Trust	Completed
To meet with HSCB and the Trust to agree urology recall/lookback review terminology and revise future UAG agenda items accordingly.	6/9/2021	DoH (Robbie Davis)	Completed
To prepare a paper to present Urology Outcomes Report options for UAG consideration at the next meeting.	6/9/2021	Paul Cavanagh	Completed
To liaise with Christine Smith to discuss issuing a communique to SHSCT staff on the USI Terms of Reference.	6/9/2021	DoH (Jim Wilkinson and Robbie Davis)	Ongoing
To approach Belfast and Western Trusts to accept the repatriation of Urology patients as a formal request from the Urology Assurance Group.	18/6/2021	Southern Trust	Completed
To consider Outcomes Report learnings.	18/6/2021	DoH (Michael O'Neill) and Paul Cavanagh (HSCB)	Completed

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Outcomes Report to become standing agenda item.	18/6/2021	DoH	Completed
To amend UAG agenda to reflect changes agreed.	18/6/2021	DoH	Completed
To consider other relevant reports (NI Audit Office, Patterson Inquiry Report and RQIA Report) in conjunction with the SAI recommendations.	14/5/2021	DoH (Michael O'Neill/Anne-Marie Bovill) and Southern Trust (Shane Devlin)	Ongoing
To explore if GDPR exemptions can be applied in order to gain direct access to Mr O'Brien's private patients.	14/5/2021	Southern Trust (Shane Devlin)	Ongoing
To consider the letters of apology being issued to SAI families and the potential for further wider media communications with private patients and GPs.	14/5/2021	DoH (David Gordon) and Southern Trust (Shane Devlin)	Ongoing
To provide an outline of the overarching themes within the draft Inquiry ToR.	14/5/2021	DoH (Michael O'Neill) and Southern Trust (Shane Devlin)	Completed

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

To consider the Patient Review form going forward and retrospectively to ensure a comprehensive and consistent review.	16/4/2021	Southern Trust (Melanie / Maria)	Completed
To consider the MDM issues raised at a system level and on a Trust wide basis.	16/4/2021	HSCB (Paul Cavanagh / Sharon Gallagher)	Ongoing
To establish a suitable date for Trust staff engagement meeting with Mr Pengelly and Dr McBride.	16/4/2021	Southern Trust (Shane Devlin)	Ongoing
Prepare the Trust to support and service a full Public Inquiry in adherence to the Inquiry Rules 2006.	19/3/2021	Southern Trust (Shane Devlin)	Completed

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Circular HSS(TC8) 6/98

Trusts and Human Resources Directorate

HSS EXECUTIVE

To: HSS Boards
Chief Executive
Director of Public Health
Director of Dental Services

File ref: BP823/98

HSS Trusts
Chief Executive
Medical Director
Director of Personnel/Human Resources

27 August 1998

British Medical Association
British Dental Association
NI Council for Postgraduate Medical & Dental Education

Dear Colleague

ISSUE OF ALERT LETTERS ABOUT HOSPITAL AND COMMUNITY MEDICAL AND DENTAL STAFF UNDER INVESTIGATION BY THE HPSS

Summary

1. This circular advises HSS Boards and HSS Trusts of the arrangements for notifying the HSS Executive about hospital and community medical and dental staff who have been dismissed, who are under suspension by their employer, or where there are sufficient, reasonable grounds to support the view that they could be considered to be a potential danger to the safety of patients, other staff or themselves, and where there is reason to believe they will seek work elsewhere. The purpose of these arrangements is so that consideration can be given to the issue of a confidential letter alerting other employers about the action taken.

2. It also reminds HSS Board and HSS Trust Chief Executives of the need to make adequate checks on doctors' and dentists' registration, qualifications and references. There is no substitute for rigorous pre-employment checks. In particular, references should be taken up with previous employers and account should be taken of any gaps in employment.

Health and Social Services Executive
Castle Buildings Upper Newtownards Road Belfast BT4 3SR Northern Ireland Telephone 01232 520500 Facsimile 01232 523272

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

3. The guidance in this circular complements the guidance in HSS(TC8) 15/91 on *'Disciplinary procedures for hospital and community medical and dental staff'.*

Action

4. HSS Board and HSS Trust Chief Executives are asked to ensure that systems are put in place to:

   (a) consider whether action should be taken to alert other employers of the dismissal or suspension of a member of medical or hospital dental staff;

   (b) retain alert letters so that staffing officers are aware of all current warnings.

   (c) withdraw and formally cancer alert letters if the doctor or dentist is exonerated.

   Confidentiality must be strictly maintained throughout the enactment of any part of this guidance.

Background

5. The objective of the alert letter system (often referred to as grey letters) is to protect patients by ensuring that employers of doctors or dentists are aware of any who have been dismissed or suspended in the most serious disciplinary cases or where the prospect of their continuing in practice gives rise to a concern for patient safety. The system has been in existence for some time but has recently been reviewed with a view to clarifying the actions to be taken by the HSS Executive and HPSS employers.

6. Alert letters are issued to ensure that information about doctors and dentists who have been dismissed by or are under suspension from HPSS employers and contracting Authorities is disseminated appropriately so as to safeguard health service patients during the (often lengthy) period that inquiries or police investigations of alleged offences are taking place. An alert letter should also be issued where serious doubts have been raised about a locum doctor or dentists and a report is being sent to the General Medical Council (GMC) or General Dental Council (GDC). HSS Boards and HSS Trusts (as well as locum agencies and private healthcare providers) have a legitimate interest in being informed that a prospective employee has been dismissed or suspended by another HPSS employer. Although employing HSS Boards and HSS Trusts should call for references from previous employers they cannot be assured that they will be told about previous employment in which the doctor or dentist

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

gave unsatisfactory service or was suspended or dismissed. The public would be justifiably concerned if suspended doctors or dentists - who may also be under police investigation that may lead to serious criminal charges being laid - were able to continue to work with patients in another part of the HPSS. The Department must take steps to ensure that prospective employers are notified of such suspensions.

7. The system recognizes that suspension is a neutral act and will occur before any allegations have been fully investigated. It is intended to provide immediate protection of the interest of patients, other staff, or the practitioner and to assist the investigative process. Doctors or dentists who are suspended may be exonerated in due course. The system covers doctors in training who may be suspended whilst their suitability is assessed or their training needs reviewed, and who may seek work during their suspension. Alert letters are only issued following consultation with employers and after taking into account professional advice from the Chief Medical Officer. Alert letters are usually issued when a report to the GMC or GDC has or will be made. It may be appropriate to issue an alert letter as an interim measure where serious criminal proceedings are expected to be brought. HSS Boards as well as HSS Trusts may also be asked to pass the alert letter onto the private health sector in order to cover the possibility of someone trying to gain work outside the HPSS eg in a private hospital or nursing home.

8. The employer must notify doctor or dentist (by writing to their last known address if necessary) that they have become the subject of an alert letter, and give an indication of the reasons for this action.

9. The alert usually takes the form of a letter from the Chief Medical Officer to HSS Boards and Trusts asking them to contact somebody at the originating Trust for a reference if the subject of the alert letter contacts them with a view to obtaining employment (example at Annex A). The form of the letter has been cleared by the Department's solicitors.

10. There is no need for an alert letter if the GMC or GDC has already suspended or placed conditions upon the doctor's or dentist's registration on an interim or substantive basis - the doctor's or dentist's registration will be "tagged" by the GMC or GDC so that on enquiry the employer will be referred to the person dealing with the case: and the HPSS will be notified in due course.

Role of the HPSS

11. HPSS employers will need to put systems in place to consider whether the alert letter system should be triggered. In appropriate cases the Medical Director should ensure that the Chief Medical Officer is urgently advised of the name of

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

the doctor or dentist about which they have concern. This will normally be done by telephone when sufficient details of the case should be discussed to enable the Chief Medical Officer to make a decision to pursue the matter with colleagues in the HSS Executive. The criteria to be used are attached as Annex B. The criteria are not meant to be exhaustive and cases not falling within the criteria should also be discussed with the Chief Medical Officer.

12. The employer which triggers the alert letter system must ensure that it monitors the progress of the case so that should, the doctor or dentist be exonerated, the alert letter can be withdrawn. Where an employer has been able to notify a doctor or dentist of the issuing of an alert letter they should also notify the doctor or dentist when, after due process, an alert letter is withdrawn. The alert letters are purely factual and are not intended to debar a doctor or dentist from employment as a doctor or dentist. The alert letter ensures that prospective employers are put in contact with previous employers whose names might not be included on application forms.

13. The Chief Medical Officer is available to provide informal, confidential support to Medical Directors for dealing with matters of this nature.

14. A summary of the process to be followed is at Annex C.

Checks on the Registration and previous employment of doctors and dentists

15. HSS Boards and HSS Trusts are reminded of the need for those with responsibility for the recruitment or other employment of medical and dental staff to take all possible steps to ensure the validity of certificates or other qualifications and that a minimum of two professional references are taken up. The good practice guidance booklet that accompanied the issue of the HSS (Appointment of Consultants) Regulations 1996 provides a checklist to cover all elements of consultant appointments procedure. This guidance, which also sets out the steps to be taken in the pre-interview process, is strongly commended to HPSS employers for incorporation into any local procedures and could equally be applied to other practitioner appointments as a useful checklist.

16. HPSS employers are asked to satisfy themselves that their procedures for employing doctors and dentists, including locum doctors and dentists:

- involve checks which ensure their registration status with the General Medical or General Dental Council is valid.

  - The GMC provides a telephone inquiry service which is available 24 hours a day, seven days a week, on 0171 9153630. Calls

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

outside office hours (09.00 to 17.00 on week days) are answered by an automated service which will provide confirmation of full registrations to callers who have a touch tone keypad on their telephones and who know the registration numbers of the practitioner about whom they are enquiring. Alternatively, callers out of hours can leave a message which will be answered the next working day.

- The GDC's Registration Department for checking registration validity may be contacted on 0171 486 2171 during office hours.

- ensures that the doctor's or dentist's registration certificate covers the tasks they are expected to undertake.

17. It is illegal to practice as a physician, surgeon or other medical officer in the HPSS without the appropriate registration with the General Medical Council [Sections 47 and 49, Medical Act 1983]. Doctors with *limited registration* are issued with certificates which indicate the range of posts or the type of employment which such doctors may undertake. Limited registration is granted for a specified period. Doctors who are required to provide medical cover for colleagues must be appropriately registered. Doctors who work outside the limitations of their registration are practising illegally.

18. It is illegal to practice as a dentist without the appropriate registration with the General Dental Council unless practised by a registered medical practitioner [Section 38, Dentists Act 1984]. Dentists with full registration have access to all areas of dental practice unless their Annual Practising Certificate specifies otherwise. Dentists eligible for *temporary registration* may apply only for substantive, locum or honorary posts in hospitals which have been approved by the GDC for that purpose. On appointment an application should be made by the dentist to the GDC for a Direction to cover this practice. Temporary registration is granted for a limited period and does not, of itself, lead to full registration. Initial practice under temporary registration should be under full supervision. A dentist practising outside the conditions of their registration is practising illegally.

19. The advice in circular HSS(TC8) 22/87 as extended in HSS(TC8) 7/93 continues to apply until further notice.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

20. Enquiries about this circular should be addressed to:

Mr Paul Cassidy
Medical and Dental Unit
Room 3D, Dundonald House
Upper Newtownards Road
Belfast, BT4 3SF
Telephone [redacted]

Yours sincerely

[redacted]

P W LYNCH
Deputy Director
[HSG(97)36]

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Annex A

STANDARD LETTER TO BE SENT BY CMO

MANAGEMENT IN STRICT CONFIDENCE

Addressed to: Trust Chief Executives

Dear Chief Executive

Dr John Smith:
Formerly worked at Newtown Hospital HSS Trust

The above person formerly worked as a locum doctor in Orthopedics at Newtown Hospital HSS Trust.

If the above-named person makes an application for a permanent post or locum work with your Trust, you are advised to contact Rodney Jones, Personnel Director at Newtown Hospital HSS Trust on 0101 222 3333 before offering him employment.

Yours sincerely

Chief Medical Officer

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

STANDARD LETTER TO BE SENT BY CMO

MANAGEMENT IN STRICT CONFIDENCE

Addressed to: HSS Board Chief Executives

Dear Chief Executive

Dr John Smith:
Formerly worked at Newtown Hospital HSS Trust

The above person formerly worked as a locum doctor in Orthopedics at Newtown Hospital HSS Trust.

Please could you write as a matter of urgency to all independent hospitals registered with your area advising them to contact Rodney Jones, Personnel Director at Newtown Hospital HSS Trust on 0101 222 3333, should Dr Smith apply for a permanent post or locum work.

Yours sincerely

Chief Medical Officer

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Annex B

CRITERIA TO BE APPLIED IN DECIDING TO ISSUE AN ALERT LETTER

The criteria should include:-

the employee is a potential danger to the safety of patients, as identified by suspension, dismissal or police investigation, usually with report to GMC or GDC;

or there are sufficient, reasonable grounds to support the view that the employee could be a potential danger to the safety of patients;

and

the HSS Board or Trust have reason to believe that he/she would seek work elsewhere (either in a permanent position or as a locum).

In considering whether the doctor or dentist is a potential danger to the safety of patients the factors to be taken into account as appropriate should include:

- whether the allegation concerns an offence against the person (eg indecent assault)
- whether there has been an alleged failing in professional performance (eg inappropriate treatment, failure to attend)
- the doctor's or dentist's health problems (including mental health and transmissible infections)
- whether the doctor or dentist is willing to accept constructive criticism and retraining
- whether a report is being made to the GMC or GDC.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Annex C

THE PROCESSES FOR ISSUING AN ALERT LETTER

Typically, the issue of an alert letter will follow the processes below while confidentiality is maintained at all times:

a. The doctor or dentist is considered to be a potential danger to the safety of patients as outlined in Annex B above;

and

In all cases, it is considered that the doctor or dentist will seek employment elsewhere, either permanently or as a locum;

b. Internal consultation within the employing body, involving only those with a need to know, as to whether an alert letter should be issued;

c. In appropriate cases, and in consideration of the criteria at Annex B, employers should ensure the Chief Medical Officer is urgently advised of the name of the doctor or dentist and the details of the case;

d. The Chief Medical Officer makes the decision as to whether to pursue the matter with HSS Executive and, if appropriate, issues the alert letter;

e. Employers monitor the case under HSS(TC8)/ 15/91 and ensure that the Chief Medical Officer is advised that the alert letter should be withdrawn if the doctor or dentist is exonerated;

f. If the doctor or dentist is exonerated the Chief Medical Officer withdraws and formally cancels the alert letter and informs HSS Executive; the doctor is advised that the letter has been withdrawn;

The Chief Medical Officer, in consultation with the HSS Executive, will oversee the implementation of this guidance and report any critical incidents to the Department.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

A PRACTICAL GUIDE TO CONDUCTING PATIENT SERVICE REVIEWS OR LOOK BACK EXERCISES

REGIONAL GOVERNANCE NETWORK
NORTHERN IRELAND SUB GROUP

February 2007

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Index

	Page No
Introduction	1
1.0 What or Who Initiates a Service Review or Look Back Exercise	1
2.0 Initial Planning	1-2
3.0 Setting up a Patient Helpline • Identification of Venue • Establishing the Patient Database • Preparation of Background Papers • Production of Algorithms • Production of Key Messages • Production of Proforma • Production of Rotas • Staff Briefing	2-7
4.0 Communication with Patients	7-8
5.0 Setting up a Service Review • Service Review Team • Initial Identification of Patients • Conducting Further Assessment (Notes/X-Ray/Test Results etc) • Conducting Further Assessment (Clinical)	8-10
6.0 Patient Cohort Database	10-11
7.0 Look Back Review • Glossary	11-12
Appendix 1 Section 1 – Process for Service Review (Advising all patients who may have been affected)	13
Appendix 1 Section 2 – Process for Service Review (Advising patients known to be affected)	14
Appendix 2 Service Review Proforma	15
Appendix 3 Notes/X-Ray Review Proforma	16

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Appendix 4	Clinical Review Proforma	**17**
Appendix 5	Draft Letters	**18**
Letter A	Advising of a Service Review or Look Back Exercise	**19**
Letter B	No Further Follow-up Required	**20**
Letter C	Version 1 – Further Follow-up is Required – Notes Only	**21**
Letter C	Version 2 – Further Follow-up is Required – Clinical	**22**
Letter D	Positive Outcome of Further Assessment – Notes Only	**23**
Letter E	Negative Outcome of Further Assessment – Notes Only	**24**
Letter F	Positive Outcome of Further Assessment – Clinical	**25**
Letter G	Negative Outcome of Further Assessment – Clinical	**26**
Membership of Sub-Group		**27**

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

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

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

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

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

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.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

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

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

- 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

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

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

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

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: -

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

- 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.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

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

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

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

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

- 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.

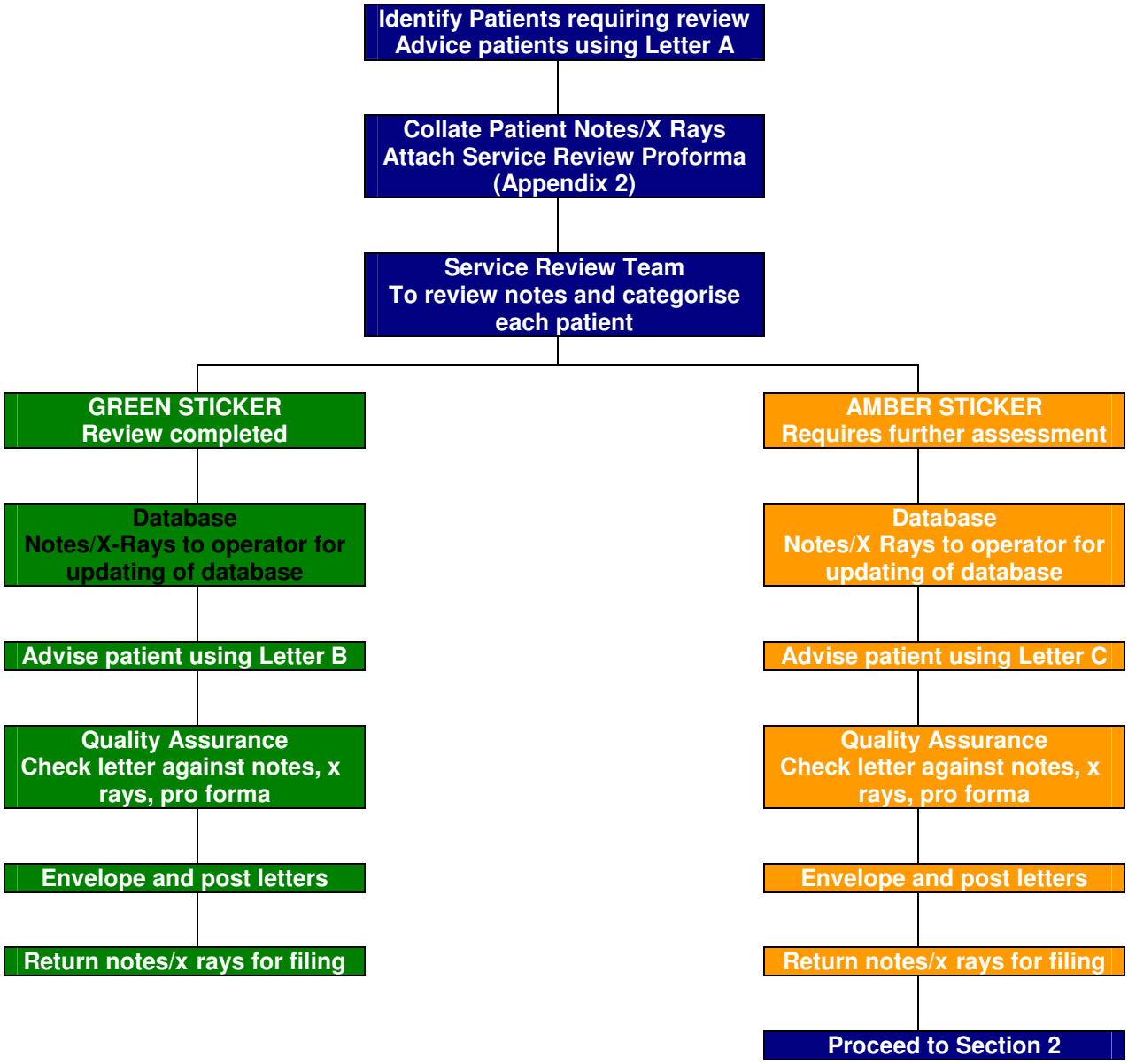
Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

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.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Appendix 1

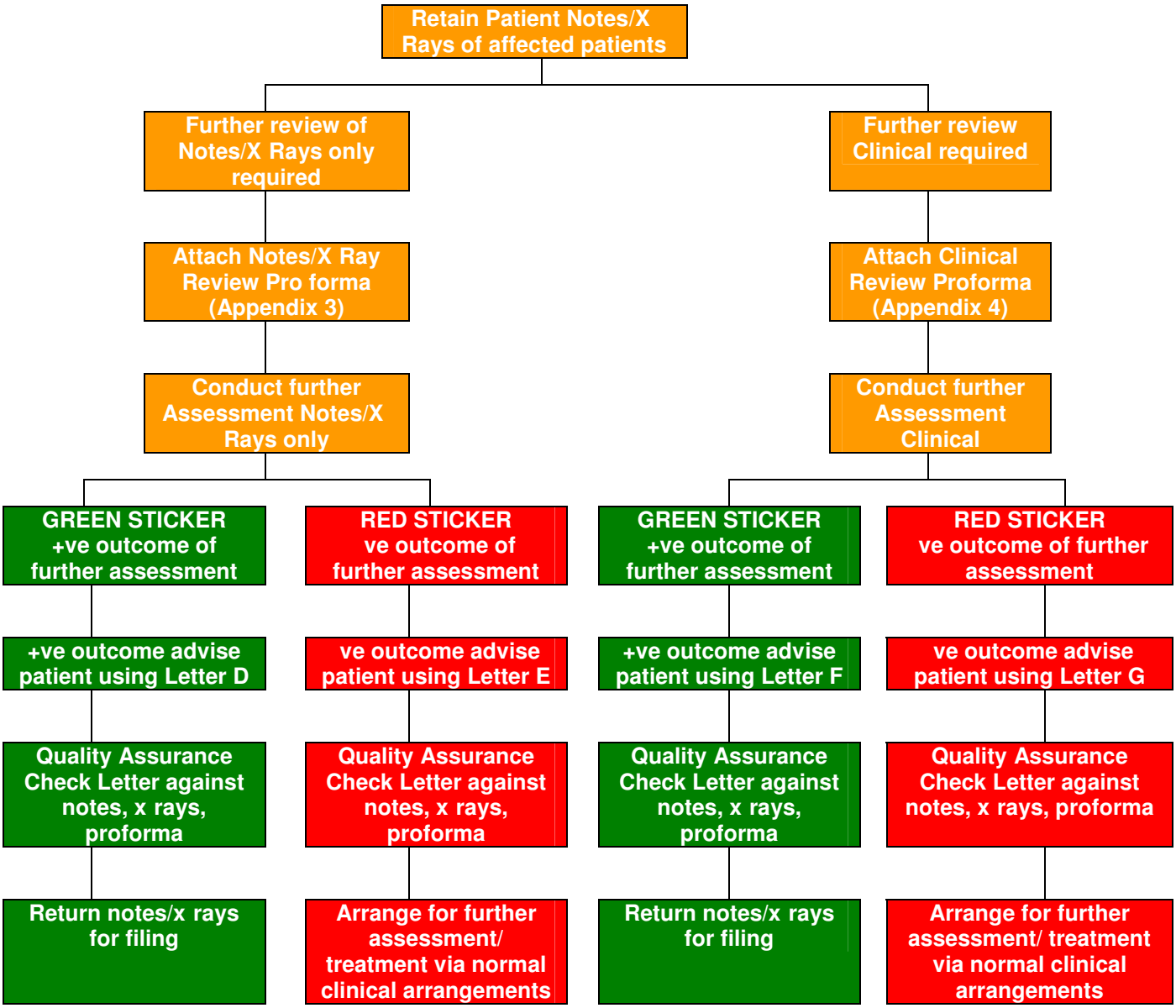
Process for Service Review
Section 1: Advising all patients who may have been affected



Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Appendix 1

Process for Service Review
Section 2: Advising patients known to be affected



Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

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)**

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

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)**	

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

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)**	

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

DRAFT LETTERS

APPENDIX 5

Although there will be one "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

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

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 factsheet 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)

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

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)

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

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)

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

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)

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

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)

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

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)

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

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)

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

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)

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

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

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

From:	Adams, James (DoH)
To:	Belfast Trust - Dr Cathy Jack; Northern Trust - Jennifer Welsh; South Eastern Trust - Roisin Coulter; Southern Trust - Shane Devlin; Western Trust - Neil Guckian; Chief Executive - HSCB ; Olive MacLeod; Briege Donaghy; Mark McCarey; NIPEC - Angela McLernon
Cc:	Director of Public Health / Medical Director, PHA.; PHA ("Rodney.Morton Personal Information redacted by the USI Lisa McWilliams; HSCB Central Co-ordinating Office (alerts.hscb@hscni.net); Head of Pharmacy - QUB; Head of pharmacy UU; Neil Kennedy (QUB); Prof mcKeown - medical education centre; Prof. Donna Fitzsimons - Nursing; Sonja McIlfatrick, Head of School of Nursing, UU; Chief Executive NIAS; donna.gallagher Personal Information redacted by the USI Aideen Keaney Personal Information redacted by the USI NICCPPET (nicpld@qub.ac.uk); Clinical Education Centre (caroline.lee Personal Information redacted by the USI NI Royal College of Nursing (ni.board@rcn.org.uk); Greenlees, Linda; Bovill, AnneMarie; Geoghegan, Lourda; Dawson, Andrew; Wilson, David (DoH); Jeffrey, Karen; White, Mark; Robinson, Ilona
Subject:	HSC (SQSD) 6/21 - Regional lookback review policy.
Date:	16 July 2021 16:00:34
Attachments:	HSC (SQSD) 6-21 Regional lookback review policy.pdf Policy for Implementing a Lookback Review Process 2021.pdf Regional Guidance for Implementing a Lookback Review Process 2021.pdf

---

Sent on behalf of Dr Lourda Geoghegan, Deputy Chief Medical Officer.

Colleagues,

Please see attached documents relating to HSC (SQSD) 6/21 – Regional lookback review policy.

Regards,
Jim Adams
Safety Strategy Unit.

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

Reference: HSC (SQSD) 6/21

Date of Issue: 16 July 2021

REGIONAL LOOKBACK REVIEW POLICY

For Action:
Chief Executives HSC Trusts
Chief Executive HSCB
Chief Executive PHA
Chief Executive RQIA
Chief Executive, NIMDTA
Chief Executive, NIPEC

For Information:
Distribution as listed at the end of this circular.

Superseded documents
HSS (SQSD) 18/07 Conducting Patient Service Reviews/Lookback Exercises

Implementation
1st September 2021

DoH Safety and Quality Circulars including Patient Safety Alerts can be accessed on: https://www.health-ni.gov.uk/topics/safety-and-quality-standards/safety-and-quality-standards-circulars

Dear colleagues

SUMMARY

The purpose of this circular is to advise you of the Department's updated policy (**Annex 1**) and regional guidance (**Annex 2**) for implementing a Lookback Review. Process. It replaces HSS (SQSD) 18/07, issued by the Office of the Chief Medical Officer on 8 March 2007.

ACTION

Chief Executives of HSC Trusts should:

- Disseminate this circular to all relevant Trust staff for immediate implementation of the updated policy and guidance.

Chief Executives, HSCB and PHA should:

- Disseminate this circular to all relevant HSCB/PHA staff for immediate implementation

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Chief Executive, NIMDTA and NIPEC should:

- Disseminate this circular to doctors and dentists in training in all relevant specialities for information.

Chief Executive, RQIA should:

- Disseminate this circular to all relevant staff and all relevant independent sector providers for immediate implementation.

BACKGROUND

Lookback Reviews are undertaken frequently in the health and social care system and there have been a number of recent high-profile examples. They are undertaken as a matter of urgency whenever a number of people have been exposed/potentially exposed to a specific hazard in order to identify if any of those exposed have been harmed and also to identify the necessary steps to ameliorate the harm (e.g. repeat diagnostic test/ investigation/ referral to relevant clinical service etc.)

Following some more recent patient service reviews and patient call back exercises further learning was identified. It was decided in 2018 that the 2007 Guidance needed to be reviewed and updated to take account of this learning along with HSC organisations' Statutory Duty of Quality, their systems of governance and extant guidance on Assurance Frameworks.

This review of the previous guidance has now been completed and a new policy document (**Annex 1**) along with new regional guidance (**Annex 2**) have been prepared, with the aim of standardising and refreshing the approach taken to Lookback Reviews by the HSC in Northern Ireland.

Any enquiries about the content of this circular should be addressed to:

Safety Strategy Unit
Department of Health
Room D1.4
Castle Buildings
BELFAST
BT4 3SQ
Tel: Personal Information redacted by USI

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Personal Information redacted by USI

Personal Information redacted by the USI

Dr Lourda Geoghegan
Deputy Chief Medical Officer

Distributed for Information to:

Executive Medical Director/Director of Public Health, PHA
Director of Nursing and Allied Health Professions, PHA
Director of Performance Management & Service Improvement, HSCB
Safety and Quality Alerts Team, HSC Board
Head of Nursing & Midwifery, QUB
Head of Medical School, QUB
Director of Centre for Medical Education, QUB
Head of School of Pharmacy QUB
Head of School of Nursing, UU
Head of Pharmacy School, UU
Chief Executive, NIAS
Staff Tutor of Nursing, Open University
Director, HSCQI
NI Centre for Pharmacy Learning and Development
Clinical Education Centre
NI Royal College of Nursing
Linda Greenlees, DOH
Annemarie Bovill, DOH

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry



Policy for Implementing a Lookback Review Process

July 2021

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Contents

Section	Title	Page(s)
1	Introduction	3-4
2	Purpose	5
3	Objectives	5
4	Scope	6
5	Roles and Responsibilities	7-10
6	Legislation and Guidance	11

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

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

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.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

- 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.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

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

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

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.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

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*

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

- 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.*

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

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;

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

- 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.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

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.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry



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

Regional Guidance for Implementing a Lookback Review Process

July 2021

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Contents

Section	Title	Page(s)
	Regional Guidance for the Implementation of a Lookback Review Process	
1.0	Introduction	3-4
1.1	What does a Lookback Review Process involve?	4-5
1.2	Summary Diagram of Stages in Lookback Review Process	5
1.3	Governance Arrangements	6
1.4	Other Related Processes/Investigations	6-8
2.0	**Stage 1 – Immediate Action and Scoping the Extent, Nature and Complexity of the Lookback Review**	
2.1	Notification of the need to consider a Lookback Review	9-10
2.2	Establish a Steering Group/Oversight Group	10
2.3	Composition of Steering Group	10-11
2.4	Role of Steering Group	11-12
2.5	Steering Group Terms of Reference and Action Planning	12
2.6	Gathering Intelligence and Information to scope the extent, complexity and nature of harm	13-14
2.7	Risk assessment	15-16
2.8	Decision to proceed to Stage 2 and Stage 3	16-17
2.9	Early Alert Notification	17-18
210	Serious Adverse Incident Notification	18-19
3.0	**Stage 2 – Identifying and tracing service users at risk**	
3.1	Role of Steering Group – Terms of Reference and Action Plan	21-22
3.2	Establishing the Service user Database	22-23
3.3	Establishing the Process for identification of affected Service users	23-24
3.4	Undertaking the service review/audit	24-25
4.0	**Stage 3 – Service User Recall**	
4.1	Planning the Recall	26-27
4.2	Service User Communication and Support	27-28
4.3	Service User notification (by letter)	28-29
4.4	Public Announcement of Lookback Review and Recall	29-30
4.5	Setting up a Service user Helpline/Information Line	30
4.6	Communication with the Media	31-32
4.7	Staff Communication and Support	32
5	**Stage 4 – Closing, Evaluating and Reporting on the Lookback Review Process**	33-34
	Glossary	35-37
	Appendices	38-65
Appendix 1	Risk Assessment Template	39-40
Appendix 2	Service User Database – core dataset	41-42
Appendix 3	Process Flow Charts and Sample Letters	43-59
Appendix 4	Setting up a Service User Helpline/Information Line	60-63
Appendix 5	Lookback Review Process Guideline Process Checklist	64-65

This policy should be read in conjunction with the Policy for Implementing a Lookback Review Process.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Regional Guidance for the Implementing of a Lookback Review Process

1.0 Introduction

A Lookback Review Process is implemented as a matter of urgency where a number of people have been exposed/potentially 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 (e.g. repeat diagnostic test/ investigation/ referral to relevant clinical service etc.).[1]

This Regional Guidance, along with the accompanying policy document, has been drafted in order to standardise and update the approach taken to Lookback Reviews by the HSC in Northern Ireland. It replaces HSS (SQSD) 18/2007, issued by the Office of the Chief Medical Officer on 8 March 2007.

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 through a service review or audit of records 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 (see summary diagram of Lookback Review Process (Diagram 1).

The triggering event or circumstances under which a Lookback Review would be considered include; faulty or contaminated equipment, missed/delayed/incorrect diagnosis relating to diagnostic services, failure of safety critical services or processes, competence issues with a practitioner(s) or identification of a practitioner with a transmissible infection or underlying health problem that may pose a serious risk to a service user following procedures undertaken (see also Policy on the Implementation of a Lookback Review Policy Section 1 for a more comprehensive list).[2]

[1] Health Service Executive (HSE) 'Guideline for the implementation of a Look-back Review Process in the HSE'. HSC National Incident Management and Learning Team, 2015. Section 7.1 Page 10.
[2] See also 'Policy for the Implementation of a Lookback Review Process' Section 1 Page 3.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

The existence of a hazard exposing a number of people to a risk of harm is not always immediately apparent. The triggering event may have been raised as a concern by a service users and/or their family/carers or it may have been highlighted by a service review/audit or it may have come to light as a result of a concern expressed by a colleague or through a Serious Adverse Incident (SAI) Review or Thematic Review undertaken by the Regulation and Quality Improvement Authority. The triggering event will alert the Health and Social Care (HSC) organisation that a number of people may have been exposed to a hazard and the need to instigate a Lookback Review Process should be immediately considered.

1.1 What does a Lookback Review Process involve?

The Lookback Review Process involves:

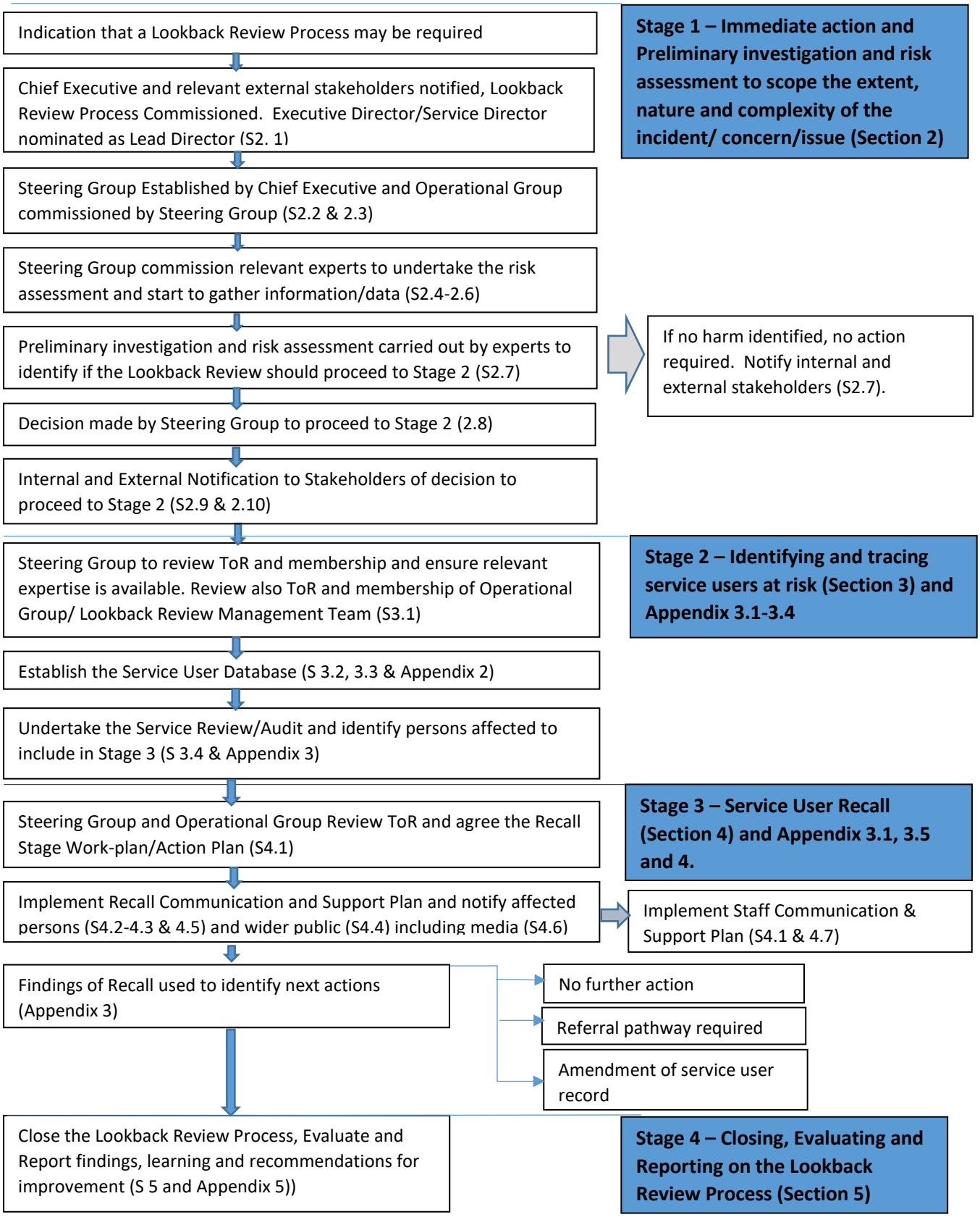
- Identifying, tracing, communicating, and providing appropriate ongoing advice to, and/or management of, the group of service users who have been exposed or potentially exposed to a hazard and who may have been harmed, or are at risk of future harm or loss;
- Notification internally to Trust Board and to appropriate external stakeholders (see Sections 2.1, 2.9 and 2.10);
- Notification to the wider public as and when required. While openness and candour are guiding principles in a Lookback, it is essential that communication occurs at a time when clear messages can be conveyed whilst ensuring that the 'at risk' population has been identified and communicated with before the wider public is alerted. Relevant healthcare professionals including General Practitioners should also be identified and communicated with in advance of any public statements. This is essential to maintain public confidence and prevent unnecessary anxiety and to ensure that services can be focused on the correct group of people (See Section 4 below).

The following diagram (Diagram 1) provides a summary of each stage of the Lookback Review Process and may be used in conjunction with the Lookback Review Process Checklist (see Appendix 5). The Process, as laid out below is a step by step guide. It is important, however, that the primary focus should remain on harm and risk of harm to service users. Therefore, there will be occasions where it is

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

clear from the outset that a Lookback Review will be necessary and where the organisation effectively runs more than one of these stages consequently.

Diagram 1 Flowchart - Summary of Stages in a Lookback Review Process



Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

1.3 Governance Arrangements

The HSC organisation should ensure that the Lookback Review Process is managed in line with extant Governance and Assurance Framework arrangements.[3] The Steering Group (Section 2.2) should be seen as a 'task and finish' group within the HSC organisation's Governance/Assurance Framework structure reporting to Trust Board through the Senior Management Team/ Executive Team of Trust Board. The Steering Group should commission an Operational Group or Lookback Review Management Team to take forward the operational aspects of the Review Process (unless the Lookback Review is anything other than limited in terms of nature, extent and complexity).

When scoping the nature, extent and complexity of the Lookback Review Process (Section 2.6 – 2.7) the Steering Group should evaluate and escalate the risk in line with the organisation's Risk Management Strategy. This will ensure that the risk(s) identified will be included in either the organisation's Board Assurance Framework, Corporate Risk Register or Directorate Risk Register and managed in line with the Risk Management Strategy.

The Lookback Review Process should be outlined in the mid-year Assurance and/or annual Governance Statement as required. The annual Governance Statement is the means by which the Accounting Officer provides a comprehensive explanation on the HSC organisations' approach to governance, risk management and internal control arrangements and how they operate in practice.[4] The Statement provides a medium for the Accounting Officer to highlight significant control issues which have been identified during the reporting period and those previously reported control issues which are continuing within the organisation.

1.4 Other Related Incident Management Processes including Investigations

As stated previously, Lookback Reviews are carried out in order to identify if any of those exposed to a hazard have been harmed, and to identify the necessary steps to take care of those harmed. The incident giving rise to the Lookback Review Process or issues identified as a result of the process may require review as a Serious

[3] DoH '*An Assurance Framework: a Practical Guide for Boards of DoH Arm's Length Bodies*.' April 2009.
[4] Department of Finance ' *Managing Public Money NI (MPMNI)*' AS.1

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Adverse incident (SAI).[5] This will require a parallel (though interlinked) review which should be undertaken in line with Health and Social Care Board guidance [6] to identify key causal and contributory factors relating to the triggering event (see Sections 2.10 and Section 5). In some circumstances, a Lookback Review Process may have been prompted by a preceding SAI review.

The circumstances leading to a decision to implement a Lookback Review may require the HSC organisation to notify other statutory agencies such as the Coroners Service for Northern Ireland and/or the Police Service for Northern Ireland (PSNI). The reporting of the Lookback Review as an SAI to the Health and Social Care Board (HSCB) will work in conjunction with, and in some circumstances inform, the reporting requirements of other statutory agencies and external bodies. In that regard, all existing local or national reporting arrangements, where there are statutory or mandatory reporting obligations, will continue to operate in tandem with this Regional Guidance.

A Memorandum of Understanding (MoU) has been agreed between the Department of Health (DoH, on behalf of the Health and Social Care Service (HSCS), the Police Service of Northern Ireland (PSNI), the Northern Ireland Courts and Tribunals Service (Coroners Service for NI) and the Health and Safety Executive for Northern Ireland (HSENI).[7] The MoU applies to people receiving care and treatment from HSC in Northern Ireland. The principles and practices promoted in the MoU apply to other locations, where health and social care is provided e.g. it could be applied when considering an incident in a family doctor or dental practice, or for a person receiving private health or social care provided by the HSCS.

A Lookback Review Process may raise issues of professional competence/conduct. HSC organisations will then be required to instigate performance management, capability and disciplinary reviews or investigations in line with their internal Human Resource policies, procedures and relevant professional regulatory guidance for

[5] Health and Social Services Board (HSCB) 'Procedure for the Reporting and Follow-up of Serious Adverse Incidents'. November 2016 Version 1.1.
[6] *Ibid.*
[7] DoH *'A Memorandum of Understanding' developed to improve appropriate information sharing and co-ordination when joint or simultaneous investigations/reviews are required into a serious incident'.* HSS (MD) 06/2006, February 2006.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

example Maintaining High Professional Standards (MHPS).[8] These processes should run as a parallel process to the Lookback Review, although relevant information from one process may inform the other. In such circumstances, confidentiality in respect of the member of staff must be taken into consideration.

[8] DoH 'Maintaining High Professional Standards in the Modern HPSS'. HSS (TC8) 6/2005. November 2005.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

2.0 Stage 1 – Immediate Action, Preliminary Investigation and Risk Assessment

Immediate action should be taken to ensure the safety and wellbeing of the service users.

2.1 Notification of the need to consider a Lookback Review Process

The Director of the service involved should be notified immediately that a hazard or potential hazard has been identified which may require the organisation to consider implementing a Lookback Review Process. The Director will report the issue(s) internally through the Chief Executive to the Board of Directors in line with the organisation's risk escalation processes. The relevant Director will also need to consider if the hazard might affect other HSC Organisations or private/ independent providers.

It is recognised that at this early stage there may be limited information available to the HSC organisation until information and intelligence is gathered and the risk assessment is undertaken (see Sections 2.6 and 2.7), however, in line with extant guidance, the Director should notify the DoH of the emerging issues by way of an Early Alert (see also Section 2.9).[9] The Early Alert should make clear, if the information is available, the details of other organisations/services potentially involved in NI or in other jurisdictions, the timeframe during which the issue may have been relevant and the potential volumes of services users who may be affected. The Director should also consider if the findings, given the potentially limited information could be considered as an SAI at this time (see Section 2.10). [10] If in doubt, the extant SAI guidance provides the opportunity for the organisation to declare the matter as an SAI, which can then be 'de-escalated' later.[11] The HSC Organisation will also have to consider possible notification of the event(s) to the Coroners Service for NI and/or the PSNI (see Section 1.4).

[9]Department of Health 'Early Alert System' HSC (SQSD) 5/19.
[10] HSCB 'Procedure for the Reporting and Follow up of Serious Adverse Incidents. November 2016.
[11] *Ibid.,* Section 7.6 Page 21

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

It is also important to advise the organisation's Head of Communications/Communications Manager at an early stage so that a communication plan including media responses can be prepared in advance.

2.2 Establish Steering Group

A Steering Group should be convened as soon as possible after the disclosure of the issue of concern to develop an action plan and oversee its implementation. Depending on the extent, nature and complexity of the triggering event the Steering Group should be chaired by either the relevant Service Director or in some circumstances it may be chaired by the relevant Executive Director/Professional Lead.

If other investigation processes are in place (e.g. Capability/Performance Management Reviews) these should run as parallel processes, however, information from the other investigative processes, taking into account confidentiality and the information governance requirements that will apply to these parallel processes, may be used to inform the decision making of the Steering Group.

The Steering Group will need to meet on a regular basis to ensure that they receive feedback/ situation reports (SITREPS) from the Operational Group/Lookback Review Management Team and provide a co-ordinated approach to the oversight of the Process. SITREPS should also be shared as required with internal stakeholders (Executive Team/Senior Management Team and Board of Directors) and external stakeholders i.e. HSCB, Public Health Agency (PHA) and DoH.

2.3 Composition of the Steering Group

The composition of the Steering Group will be dependent on the service involved and the nature and extent of the Lookback Review Process. The Steering Group should not normally involve personnel who may have been directly involved in the event/hazard that triggered the Lookback Review Process.

Depending again on the extent and nature of the Lookback Review the HSC organisation should consider the following as core members; a Non-Executive Director, the Director of service/speciality concerned, relevant professional Executive Director(s), Risk and Governance representative, Head of Communications, Information Technology manager, Medical Records manager and senior service

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

representatives with expertise (including clinical and/or social care) in the services/ processes which are the subject of the Review Process, a PHA representative and an HSCB representative (in the case where the Lookback Review has been identified as an SAI, the role on the Steering Group will be clearly identified to ensure that the independence of the PHA/HSCB is not jeopardised).

The organisation may also wish to consider a member of a relevant service user representative/advocacy group is included as a member of the Steering Group.[12] In these instances, a confidentiality agreement must be signed by the service user representative. The representative should not have access to service user identifiable data. Such an agreement should be proportionate and reflect the need of the organisation to protect the information of individuals and to ensure that information disseminated is accurate, proportionate and timely and that support mechanisms are in place for service users and staff.

The Steering Group should also commission an Operational Group or Lookback Review Management team which should report to and support the Steering Group in taking forward the operational aspects of the action plan e.g. establishing the service user database (Section 3.2) and supporting the Recall Stage (Section 4).

2.4 Role of the Steering Group

Within 24-48 hours from being established the Steering Group should decide on the immediate response which includes;

- Methodology to determine the size/magnitude, complexity and nature of the risk/harm to service users/carers in order to plan an appropriate Lookback Review Process e.g. risk assessment (see Section 2.7 below);
- Determine if the Lookback Review Process is limited to one HSC organisation or if the process will involve a number of HSC organisations as well as the independent sector and organisations in other jurisdictions;

[12] The Patient and Client Council (PCC) is responsible for delivering and/or providing access to advocacy and support services as specified by the DoH and HSCB guidance in supporting families through a 'hub and spoke' model of service delivery working with providers of advocacy services. Other independent services may be accessed as required through the PCC, including the development of a network of available advisory services.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

- Determine the extent of notifications to the DoH, HSCB and PHA that is required, if these notifications have not already been initiated (see Section 2.1 above and Sections 2.9 and 2.10);
- Address and manage notification internally through the Senior Management Team/Executive Team to the Board of Directors;
- Agree on the formation of an expert advisory sub group comprising experts in the area of concern, relevant clinicians, and department or directorate heads to undertake the risk assessment and service review or audit . Consideration should be given as to whether or not that expertise should come from outside the organisation;
- Agree on a service user communications plan. Communication with the service user/family is a priority and the organisation should be proactive in managing the manner and timing in which affected service users receive relevant information (see Section 4.2).
- Agree on a communication plan/liaison plan for other HSC organisations or independent/private providers which might be affected.
- Agree on a media/communications management plan if required, that aims to be proactive in disclosure to the general public and considers responses to media enquiries (see Section 4.6).[13]

2.5 Steering Group Terms of Reference and Action Planning

The Steering Group should develop and approve Terms of Reference and establish a Lookback Review Action Plan for Stage 1 of the Process. Both the Terms of Reference and action plan should be reviewed and revised as and when the Process proceeds to the next stages.

The action plan should include as a minimum; the management of immediate safety issues, identify those who may have been exposed to harm, care for those who may have been harmed/affected, actions to prevent further occurrences of harm, a communication plan, contingency planning for business continuity of the service and plans for potential service user follow-up.

[13] New South Wales 'Lookback Policy Directive', Clinical Excellence Commission Safety & Quality, System Performance & Service Delivery, September 2007. Section 4 Page 5.

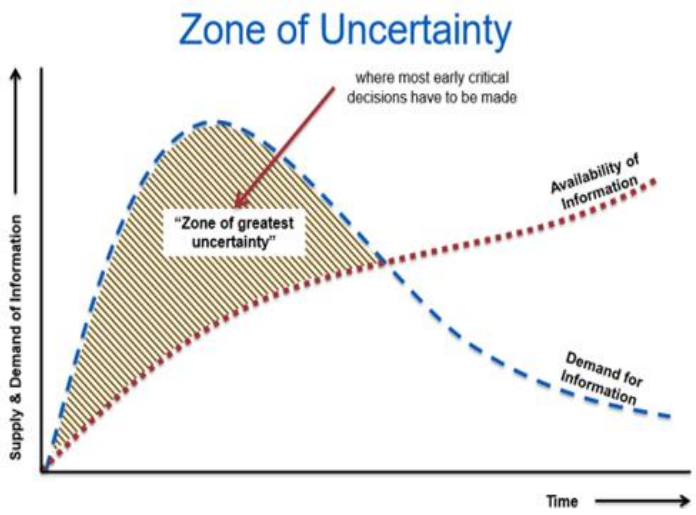
Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

2.6 Gathering Information and Intelligence to Scope the Extent, Complexity and Nature of Harm

Key decisions have to be made at this early stage of the process when minimal information may be available to the Steering Group. Decision making should be based on a joint understanding of risk (see below) and shared situation awareness.[14] Situation awareness is having a common understanding of the circumstances, immediate consequences and implications of the triggering event along with an appreciation of the available capabilities and the priorities of the response.[15]

It is important that internal and external stakeholders are aware that the Steering Group may be required to make decisions during a time of uncertainty (or zone of uncertainty) about the level of risk or harm to service users (see Figure 1 below).[16] Depending on the extent, nature and complexity of the Lookback Review Process it can be difficult for the Steering Group to predict when it has gathered the optimum level of information to make decisions such as the decision to announce the Service User Recall stage.

Figure 1 Zone of Uncertainty



At the early stage, as above when limited information is available upon which the Steering Group will be required to make crucial decisions then a Decision Making Model, widely used amongst the emergency services as a tool, could be considered.

[14] Joint Emergency Services Interoperability Principles (JESIP) ' www.jesip.org.uk
[15] *Ibid*.
[16] *Ibid*

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Tools to aid decision making include for example the Joint Decision Making (JDM) Model (Figure 2)[17] which helps bring together the available information, reconcile objectives and make effective decisions.

Figure 2 Joint –Decision Making Model



Further information and use of the JDM are available via the Joint Emergency Services Interoperability Principles (JESIP).[18]

All decisions should be recorded/logged, justified, seen to be reasonable and proportionate to the information available at the time. Therefore the Steering Group will require the services of an experienced minute-taker or 'loggist'[19] to ensure an accurate record of actions and decisions is maintained at each stage of the process.

2.7 Risk Assessment [20]

As indicated above, the first stage in the process is to undertake a risk assessment to determine whether the scope, size/magnitude, complexity and nature of harm

[17] Joint-Decision Making Model @ www.jesip.org.uk/joint-descision-model
[18] *Ibid*.
[19] A term used in Major Incident Planning a loggist is the person who is responsible for capturing, through decision logs, the decision making process that might be used in any legal proceedings following an incident ' www.epcresilience.com
[20] HSE. *Op.Cit* Section 7.6 Preliminary Risk Assessment Page 115-16.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

arising from the triggering event should progress to the next stage(s) i.e. a service user lookback and potential service user recall. In order to do this, the Steering Group should commission relevant experts to undertake this risk assessment. As above (Section 2.3), the relevant experts may include but are not exclusive to: people with the clinical or social care expertise in the services/ processes which are the subject of the Lookback Review Process, Risk and Governance Managers, and a Public Health Specialist. This will be determined by the Steering Group on a case by case basis.

A decision to undertake the completed Lookback Review Process has significant implications for service users, providers and resources. The risk assessment, therefore, should provide a thorough assessment of the chance of harm and the seriousness of that potential harm. It must be conducted in a manner that balances the need to identify and address all cases where there might be safety concerns on the one hand, with the need not to cause any unnecessary concern to service users or to the public on the other.[21]

The risk assessment should look at:

- If the Lookback Review Process is limited to one HSC organisation or if the process will involve a number of HSC organisations including the independent sector;
- The potential extent of the issue and the level of exposure to the hazard;
- Evidence of harm that has occurred;
- The likelihood of future harm occurring;
- The potential and actual (if relevant) outcomes of the issue e.g. missed diagnosis/ missed return appointments for follow up etc.;
- The potential impact of the issue;
- The potential cohort of service users affected (including service users of other HSC and non-HSC Organisations);
- The potential impact on other service users (not in the 'at risk' cohort) e.g. potential delays in treatment and diagnosis;

[21] *Ibid*. Appendix 1

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

- The manner in which harm would be ameliorated (e.g. repeat investigation/ onward referral for treatment).

The HSC Regional Risk Matrix and Impact Table may be used as guidance to evaluate the risk.[22] A template for undertaking a preliminary risk assessment is included in Appendix 1 of this Guidance.[23]

The Steering Group will use the information obtained from this assessment to decide if the Process should continue to the Service User Lookback and Recall stages (see Section 2.8). If there is no harm or risk to service users, the Lookback Review Process can be closed. The Steering Group will inform the relevant internal and external stakeholders. It is advised that the Early Alert is updated to indicate that the process has been closed, outlining clear reasons for the decision. The HSC organisation should consider the incident as a 'near miss' and undertake a systems analysis to establish contributory factors, learning and recommendations.

2.8 Decision to proceed to Stage 2 Service User Lookback and Stage 3 Service User Recall

The decision to proceed to the Service User Lookback and Recall stages is a difficult and complex one and should not be taken lightly. As above, the decision should only be considered in circumstances where it is indicated following careful risk assessment, which may necessitate external peer review and advice from senior decision-makers and/or others with knowledge and experience in the specialty in which the Process is being considered and with advice from those who have experience in conducting a Lookback Review Process (see Section 2.7 Risk Assessment).[24] The decision should also include consideration of the impact on other service users (i.e. not the 'at risk' cohort) for potential delays in diagnosis and treatment.

Lookback Reviews by their nature are often high-volume, involve high-complexity and high-cost (including opportunity cost which diverts time and resources from

[22] HSCB. *Op.cit*. Appendix 16.
[23] HSE. *Op.cit*. Preliminary Risk Assessment Stage pages 15 to 16 and Appendix 1.
[24] *Loc.cit*.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

ongoing care.) As described above, they involve a number of stages and logistical challenges.

If a decision is taken to proceed to the Service User Lookback and Recall stages then the Chair of the Steering Group must inform the Chief Executive and Board of Directors and notify the relevant external bodies. The Early Alert should be updated (Section 2.9). If the Process has not already been reported as an SAI then the Steering Group should review the SAI criteria and take appropriate action (see Section 2.10).

The Steering Group should continue to consider any safety concerns that may arise at any stage of the Review Process which may need prompt action. Concerns may include the following:

- Taking preventative action such as the removal of the hazard [25];
- Consideration of the benefits and risks of suspending or transferring the service under review;
- Management of staff member(s)/service whose caseload is under review in line with Professional/Regulatory Guidance/HR/Occupational Health policy and procedure;
- Clinical and social care management of service users/ staff identified by the preliminary review and suspected of being adversely affected;
- Providing support to service users and staff involved.

The Steering Group should ensure that business continuity plans are considered and implemented, where necessary, including providing for additional health and social care demands which may arise as a consequence of the Lookback Review. The HSC organisation is responsible for securing service capacity and for ensuring that the necessary resources are allocated to conduct all the stages of the Review Process and subsequent follow-up processes. If the resources required exceed what is available then this should be escalated to the organisation's Board and if necessary to the Health and Social Care Board.

[25] If the hazard is associated with a medical device then the HSC organisation should report this in line with Norther Ireland Adverse Incident Centre (NIAIC) adverse incident reporting – guidance and forms. October 2018 ' www.health-ni.gov.uk.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

The Steering Group should be prepared for the fact that when a full Lookback Review Process is being considered this information can often become publicly known at the planning stage and should have a contingency plan in place for notification of affected persons and the wider public if this should occur.

2.9 Early Alert Notification [26]

The established communications protocol between the Department and HSC organisations emphasises the principles of 'no surprises', and an integrated approach to communications. Accordingly, HSC organisations should notify the Department promptly (within 48 hours of the event in question) of any event which has occurred within the services provided or commissioned by their organisation, or relating to Family Practitioner Services. Events should meet one or more of the following criteria;

1. *Urgent regional action may be required by the Department, for example, where a risk has been identified which could potentially impact on the wider HSC service or systems;*
2. *The HSC organisation is going to contact a number of patients or clients about harm or possible harm that has occurred as a result of the care they received. Typically, this does not include contacting an individual patient or client unless one of the other criteria is also met;*
3. *The HSC organisation is going to issue a press release about harm or potential harm to patients or clients. This may relate to an individual patient or client;*
4. *The event may attract media attention;*
5. *The Police Service of Northern Ireland (PSNI) is involved in the investigation of a death or serious harm that has occurred in the HSC Service, where there are concerns that a HSC service or practice issue (whether by omission or commission) may have contributed to or caused the death of a patient or client. This does <u>not</u> include any deaths routinely referred to the Coroner, <u>unless</u>:*
    i. *there has been an event which has caused harm to a patient or client and which has given rise to the Coroner's investigation; or*

[26] Department of Health 'Early Alert System' HSC (SQSD) 5/19.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

ii. *evidence comes to light during the Coroner's investigation or inquest which suggests possible harm was caused to a patient or client as a result of the treatment or care they received; or*

iii. *the Coroner's inquest is likely to attract media interest.*

6. *The following should always be notified:*

i. *the death of, or significant harm to, a child, and abuse or neglect are known or suspected to be a factor;*

ii. *the death of, or significant harm to, a Looked After Child, a child on the Child Protection Register or a young person in receipt of leaving and after care services;*

iii. *allegations that a child accommodated in a children's home has committed a serious offence; and*

iv. *any serious complaint about a children's home or persons working there.*

7. *There has been an immediate suspension of staff due to harm to patient/client or a serious breach of statutory duties has occurred.*

The next steps will be agreed during the initial contact/telephone call and appropriate follow-up action taken by the relevant parties. In **all** cases, however, the reporting organisation must arrange for the content of the initial contact to be recorded on the updated pro forma attached at Annex C, and forwarded, within 24 hours of notification of the event, to the Department at earlyalert@health-ni.gov.uk and the HSC Board at earlyalert@hscni.net.

The Early Alert must provide a succinct description which clearly outlines the key issues and the circumstances of the event. Information contained within the brief is to include:

- urgency;
- determining who has been affected and how - physical and/or psychological harm, or no known harm;
- process for determining risks; and
- need for Department participation/involvement/oversight.

2.10 SAI Notification and Investigation

In some circumstances an SAI review may have triggered the Lookback Review Process (Section 1). However, often the Lookback Review will be triggered by a

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

concern that has been raised by a service user or their family/carers or a member of staff. The Steering Group should consider at an early stage if the findings of the Lookback Review meets any of the criteria for reporting the concerns as an SAI (see also Section 7.2.1). The criteria for reporting an SAI are defined within the HSCB Procedure for the Reporting and Follow up of Serious Adverse Incidents, November 2016 at www.hscboard.hscni.net [27]

[27] HSCB Loc. Cit Section 4

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

3.0 Stage 2 Identifying and tracing service users at risk

One of the most important stages of the Lookback Review Process is the accurate identification and tracing of the service user cohort who have been identified as being affected by the triggering event. The HSC organisation is responsible for the identification and tracing of the affected service users must allocate appropriate resources to ensure that this is undertaken.

In the context of the Lookback Review process, this Stage involves the review of care/ processes against explicit standards and criteria to identify those who may not have received the required standard of care or where the procedure used did not adhere to explicit standards and criteria. [28]

3.1 Role of the Steering Group –Terms of Reference and Action Planning

The Steering Group should continue to ensure the management of immediate safety issues and care for those harmed or potentially harmed by the triggering event.

The Steering Group is responsible for ensuring the identification and tracing of the cohort of service users to be included in the service user lookback and recall phases of the Lookback Review Process. The Steering Group will need a clear definition of which service users should be recalled/ offered further tests/assessments, what they should be recalled for, how test/assessment outcomes will be categorised and how each category will be managed/followed-up (Sections 3.2 – 3.4 and Appendix 3).

The Steering Group should review their Terms of Reference and Group membership at this stage and consider if additional membership from the service area/support services and from service users advocacy services are required for either the Steering Group or the Operational Group/ Lookback Review Management Team if applicable (see Section 2.3). The extent and complexity of the Lookback Review Process will determine the resources and responses required.

The Steering Group should also review the Lookback Review Action plan (Section 2.5). As required, expert advice or linkages may be also made with resources such as relevant Professional Bodies and Faculties (e.g. Royal Colleges) to assist with this stage of the Lookback Review.

[28] HSE. *Op.Cit*. Section 7.7 Page 17

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

The Steering Group should also consider the service user recall methodology for the next stage and further develop the Communication Plan (including the formation of Helplines/Information Lines and use of the organisation's web page to provide general information and Frequently Asked Questions and responses Section 4.4).

The Steering Group will need to meet on a regular basis to ensure that they receive situation reports (SITREPS) and provide a co-ordinated approach to the oversight of the Process. SITREPS should also be shared with internal stakeholders (Executive Team/Senior Management Team and Board) and external stakeholders i.e. HSCB, PHA and DoH.

3.2 Establish the Service User Database

The HSC organisation will need to develop a service user database to collate the details of the service users that have been identified for inclusion in the service review/ audit stage of the Process. It is important to consider the output from the service user notification database at the outset. The list of service users will be needed to:

- Generate letters to service users;
- Check if service users at risk have made contact;
- Keep track of who requires further review/testing;
- Record who has had results; and
- At the end of the Lookback Review Process to generate information on numbers of service users identified, further assessed and their outcomes.

The database needs to be updated, by administrative staff, on a regular, and at some stages at least on a daily basis. This will ensure the information held is the most up to date and reliable.

The database may already exist on one of the organisations Information Technology (IT) systems. In some circumstances (for example service users who have not been reviewed for a period of time), it may be necessary to check the service user details with the General Register Office for NI to identify if any of these service users have

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

since deceased.[29] Information Technology staff are essential members of the sub team to assist in accessing existing databases/establishing databases. Specific data variables, will be determined by the nature of the triggering event and the audit methodology to be applied. If a database of service user details does not already exist then a suggested core dataset for service users at risk has been outlined in Appendix 2.

The Steering Group should give special consideration in the Lookback Review Action Plan as to whether or not the cases of deceased persons meet the inclusion criteria, how their records should be handled and how best to communicate with their relatives.[30]

3.3 Establish the Process for the Identification of Affected Service Users[31]

The Steering Group should establish and record clear processes for the identification of the service users/ staff to be included in the Recall Stage. This will include the development/ agreement of the:

- Audit criteria (criteria as to what will be considered within acceptable practice limits, minor or major discrepancy, the clinical significance of these discrepancies, and actions to be taken in each category, guided by national and international best practice, faculty requirements etc.);
- Scope of Audit (including timeframes and definition of records to be reviewed);
- Audit Methodology;
- Audit Tool;
- Instructions to ensure consistent recording of audit results;
- Instructions for analysis of audit data;
- Procedures for ensuring the validity and reliability of the audit to ensure that all auditors interpret and apply audit criteria in the same way; and
- Process for the submission of audit outcomes to the Steering Group.

[29] General Register Office for Northern Ireland @ www.gov.uk.
[30] HSE. *Op.Cit.* Section 7.7.4, page 18.
[31] Ibid. Section 7.7.3 Page 17

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

The HSC organisation should take account of extant guidance in relation to maintaining service user confidentiality.[32] [33] [34] The audit of service user's healthcare records should be undertaken by the healthcare team who would ordinarily have the right to access the service user's healthcare records as part of the delivery of health and social care. However, if the audit team is extended to include healthcare personnel who would not have a right to access the service user's healthcare records, and consent has not been provided by the service user for these personnel to access their records, then these records must be sufficiently anonymised, such that an individual is not identifiable to those undertaking the audit.[35]

3.4 Undertaking the Audit

The Steering Group will commission the audit of the healthcare records of the affected service users as identified in Stage 1 (risk assessment). The audit methodology and tools will have been defined by the Steering Group (see Section 3.3).

The audit will involve clinical staff with the necessary skill and knowledge of the specialty involved. However, depending on the nature, extent and complexity of the Lookback Review the HSC organisation may need to commission relevant experts to undertake the audit or service review.

Again, depending on the nature of the Lookback Review the team may initially be required to screen the service users' notes/x- rays/test results etc. to establish if they are in the affected cohort. A system for the initial identification of the service users including flow charts, service review proformas and service user notification letters are contained in Appendix 3. These are examples only and are provided as reference material and should be adapted by the HSC organisation for the specific health and social care trigger event on a case by case basis.

Following initial screening and identification of service users affected, further assessment may be required.

---

[32] General Data Protection Regulation ((EU) 2016/679) (UK GDPR) @ https://eugdpr.org
[33] Data Protection Act 2018 @ www.legislation.gov.uk .
[34] DoH 'Code of Practice for protecting the confidentiality of service user information' April 2019 @ www.health,n-i.gov.uk
[35] HSE. *Op.cit*. Section 7.7.3.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

The service user database will be used to document the service users/ staff who are included and excluded following each stage of the Lookback Review Process (see Section 3.2 above). In general, it will be used to track persons affected and to record actions, interventions and outcomes.

Upon completion of the audit, the service review team will provide the Steering Group with the results of the audit which will inform the Steering Group of the persons affected to be included in the Recall Stage.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

4.0 Stage 3 Service User Recall

4.1 Planning the Recall

Following completion of Stage 2, the Steering Group will move to the third stage, the Service User Recall Stage. The Steering Group and Operational Group should ensure that their Terms of Reference include the following; purpose of Recall, scope, method and timeframe.

The Steering Group will also establish the Recall Team(s) which will consist of experts in the subject area/ discipline which is the covered by the Lookback Review Process.

The Steering Group must agree with the Recall Team(s) a realistic work-plan with timelines that reflect the urgency and complexity of the Lookback Review Process.

The Steering Group will have to consider the following which will form the basis of the Operation Group/Lookback Review Management Team work-plan:

- Identify venue for the conduct of the Recall stage;
- Secure administrative support;
- Establish an appointment system including DNA management;
- Secure clinical and other specialist support e.g. laboratory/x-ray etc.;
- Arrange transportation of samples and results;
- Manage arrangements for assisting service users affected to attend the Recall Stage (for example car parking, site maps, signage/ 'meet and greet' arrangements, public transport, taxis, meals);
- Agree a system for recording of results;
- Ensure that counselling and welfare services are available to service users and to staff;
- Agree the communication and service user support arrangements (see Section 4.3); and
- Consider the arrangements for overtime/out-of- hours working for staff.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Ideally, a liaison person/team should be appointed to oversee the seamless conduct of each attendance a service user has as part of the Recall stage, whether they are clinic appointments or repeat tests/x-rays etc. Responsibilities would include; providing a point of contact, follow-up of DNAs , quality assurance of the Process (correct letter to correct person) and checking that any service user affected are referred into the 'system' for subsequent follow-up.[36]

Depending on the extent, nature and complexity of the Process, the Steering Group will have to meet on (at least) a daily basis to ensure they receive SITREPS and continue to have an accurate oversight of the Lookback Review at this Stage (see Section 3.1).

4.2 Service User Communication and Support

One of the most important areas of managing any Lookback Review Process is the communication with all the affected service users. When communicating it is equally important to be able to say who is not affected. The timing of any communication is critical and every effort should be made to notify the entire group simultaneously. The method of doing this will be dictated by the numbers of service users involved (see Section 4.3). Service user notification must be co-ordinated with public announcements made by the organisation. In an ideal situation service users should be contacted before a media announcement is made. However, this is not always possible given the nature/scale of some Lookback Review Processes or if there is a breach in confidentiality at an earlier stage. Where applicable, the Steering Group should identify any service user representative bodies/third sector and brief them.

The Steering Group should agree key messages to ensure consistent and accurate information to provide confidence in the process. The Steering Group should consider the person(s) best suited to communicating bad news with affected service users, their families and/or carers. A spokesperson, should be identified to act as the organisation's spokesperson and be available for interview by the media etc. Media training should be provided on a case to case basis (see also Section 4.6).

The following should be included in the service user communication and support plan:

[36] *Ibid.* Section 7.8.2 Page 22.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

- access to professional interpreters as required;
- a designated point of contact for service users, their families and/or carers;
- regular and ongoing information updates provided to service users and families and/or carers;
- affected service users offered a written apology by the health service organisation;
- establishment of a Helpline/Information Line/website to ask questions and to obtain information (see Section 4.5 and Appendix 4 for practical guidance); and
- affected service users who need additional consultation have these appointments expedited to allay any anxieties or concern that they may have.

Communication and support of families should include:

- identifying immediate and ongoing management needs of service users, their families and/or carer;
- ensuring that service users understand the processes for ongoing management and have written advice/fact sheets concerning this;
- ensuring that relevant fact sheets containing information on the lookback review are published on the health service inter/intranet website;
- ensuring adequate resources are in place to provide the level of service required;
- provide counselling and welfare services; and
- initial communication should be direct, either face-to-face or via telephone, where the service user must be given the opportunity to ask questions.

4.3 Service User Notification by Letter

Depending on the extent of the Lookback Review Process notification may be by a letter sent to the service users affected by the issue. As above, the timing of service user notification must be carefully choreographed with any public announcement made by the organisation. If the Process has affected small numbers of service

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

users organisations may wish to consider alternative forms of direct communication e.g. telephone calls in first instance which should be supplemented by a follow-up letter containing the pertinent information. A sample of letters has been provided in Appendix 3 for reference/guidance.

The service user letter should be signed by the Chief Executive or a Director of the HSC organisation. Service user 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*)...”

Letters to the service user should include the following if appropriate:

- Unique service user identifier number;
- Service user information leaflet/ fact sheet;
- The website/freephone helpline number(s) and hours of opening;
- Location map with details of public transport routes;
- Free access to parking facilities; and
- Arrangements for reimbursement of travelling expenses.

It can be helpful to include a reply slip with a pre-paid envelope to confirm that service users have received the letter. Alternatively, the organisation may consider using a recorded delivery service or hand delivering the letters if numbers are manageable.

Depending on the individual Lookback Review Process the HSC organisation may need to identify any service users under 16 and/or other vulnerable groups to write to their parent/guardian/ representative.

The Steering Group should plan for how service users who do not respond to an invitation and/or ‘lost to follow-up should be managed. The Steering Group should ensure that ‘every reasonable effort’ is made to contact all service users at risk for example by telephone or through General Practitioners. It is accepted that service users may have moved out of the region or abroad.

4.4 Public Announcement of the Recall Stage

The Steering Group will determine the timing of the Public Announcement of the Recall Stage of the Lookback Review Process. Communications management

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

throughout the Lookback Review Process should be guided by the principles of 'Being Open'[37] balanced with the need to provide reassurance and avoid unnecessary concern.

Recall Stage will be announced to the public by the relevant HSC organisation lead Director in line with the Communication Plan (Section 4.2 and 4.6). As stated in Section 4.3, it is vital that the Steering Group strive to ensure that the Lookback Review Process is not publicly announced until all of the persons affected have been notified and a clear public message can be given regarding the extent of the cohort and those that are not affected. This is not always possible, as breaches of confidentiality may occur and therefore the Communication Plan should be prepared for this eventuality at all times.

When it is determined that communication with the public is required it should not be announced until all of the service users affected have been notified. As above it is recognised that this is not always possible. Key principles of public announcements include:

- Being open with information as it arises from the Lookback Review Process;
- Ongoing liaison with the media throughout the Lookback Review Process;
- Preliminary notification being made public where a situation requires additional time for the discovery of accurate information to be provided to service users and the wider public.

It essential that the findings in relation to the Lookback Review Process should not be released into the public domain until the Process is complete, all the findings are known and all affected service users are informed of the implications of the findings for them.[38]

4.5 Setting up a Service User Helpline/ Information Line

Once it has been agreed that the Lookback Review process is to be publicly announced HSC organisations need to have in place a system to deal with potentially large numbers of enquiries from service users, their families and the general public. It is recommended that site-specific helplines are considered for

[37] DoH 'Saying sorry – when things go wrong'. January 2020.
[38] HSE *Op Cit* Page 20

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

persons affected and a more general information line for the wider public. Consideration should also be given to providing information on the Trust's website for example Frequently Asked Questions (FAQs) and responses. Planning at this stage is vital to ensure that public confidence in the service is not further eroded. Guidance on setting up a service user helpline/information line is contained in Appendix 4.

4.6 Communication with the Media

Adverse incidents, especially those involving a service user lookback generate intense media attention. Regardless of the nature or intensity of media inquiries, information given to them should never exceed that which has been shared with the service users affected.[39]

The Steering Group should consider developing a 'media pack' (see below). The Head of Communications/Communications Manager should take a lead on developing this strategy. Depending on the extent, nature and complexity of the Lookback Review Process the Head of Communications/Communications Manager will liaise with the DoH Communications branch to seek advice on the communication strategy for the media and general public.

As part of the Communications Plan for dealing with the media, the Steering Group should:

- nominate a spokesperson for public and media communications;
- minimise the delay in response to the public and the media;
- develop a media pack which should contain; and
    - key messages
    - frequently asked questions (FAQs) and answers
    - draft media statements for each phase of the review process.

Media statements in relation to the issue, should be accurate and not add to the anxiety of the service users and their families/carers. Media statements should not be released prior to notification of the Lookback Review Process (see Sections 4.3 and 4.4). In the circumstances where a media statement is released it should state that a Lookback Review Process is being carried out, and immediately limit the area

[39] *Ibid.* Section 7.11.2 Page 26

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

of concern to time period, region and service area within which the Process is being conducted. It should detail the numbers of persons affected being included in the recall stage of the process and the expected timeframe for the completion of the recall stage, if known.[40]

The media statement should note that all service users affected have been contacted (and method of contact) and that a Helpline/Information line/website has been established, giving the opening time(s) of the line and the contact details. The FAQs can be provided to the media as well as any additional briefing information such as an information leaflet.

All media statements and briefing notes should be ratified by the Steering Group.

4.7 Staff Communication and Support

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 involved healthcare workers are protected and supported during this time. They need 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 lookback review process 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. In the case of an individual(s) being managed under the HSC organisation's capability/performance management/disciplinary procedures then the relevant HR policies should apply. These parallel processes are not included in the scope of this guidance (see Section 1.3).[41]

A communication and support plan should be devised for staff. This should include communication and support for:

- All staff who are managing the lookback process;
- All staff working in the area of concern; and
- All other staff that may be affected.

[40] *Ibid*. Page 27.
[41] DoH Policy for Implementing a Lookback Review Process Section 4.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

5.0 Stage 4 Closing, Evaluating and Reporting on the Lookback Review Process

A Lookback Review Process Guideline Checklist has been included in Appendix 5. The Checklist is a memory aid only and must be used in conjunction with the guidelines.[42]

The Steering Group are responsible for formally closing the Lookback Review Process when all service users affected have been reviewed and the care of service users requiring further treatment and care management have been transferred to the appropriate service and all the service users have been written to with the outcome of the review.

At the end of any Look Back process it is the responsibility of the Lead Director/Chair of the Steering Group to evaluate the management of the Lookback Review to assess the efficiency and effectiveness of the process and to identify any lessons learned from the process. Key measures should be assessed and strategies for further improvement should be implemented and reported to the Chief Executive as required.

The findings should be included in a Look Back Review Report. The content will be unique to each Lookback Review Process. The report should be shared with all relevant internal and external stakeholders. This report should be used to form the basis of the Serious Adverse Incident Report (Section 2.10) to facilitate the dissemination of learning across the HSC as a whole.

For the purposes of a report on a Lookback Review Process the report should contain the following information:

- Introduction including:
  - Details of Terms of Reference(s) (include Terms of Reference(s) in the
  - Appendices section of the report)
  - Composition and roles of the Safety Incident Management Team
  - Composition and roles of the Audit Team
  - Composition and roles of the Recall Team
- Methodology applied to the Look-back Review Process including:

[42] HSE. *Ibid*. Appendix 8.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

- Methodology applied to preliminary review/Risk Assessment
- Clear audit methodology for the Audit Stage including:
  - Audit Criteria
  - Scope of Audit
  - Audit Methodology
  - Audit Tool
- Procedures for ensuring the validity and reliability of the Audit stage to ensure that all auditors interpret and apply audit criteria in the same way
- Recall Stage methodology
- Communications Plan
- Information and Help Line Plan
- Plans for follow up for persons affected following both the Audit and Recall Stage

- Results/ Findings of Stage 1 Preliminary Findings/Risk Assessment;
- Results/ Findings of Stage 2 service review/ audit;
- Results/ Findings of the Recall stage;
- Actions taken to date to address findings; and
- Learning and further recommended actions to address findings.

Peer review publication of issues relating to the Lookback Review Process, for instance; the development of an audit tool, logistics and communication with service users/families and staff may be of benefit and should be encouraged.[43]

[43] HSE. *Op. Cit*. Section 7.10.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Glossary

Term	Definition
Adverse Incident	Any event or circumstance that could have or did lead to harm, loss or damage to people, property, environment or reputation.
Audit	In the context of the lookback review process, audit involves the review of care/processes against explicit standards and criteria to identity those who may not have received the required standard of care or where the procedure used did not adhere to explicit standards and criteria.
Clinical Review	A re-examination of a medical and or clinical process/es which has delivered results that were not to the expected quality standard.
Cohort	A group of people who share a common characteristic or experience within a defined period (e.g., are currently living, are exposed to a drug or vaccine or pollutant, or undergo a certain medical procedure) i.e. a sub-group selected by a predetermined criteria.
Contributory factor	A circumstance, action or influence which is thought to have played a part in the origin or development of an incident or to increase the risk of an incident.
Database	The ability to record information for retrieval at a later date. In this instance it may be on paper if the numbers involved are small. If the numbers are large, ITC equipment and competent administration staff may be required.
Harm	1 **Harm to a person**: Any physical or psychological injury or damage to the health of a person, including both temporary and permanent damage.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

	2 **Harm to a thing**: Damage to a thing may include damage to facilities or systems; for example environmental, financial data protection breach, etc.
Hazard	A circumstance, agent or action with the potential to cause harm.
Lookback Review	A re-examination of a process (es) which has delivered results that were not to the expected quality standards.
Proforma	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.
Recall	An act or instance of officially recalling someone or something. In the context of the Lookback Review Process, the recall will involve the examination of the service user and/ or the review all relevant records in line with the Terms of Reference and will identify any deviations from required standards of care. Appropriate corrective actions will be identified as appropriate.
Risk	The chance of something happening that will impact on objectives.
Risk Assessment	A careful examination of what could cause harm to people, to enable precautions to be taken to prevent injury or ill-health.
Serious Adverse Incident	In the context of a Lookback Review Process an SAI is any event or circumstance that meet the specific criteria laid out within the HSCB Procedure for the Reporting and Follow up of SAIs 2016 at www.hscboard.hscni.net.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Service Review Team/expert advisory group	A specially selected group of individuals, competent in the required field of expertise, to perform the Lookback Review Process
Service User	Members of the public who use, or potentially use, health and social care services as patients, carers, parents and guardians. This also includes organisations and communities that represent the interests of people who use health and social care services.
Triggering Event	The initial concern(s) or adverse incident which lead to the HSC organisation considering the initiation of the Lookback Review Process.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Appendices

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Template for Risk Assessment

Appendix 1

Information about the event or concern that has given rise to the need to consider a lookback review process (include information in relation to any actual harm that has been caused as a result of this issue)**:**

Information about the potential extent of the issue (include information about the number of people, number of HSC organisations that might be adversely affected by the issue)**:**

Information about the potential outcomes of the issue (include information about the potential consequences of the issue e.g. missed diagnosis / missed return appointments / harm from contaminated equipment):

Information about the risk level of the issue (include information about the severity of harm that might occur in the people adversely affected by the issue). Use the Regional Risk Matrix (Section 2.7) to evaluate the risk.

Please tick one:

Extreme	
High	
Medium	
Low	

Additional Details:

Information about the potential cohort of service users affected (number, gender, age range):

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Details of Immediate Action Required

Recommendations to Steering Group regarding Stage 2 Lookback Review (include recommendations for the Terms of Reference for the Lookback Review including recommended inclusion and exclusion criteria; and for scoping audit(s) of service users that might fall within the inclusion criteria):

Details of personnel who undertook the Risk Assessment:

Name	Title

Date of Risk Assessment:

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Establishing the Service User Database – Core Dataset Appendix 2

The data below is a minimum dataset, it is however subject to change depending on the individual situation. Ideally the use of an existing HSC organisation database(s) is preferred.

- Unique 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;
- Postcode.

- Named consultant;
- Date of appointment/procedure1;
- Date of appointment/procedure 2;
- Date of appointment/procedure 3;
- Procedure one description;
- Procedure two description;
- Procedure three description.

- Reviewer 1 description;
- Reviewer 2 description;
- Data entered by – identification;
- Data updated 1 by – identification;

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

- Data updated 2 by – identification;
- Data updated 3 – identification.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Appendix 3

Initial Identification of Service Users involved in the Service Review/ Audit Stage

See Flow Chart - Process for advising that all service users who may have been affected (Appendix 3.1 Section 1)

See Flow Chart - Process for advising all service users known to be the affected cohort (Appendix 3.1 Section 2)

The retrieval of notes/x-rays/test results must be co-ordinated with the support from Medical Records staff.

A Service Review Proforma (Appendix 3.2) is attached to each set of notes.

The service user database needs to be updated after completion of this Proforma.

A quality assurance check is provided by Administration which is essential to ensure that the correct letter is sent to the correct service user.

The Service Review Proforma should be transferred from the front of the notes and filed into the service users' records.

Conducting Further Assessment (Notes/X-rays/Test Results etc.)

A Notes/X-ray/Test Results Review Proforma (Appendix 3.3) is attached to the front of each set of service user notes.

The service review team will undertake a further detailed audit of the notes to review the outcomes of previous assessment/scans/tests.

The service review team will then decide if previous outcomes/diagnosis were accurate.

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 service user.

- A **red** sticker identifies a negative outcome that requires a further assessment – Letter E is sent to service user.

The service user database needs to be updated after completion of this pro forma.

A quality assurance check is provided by Administration which is essential to ensure that the correct letter is sent to the correct service user.

The Notes Review Pro forma should be removed from the front of the notes and filed into the healthcare record.

Conducting Further Assessment (Clinical)

A Clinical Review Pro Forma (Appendix 3.4) is attached to the front of each set of healthcare record.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

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.

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 service user.

- A **red** sticker identifies a negative outcome that requires further treatment which should be managed within normal clinical arrangements – Letter G is sent to service user.

The service user database needs to be updated after completion of this proforma.

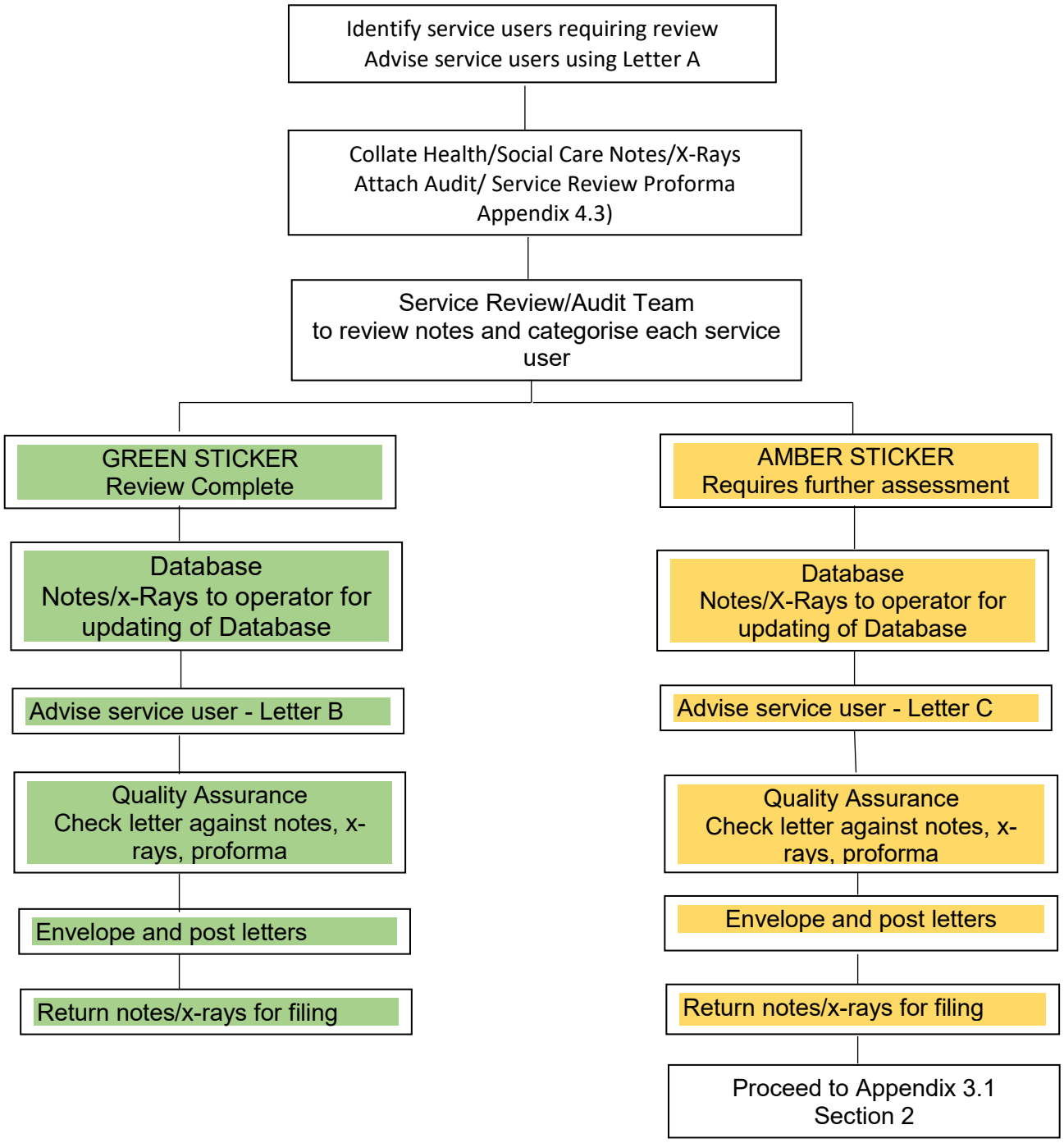
A quality assurance check is provided by Administration which is essential to ensure that the correct letter is sent to the correct service user.

The Clinical Review Pro Forma should be transferred from the front of the notes.

- If it has a **green** sticker attached: file into service user notes.
- If it has a **red** sticker attached: return service user notes and pro forma to admin support for processing within normal clinical arrangements.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

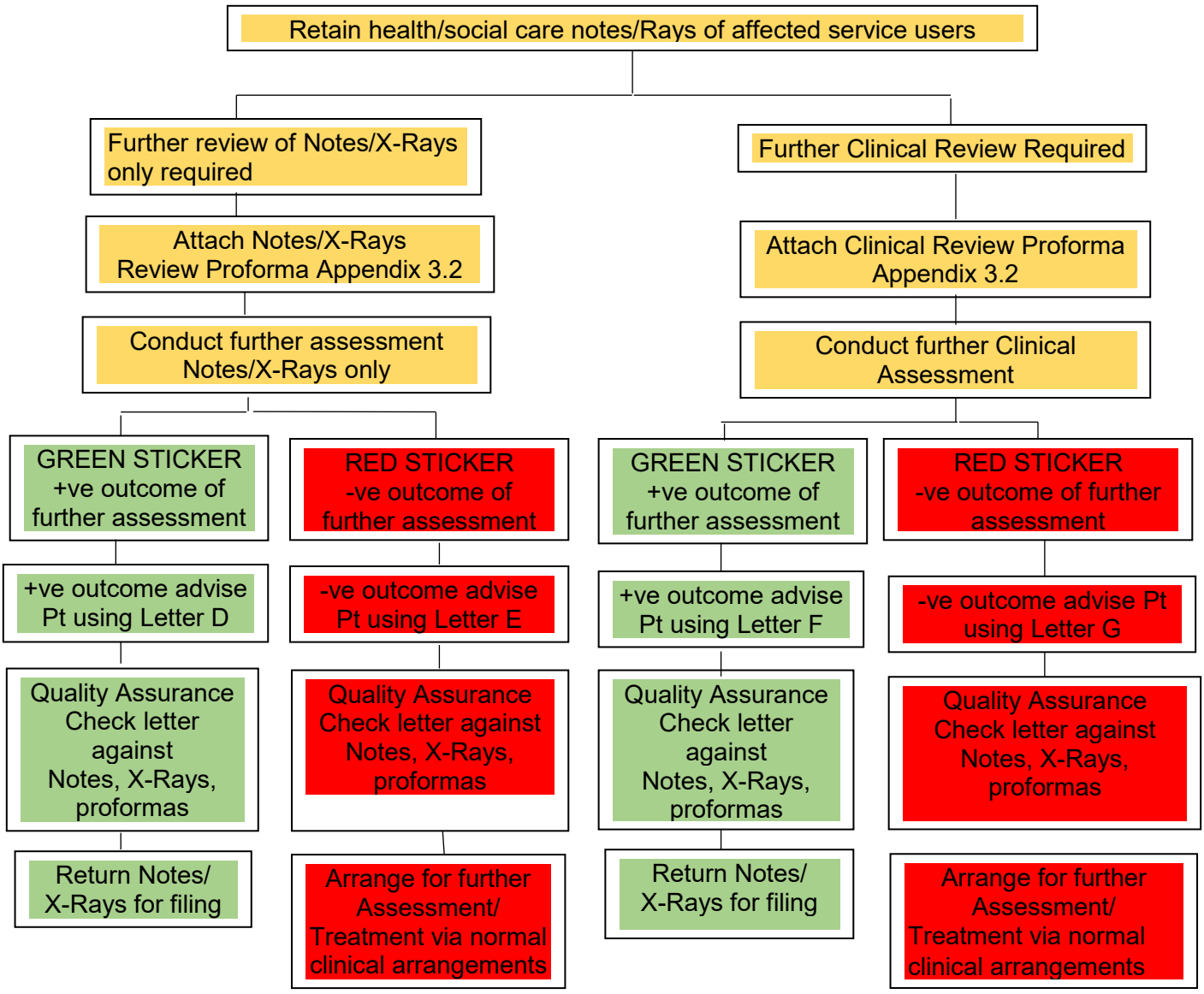
Appendix 3.1 (Section 1) Advising service users who may be in the affected service user cohort



Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Appendix 3.1 (Section 2)

Process for Advising Service users known to be in the affected cohort.



Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Appendix 3.2 Service Review Proforma

SERVICE USER 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 COMPLETE

AMBER STICKER – FURTHER FOLLOW UP REQUIRED

DATABASE UPDATED ☐ **(Signature & date)**

ADMIN QA CHECK ☐ **(Signature & date)**

LETTER SENT ☐ **(Signature & date)**

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Appendix 3.3 NOTES/X RAY REVIEW PROFORMA

SERVICE USER DETAILS (ATTACH LABEL)

ADDITIONAL INFORMATION

CASENOTES REVIEWED ☐

X-RAYS/SCANS REVIEWED ☐

OTHER MEDICAL DIAGNOSTIC/DATA REVIEWED ☐

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)**

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Appendix 3.4 CLINICAL REVIEW PROFORMA

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 REQUIRED: PROCESS INTO NORMAL CLINICAL ARRANGEMENTS	☐	☐

CONSULTANTS SIGNATURE: _____DATE:_____

GREEN STICKER – REVIEW COMPLETED

AMBER STICKER – FOLLOW UP REQUIRED
PROCESS INTO NORMAL CLINICAL ARRANGEMENTS

RED STICKER - FOLLOW UP REQUIRED
REQUIRED URGENT REFERRAL

DATABASE UPDATED ☐ (Signature & date) _____

ADMIN QA CHECK ☐ (Signature & date) _____

LETTER SENT ☐ (Signature & date) _____

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Appendix 3.5 DRAFT LETTERS

Although there will be one “master” letter, you will need to generate several variants from it for different circumstances e.g. when the service user is a child.

The following are provided for suggested content only.

LETTER A: Advising of a Lookback Review Process

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 H: Letter to General Practitioner to advise them that the service user(s) are being included in the Recall Phase of Lookback Review Process

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

LETTER A: Advising of a service review/lookback review process

Healthcare Reference Number

Confidential Addressee Only

DD Month Year

Dear < Title>

<***Title of Lookback Review Process***>

It has come to the attention of <*HSC organisation*> that < *a healthcare worker/system*> has <brief outline of the incident>.

We have decided as a precautionary measure to review each of the cases with which this <*healthcare 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 endeavour 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 factsheet 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 unique reference number from the top of the page.

Yours faithfully

(Chief Executive/Director of HSC Organisation)

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

LETTER B: No further follow up required

Healthcare Reference Number

Confidential Addressee Only

DD Month Year

Dear <*Title*>

<Title of Lookback Review Process>

We had previously written to advise you that <*HSC Organisation*> 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 HSC Organisation)

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

LETTER C (version 1): Further follow up is required – Notes only

Healthcare Reference Number

Confidential Addressee Only

DD Month Year

Dear <*Title*>

<Title of Lookback Review Process>

We had previously written to advise you that <HSC Organisation> 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 emphasise 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 notes/assessment*> and we will contact you again as soon as this is complete.

Yours faithfully

(Chief Executive/Director of HSC Organisation)

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

LETTER C (version 2): Further follow up is required – Clinical

Healthcare Reference Number

Confidential Addressee Only

DD Month Year

Dear <*Title*>

<***Title of Lookback Review Process***>

We had previously written to advise you that <*HSC Organisation*> 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 emphasise 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 HSC Organisation)

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

LETTER D: Positive outcome of further assessment – Notes only

Healthcare Reference Number

Confidential Addressee Only

DD Month Year

Dear <*Title*>

<***Title of Lookback Review Process***>

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 unique 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 HSC Organisation)

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

LETTER E: Negative outcome of further assessment – Notes only

Healthcare Reference Number

Confidential Addressee Only

DD Month Year

Dear <*Title*>

<***Title of Lookback Review Process***>

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 unique 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 HSC Organisation)

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

LETTER F: Positive outcome of further assessment – Clinical

Healthcare Reference Number

Confidential Addressee Only

DD Month Year

Dear <*Title*>

<***Title of Lookback Review Process***>

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 unique 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 HSC Organisation)

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

LETTER G: Negative outcome of further assessment – Clinical

Healthcare Reference Number

Confidential Addressee Only

DD Month Year

Dear <*Title*>

<***Title of Lookback Review Process***>

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 unique 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 HSC Trust)

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Letter H: Letter to General Practitioner (informing them of the inclusion of their patient(s) in the Recall Phase of the Lookback Review Process)

Service user name & address

Dear <*Doctor Name*>

<Title of Lookback Review Process>

<*Service Name*> recently reviewed <*Procedure*> undertaken at the hospital in <*Date(s)/Year(s*)>. This review was part of a quality assurance process as we were not satisfied with the quality of a number of <*Procedure(s)*> carried out. As a precautionary measure our medical advisors have recommended that a number of service users who attended for <*Procedure*> are offered a <*Specialty*> outpatients appointment.

Our records show that your patient <*Name*> previously attended <*name of location*> for <*name of procedure*>. We have written to your patient to advise them that their file was reviewed as part of this process and to offer them an outpatient appointment.

If you have any queries about this letter, please contact <*Name person and contact details*>.

Yours Faithfully

(Chief Executive/Director of HSC Organisation)

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Appendix 4 Setting up a Service User Helpline or Information Line

Once it has been agreed that the Lookback Review process is to be publicly announced HSC organisations need to have in place a system to deal with potentially large numbers of calls from service users, their families and the general public. It is recommended that site specific helplines are considered for persons affected and a more general information line for the wider public.

The following points should be considered by the Steering Group:

- An individual, such as a senior manager should be identified to coordinate and implement the Telephone Help Line;
- A meeting needs to be convened with a small number of individuals, with the necessary knowledge of the speciality, to establish the necessary systems to support the helpline/information line. It may be that Lead and Specialist Nurses are ideally placed to assist at this crucial stage of planning;
- 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.

Identification of Venue for Helpline/Information Line

- 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.
- Cabling to allow sufficient telephones is required. Once the media report on the issue is in the public domain then there is likely to be an influx of calls.
- Free phone telephone numbers need to be agreed with Telephone Exchange staff or relevant department.
- It is advisable to have a failsafe 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.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

- Once the number of Helpline stations are agreed, personal computers are required for each to facilitate easy access to service user information. IT staff will assist in accessing the necessary cabling and hardware.

Briefing Paper for Helpline Staff

- 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.
- Files should be prepared and updated daily with the initial press release and briefing notes on the subject (see Key Messages below).

Production of Algorithms

- 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 service users.

Production of Key Messages

- 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.
- Key messages will change as the review progresses. These then require to be updated in the individual files for Helpline staff.

Production of Proforma

- 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.
- 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

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

a red dot. By the following day these need to have been actively followed up, probably by clinical staff in the speciality being reviewed.

- For completeness and post Look Back audit purposes a database of Helpline calls might be helpful.

Production of Rotas

- 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.
- 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.
- 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. Overtime and out-of-hours arrangements should be considered and agreed through the Human Resources Department prior to the commencement of the Helpline.
- 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.

Staff Briefing

- 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.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

- 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.
- Catering arrangements should be in place for staff who assist in this work. Regular coffee breaks should be accommodated.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

Appendix 5 Lookback Review Process Guideline – Process Checklist Template

	Look-back Review Process **The purpose of the check-list is to act as an aide memoir to managers and staff to assist them to ensure compliance with the HSE Look-back Review Process Guidelines.** **The check-list must always be used in conjunction with the Lookback Review Process Guidelines. References to the relevant sections of the Guideline have been included in the check-list.**	**You should refer to the relevant Guideline Section(s) for guidance on each stage of the process.**	**Tick as appropriate**		
1	**Stage 1: Scoping the extent, nature and complexity of the Lookback Review**	**Section**	**Yes**	**No**	**N/A**
1.1	Chief Executive notified that a Lookback Review Process may be required	**2.1**			
1.2	Chief Executive or nominated Director has established a Steering Group and Terms of Reference were agreed	**2.2 – 2.4**			
1.3	The Risk Assessment was commissioned by the Steering Group	**2.7**			
1.4	Using the information obtained from the Risk Assessment, the Steering Group made a decision to progress to the Service Review/ Audit and Recall stages of the Lookback Review Process	**2.7 – 2.8**			
1.5	The Chair of the Steering Group has notified the relevant bodies (DoH, HSCB, PHA) of the decision to progress with the Lookback Review Process	**2.9 – 2.10**			
2	**Stage 2: Identifying and Tracing Service Users at Risk**	**Section**	**Yes**	**No**	**N/A**
2.1	The Steering Group agreed the Scope and the Terms of Reference of the Service Review/ Audit and Recall stages of the Lookback Review Process	**3.1**			
2.2	The Steering Group developed a Lookback Review Action/Work Plan to inform the Audit and Recall Stages of the Lookback Review Process	**3 .1 – 3.2**			
2.3	A database was established to collate and track the information gathered by the Lookback Review Process	**3.2 – 3.3**			
2.4	The Service Review/ Audit was undertaken by nominated team or experts commissioned by the Steering Group	**3.4**			
2.5	The Service Review/Audit identified persons affected to be included in the Recall stage	**3.4**			
2.6	The Helpline/ Information Line was established by the Steering Group	**4.2 , 4.5 & Appendix 4**			

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

3	Stage 3: Recall Stage	Section	Yes	No	N/A
3.1	The Recall stage was announced by the relevant Director	**4.3 – 4.4**			
3.2	The Recall stage was announced after persons affected had been informed of their inclusion in the Recall stage of the Lookback Review Process	**4.4**			
3.3	The Recall Team(s) implemented the Recall stage as per the Steering Group Action Plan	**4.1**			
3.4	The Recall Team identified actions to be taken to address any deviations from required standards of care	**4.1**			
3.5	The Recall Team implemented actions and/ or communicated required actions to the Steering Group	**4.1**			
3.6	The Steering Group undertook an evaluation of the Lookback Review Process and developed an anonymised report with recommendations and learning	**5**			
3.7	The Chair of the Steering Group submitted the anonymised report to Chief Executive and relevant external bodies	**5**			

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

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:

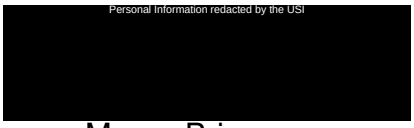
- Initiating a service review;
- Initial planning;
- Establishing patient helplines (staffing, training, record keeping and location);
- Establishing a patient database;

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

- 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

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

From:	DoH Private Office
To:	TEO PS Ministers; Griffith, Deirdre; Wilson, Karen (TEO); Moran, Donal; Magill, Paula
Cc:	Pengelly, Richard; O"Neill, Michael (DoH); Burns, Kim; DoH Private Office
Subject:	SUB-2174-2020 Letter to FMDFM Oral Statement - Urology in SHSCT
Date:	23 November 2020 09:16:23
Attachments:	SUB-2174-2020 Letter to FMDFM Oral Statement.pdf
Importance:	High

Please find attached letter issued on behalf of Minister Robin Swann.

Kindest regards
Suzanne

Suzanne Ferris
Assistant Private Secretary to Robin Swann MLA
Minister for Health
Department of Health
Castle Buildings
Stormont Estate
Belfast BT4 3SQ
Personal Information redacted by the USI
Personal Information redacted by the USI

FROM THE MINISTER OF HEALTH

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

Arlene Foster & Michelle O'Neill
First Minister & Deputy First Minister
The Executive Office
Stormont Castle
BELFAST
BT4 3TT

Castle Buildings
Stormont Estate
BELFAST, BT4 3S
[redacted]
Email: Personal Information redacted by USI

Our ref – SUB-2174-2020

Date: 23 November 2020

Dear Arlene and Michelle

PROPOSED ORAL STATEMENT TO THE ASSEMBLY: CLINICAL CONCERNS WITHIN UROLOGY AT SOUTHERN HEALTH AND SOCIAL CARE TRUST

I am writing to inform you that I intend to make an oral statement to the Assembly on Tuesday 24 November 2020 on clinical concerns within urology at Southern Health and Social Care Trust.

Copies of the statement will be distributed to Members in advance of it being made.

Personal Information redacted by the USI

Robin Swann MLA
Minister of Health

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

From:	DoH Private Office
To:	Assembly Business Office; Private Office Attorney General; DfC Private Office; DfE Private Office; DfI Private Office; DoF Private Office; DOJ Minister"s Office; DOJ Minister"s Office; TEO execomm secretariat; Hansard; Health Committee; Private Office DAERA; Private Office DE; TEO PS Ministers
Cc:	Pengelly, Richard; Meredith, Karina; Gordon, David; DoH SpAd; Burns, Kim; Curran, Lynne; Montgomery, Laverne; Howe, Suzanne; TEO execomm secretariat; Barclay, Suzanne; Cartland, Dan; Coleman, Roisin; Devine, William; DOJ Assembly Section; Goodfellow, Mark; Griffith, Deirdre; Harbinson, Anthony; Jackson, Neill (TEO); Kerr, Kevin; Logan, Tim; Losty, Tim; Magill, Paula; Matchett, Michele; McCoy, Fiona; McDermott, Joanne; McFerran, Jonathan; McFerran, Kathryn; McKibbin, Gail; Moran, Donal; Muldoon, Marie; Stewart, Chris (TEO); TEO HOCS (DS); Thompson, Rosheen; Wilson, Karen (TEO); Wilson, Sarah (DoF); Anderson, Louise; Patterson, Wendy; O"Neill, Michael (DoH); Johnston, Jackie (DoH); DoH Private Office
Subject:	SUB-2174-2020 - Urgent Oral Statement by Minister Swann - Clinical Concerns within Urology at the SHSCT
Date:	24 November 2020 10:01:11
Attachments:	SUB-2174-2020 Letter to Executive Colleagues - Oral Statement.pdf SUB-2174-2020 ORAL STATEMENT TO THE ASSEMBLY - Urology in SHSCT.DOCX
Importance:	High

Please find attached letter issued on behalf of Minister Swann for the attention of your Minister.

Apologies for the lateness in sending the statement but officials have been working on finalising the details and have also been preparing for the Executive meeting this morning.

Please note the statement is embargoed until Minister Swann makes his statement in the Assembly.

Kindest regards
Suzanne

Suzanne Ferris
Assistant Private Secretary to Robin Swann MLA
Minister for Health
Department of Health
Castle Buildings
Stormont Estate
Belfast BT4 3SQ
Personal Information redacted by the USI
Personal Information redacted by the USI

FROM THE MINISTER OF HEALTH

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

FROM: ROBIN SWANN
Minister of Health

Castle Buildings
Stormont Estate
BELFAST, BT4 3SQ
Tel: Personal Information redacted by USI
Email: [redacted]

DATE: 24 NOVEMBER 2020

TO: EXECUTIVE COLLEAGUES

PROPOSED ORAL STATEMENT TO THE ASSEMBLY: CLINICAL CONCERNS WITHIN UROLOGY AT SOUTHERN HEALTH AND SOCIAL CARE TRUST

I am writing to inform you that I intend to make an oral statement to the Assembly on Tuesday 24 November 2020 on clinical concerns within urology at Southern Health and Social Care Trust.

A copy of the statement is attached.

Personal Information redacted by the USI

Robin Swann MLA
Minister of Health

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

From:	DoH Private Office
To:	Personal Information redacted by USI
Cc:	Pengelly, Richard; O"Neill, Michael (DoH); Burns, Kim; DoH Private Office; Patterson, Wendy
Subject:	SUB-2174-2020 Letter to Speaker re Oral Statement - Urology at SHSCT
Date:	23 November 2020 09:13:02
Attachments:	SUB-2174-2020 Letter to Speaker re Oral Statement.pdf
Importance:	High

Please find attached letter issued on behalf of Minister Robin Swann.

Kindest regards
Suzanne

Suzanne Ferris
Assistant Private Secretary to Robin Swann MLA
Minister for Health
Department of Health
Castle Buildings
Stormont Estate
Belfast BT4 3SQ
Personal Information redacted by the USI
Personal Information redacted by the USI

FROM THE MINISTER OF HEALTH

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

Mr Alex Maskey MLA
Speaker
The Speaker's Office
Northern Ireland Assembly
Parliament Buildings
BELFAST
BT4 3XX

Castle Buildings
Stormont Estate
BELFAST, BT4 3SQ
Tel: Personal Information redacted by USI
Personal Information redacted by USI

Our ref: SUB-2174-2020

Date: 23 November 2020

Dear Alex

PROPOSED ORAL STATEMENT TO THE ASSEMBLY: CLINICAL CONCERNS WITHIN UROLOGY AT SOUTHERN HEALTH AND SOCIAL CARE TRUST

In accordance with Standing Order 18B of the Northern Ireland Assembly, I hereby give notice that I intend to make an oral statement to the Assembly on Tuesday 24 November 2020 on clinical concerns within urology at Southern Health and Social Care Trust.

Copies of the statement will be distributed to Members in advance of it being made.

Personal Information redacted by the USI

Robin Swann MLA
Minister of Health

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

From:	Carson, Jane
To:	RQIA - Briege Donaghy
Cc:	May, Peter; Geoghegan, Lourda; Wilkinson, Jim; Davis, Robbie; Dawson, Andrew; Worth, Brigitte; Ruddy, Donna; Bovill, AnneMarie; Ferguson, Paula; Mallon, Bradley
Subject:	RQIA REVIEW OF SOUTHERN HSC TRUST UROLOGY SERVICES AND LOOKBACK REVIEW
Date:	11 August 2022 17:10:42
Attachments:	Letter from Prof Sir Michael McBride to Briege Donaghy - RQIA REVIEW OF SOUTHERN HSC TRUST UROLOGY SERVICES AND LOOKBACK REVIEW.pdf RQIA REVIEW OF SOUTHERN HSC TRUST UROLOGY SERVICES AND LOOKBACK REVIEW - TERMS OF REFERENCE.pdf RQIA REVIEW OF SOUTHERN HSC TRUST UROLOGY SERVICES AND LOOKBACK REVIEW - BACKGROUND.pdf image001.png

Briege

Please see attached letter, with enclosures, from Prof Sir Michael McBride.

Kind regards.

Jane

Jane Carson
Personal Secretary to Prof Sir Michael McBride (Chief Medical Officer)
Room C5.21
Castle Buildings
Stormont Estate
Belfast, BT4 3SQ

Tel: Personal Information redacted by the USI

Stay Home Stay Safe

From the Chief Medical Officer
Prof Sir Michael McBride

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

BY EMAIL

Ms Briege Donaghy
Chief Executive
Regulation and Quality Improvement Authority

Castle Buildings
Stormont Estate
BELFAST
BT4 3SQ
Email: Personal Information redacted by the USI
Tel: Personal Information redacted by the USI

Your Ref:
Our Ref:
Date: 11 August 2022

Dear Briege

RQIA REVIEW OF SOUTHERN HSC TRUST UROLOGY SERVICES AND LOOKBACK REVIEW

I understand discussions between officials from RQIA and the Department of Health (DOH) have taken place regarding the requirement for an independent review of SHSCT Urology Services and Lookback Review, which relates to potential concerns for patient safety. I am writing to formally direct RQIA to undertake this review.

Please find attached a draft Terms of Reference for this work. I also attach some background information which I hope you will find helpful.

Robbie Davis will be in touch as the policy lead contact, to discuss appropriate timeframes and to finalise the Terms of Reference. In the meantime, please do not hesitate to contact Robbie Davis Personal Information redacted by the USI in the first instance if you have any queries.

Yours sincerely

Personal Information redacted by the USI

PROF SIR MICHAEL McBRIDE
Chief Medical Officer

Encs

cc Peter May
Jim Wilkinson
Andrew Dawson
Donna Ruddy
Paula Ferguson
Lourda Geoghegan
Robbie Davis
Brigitte Worth
Anne-Marie Bovill

INVESTORS IN PEOPLE

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry