RECOMMENDATION 1					
The Trust should review the comments made in this report, alongside the local information it holds, and determine if the patient records contain the information they would expect for the patient episode(s). The Trust should ensure that the current practice meet the agreed standards as set out in the RCS England Surgical Care Team Guidance Framework.					
Comments	**Responsible Director**	**Action(s) Required to Deliver Recommendation(s)**	**Target Date**	**Status RAG**	**Evidence of Completion**
A number of audit tools are available to review the content of surgical notes (STAR / e-CRABEL). These tools will be adapted for use in the Trust against the Recommendations in the RCS Report. STAR Surgical Tool for Auditing Records.c The STAR Score - A method for auditing e-CRABEL score.pdf **The Trust would welcome further clarification on the RCS Guidance and which aspects could assist with record standards.** RCS Surgical Care Team Guidance Frame	Service Director	A chart review audit of the patient records will be undertaken using a surgical note audit tool (STAR / e-CRABEL). Learning will be developed from the results of this audit and recommendations implemented as required. **Update 5/6/23** Audit tools relate to patients who had surgery only and not outpatient episodes, therefore, not applicable. Recommendation is for ST to determine if what RCS has in the notes is agreed by ST. Trust to agree who will audit the 100 notes; and if there is adequate information recorded in the notes. A clinician group (does not need to be urologist) to undertake this review, suggestion of the medical leaders group to undertake the review. Estimate 15 minutes review per chart x 100 charts = 1500 minutes (25 hours). Group to draw up practical standards. Action: Consider use of medical leaders group to do this audit. Southern Trust would welcome further clarification on the RCS Guidance and which aspects could assist with record standards – have requested from RCS but no response to date **Update 09/10/23** It should be noted that almost all of these cases have been reviewed using the SCRR process, but a specific audit has not yet taken place. Use of Medical Leaders Group has been considered, but due to the range of specialties (paediatrics, general medicine, anaesthesia, ED, and psychiatry), use of this group would prove challenging in respect of both familiarity with the issues to be considered and also consistency of approach. Additional options will be considered to address this.	Aug 2023		

RECOMMENDATION 2					
The Trust should consider the conclusions of this report, as well as the other information it holds, and on this basis, provide further follow-up of any patients for which it considers this to be required, in particular those patients identified in Section 3.12 of this report. This should protect patient safety and ensure that patients or their families have received communication in line with the responsibilities set out in the Health and Social Care (Reform) Act (Northern Ireland) 2009.					
Comments	**Responsible Director**	**Action(s) Required to Deliver Recommendation(s)**	**Target Date**	**Status RAG**	**Evidence of Completion**
Identify Patients (96) referenced in section 3.1 - 3.12 and ensure follow up provided as required. The Trust has established that a proportion of these reviews have been completed as part of the Trust's Lookback process. Any patients who have not been reviewed under the Lookback process will be reviewed separately. Correspondence were necessary to be drafted for updating patients and families.	Service Director Lookback Team	The Trust is following up on patients were it has considered this is required to maintain patient safety. Relevant communication with these patients is being progressed in line with relevant responsibilities. The Look Back Team have provided details of 35/96 patients known as part of the Urology Lookback Review. The Urology Service to complete the remaining review for the other patients. There are 7 patients noted in section 3.12. 5 of these 7 patients are known to the Lookback Review. • 1 Patient's case is undergoing a Structured Clinical Record Review • 4 Patients are undergoing 1st Level Triage • 2 Patients are not known to the lookback review and are being followed up by the Trust Urology Team 13 Patients are noted in section 3.7 of the report as requiring follow-up care. • 3 Patients' cases have been closed following review with no concerns identified • 5 Patients' cases are awaiting 1st Level Triage • 8 Patients' cases are not known to the lookback and are being followed up by the Trust Urology Team The 96 patient's notes will be reviewed by members of the substantive southern trust team and where follow up is required will be arranged.	Estimate Jan 2024		

		The ability to complete this work will be balanced against the need to meet the current uro-oncology and clinically urgent urological demand from patient referrals to Southern Trust. The current urology team in Southern Trust consists of 3 full time substantive consultants, 1 locum consultant and 2 part time consultants. Current clinical capacity is therefore limited with difficulty managing current clinical demand and against the capacity of the clinical team. Any work to undertake clinical review of the patients identified in the RCS Review will be provided by the same limited clinical resource as listed above. **Updated 5/6/23** The 35 patients with the cohort 1 of the Lookback have all been reviewed and actioned within the Lookback Review process. They are now closed on the Lookback database For the remaining patients - these patients Review backlog has been validated, to determine how many patients are left to be reviewed. **02/10/2023** The Trust is currently working through the 100 patients - estimated to be complete by end of October 23.			

RECOMMENDATIONS OF ROYAL COLLEGE OF SURGEONS UROLOGY SERVICES REVIEW IMPLEMENTATION PLAN 2022

RECOMMENDATION 3					
The Trust should review the consent-taking practices within the urology service to ensure appropriate discussion of risks, complications, benefits and alternatives of treatment takes place and is legibly documented and signed by the surgeon and the patient. Clinical records should clearly detail the giving of information and the decisions made by the **The RCS England good practice guide may be of assistance in this process.**					
Comments	**Responsible Director**	**Action(s) Required to Deliver Recommendation(s)**	**Target Date**	**Status RAG**	**Evidence of Completion**
Trust Policy on 'Gaining Consent' has been reviewed and updated (November 2022) and includes reference to the Montgomery ruling. The new consent policy will apply Trust wide.	Service Director	The consent policy was formally approved by the Trust in January 2023. A communications plan to all staff is being developed by the Trust communications team with launch of the policy and training development currently taking place. Follow up audit of the consent processes in urology will take place 3 months after the implementation of the new consent policy. It is planned that a random sample of urology procedures will be audited. Use of Internal Audit processes are being considered to assist with this audit as part of a wider Trust consent audit. **Update 5/6/23** Describe what the consent process is at present, compare against the Montgomery Ruling; include documentation used. Urology Team to complete – to be added to agenda of Department al meeting. Dr Austin to ask another clinician to review findings when complete **02/10/2023** Added to Urology November Department meeting agenda for update Also to be added to Urology audit plan for 23/24	2023/24 Internal audit cycle		

RECOMMENDATIONS OF ROYAL COLLEGE OF SURGEONS UROLOGY SERVICES REVIEW IMPLEMENTATION PLAN 2022

RECOMMENDATION 4					
In addition to recommendation 3, the Trust should review this sample of records and ensure that there was appropriate informed consent obtained for each procedure or operation.					
Comments	**Responsible Director**	**Action(s) Required to Deliver Recommendation(s)**	**Target Date**	**Status RAG**	**Evidence of Completion**
Audit of the consent process / documentation for the patients identified in the RCS report will be undertaken take place as per Recommendation 3 above.	Service Director	Use of Internal Audit processes are being considered to assist with audit of consent processes as part of a wider Trust consent audit. **Update 5/6/23** Medical clinicians who are reviewing the 100 notes to undertake consent audit **Update 09/10/23** This audit has not taken place to date. See response to Recommendation 1. Alternative proposals to be developed address this	2023/24 Internal audit cycle		

RECOMMENDATIONS OF ROYAL COLLEGE OF SURGEONS UROLOGY SERVICES REVIEW IMPLEMENTATION PLAN 2022

RECOMMENDATION 5					
The Trust should share this report with the wider urological team for the 96 cases reviewed and discuss its contents with them. They should be given the opportunity to reflect on					
Comments	**Responsible Director**	**Action(s) Required to Deliver Recommendation(s)**	**Target Date**	**Status RAG**	**Evidence of Completion**
Report to be shared and discussed at Urology Service patient safety / governance meeting. The urology multidisciplinary team will be encouraged and supported to reflect on the contents of the RCS Report and to identify learning for the service.	Service Director	The RCS Report has been shared with individual consultant urologists. The RCS Report will be formally been shared with the Urology Service Team at the Urology department meeting on 2nd / 9th February 2023. Reflection will be undertaken to develop any additional learning.	09/02/2023		

RECOMMENDATIONS OF ROYAL COLLEGE OF SURGEONS UROLOGY SERVICES REVIEW IMPLEMENTATION PLAN 2022

RECOMMENDATION 6					
The Trust should review the MDT arrangements within the urology service to ensure that there is appropriate MDT input into the decision-making for every patient. All MDT decisions and communication should be adequately documented in each patient's record.					
Comments	**Responsible Director**	**Action(s) Required to Deliver Recommendation(s)**	**Target Date**	**Status RAG**	**Evidence of Completion**
The Trust will undertake a review of patient pathways in Urology with respect to MDT arrangements and decision making using i. Process mapping of the relevant urology oncology MDT pathways ii. Audit of MDT decision making processes, documentation and communication with patients for respective patient records. Existing audit work in this area will be reviewed for additional learning taking account of the recommendations of the RCS report.	Service Director	Process mapping of the MDT patient pathway has been completed. Audits of the MDT Pathways has commenced focussing on MDT attendance / quoracy, cross referencing pathology confirmed cancers to patients discussed at MDT, allocation of Cancer Nurse Specialist as the key worker and spot checks of MDT actions to confirm actions have been progressed. Additional work is ongoing within Cancer Services to further develop the MDT pathway and to develop enhanced methods of assurance relating to decision making for patients. Regional work will be required to further develop regional / specialist MDT arrangements. The Trust will input to this work, but this will be outside the control of the Trust. **<u>Update 5/6/23</u>** Monthly audits up and running for Urology, reviewing 5 cases for MDT per month. This is part of a rolling audit	Jan 2023 Ongoing July / August 2023 Regional timescale		

RECOMMENDATIONS OF ROYAL COLLEGE OF SURGEONS UROLOGY SERVICES REVIEW IMPLEMENTATION PLAN 2022

RECOMMENDATION 7					
It was unclear to the review team whether the MDT meetings that Surgeon 1 attended and chaired, were local urology MDT or specialist urology MDT. The Trust should ensure that complex cancer cases, especially those where major surgery are being considered, should always be discussed at a specialist MDT. In the review team's opinion, these decisions should not be made on a purely local basis.					
Comments	**Responsible Director**	**Action(s) Required to Deliver Recommendation(s)**	**Target Date**	**Status RAG**	**Evidence of Completion**
In line with IOG and NICE defined complex cancer guidance, cases must be discussed at Specialist Urology Cancer MDT. There is a specialist urology cancer MDT and there is clear guidance as to what cases should be discussed. The designation of urology MDT meetings (general or specialist urology MDT) should be recorded against each MDT meeting.	Service Director	Complex urology cancer cases will be discussed at specialist MDT meetings developed on a regional basis with neighbouring HSC Trusts. The designation of urology MDT meetings (general or specialist urology MDT) will be recorded against each MDT meeting. At the time of the RCS Report the specialist renal services had not been commissioned, however, this surgery currently being commissioned now (from 2018). Regional work will be required to further develop regional / specialist MDT arrangements. The Trust will input to this work, but this will be outside the control of the Trust. **<u>Updated 5/6/23</u>** There an audit being undertaken currently. The designation of the MDT meeting is being recorded i.e MDT in Southern Trust (local) or Belfast Trust (regional). **<u>02/10/2023</u>** Cancer - the audit refers to one being conducted by Belfast MDM. MDH to double check re penile and testicular cancers being discussed regionally is addressed as part of this audit. Last update received was that data collection was underway and anticipating the audit to be completed relatively quickly.	Ongoing April 2023 Completed 2018 Regional timescale		

RECOMMENDATIONS OF ROYAL COLLEGE OF SURGEONS UROLOGY SERVICES REVIEW IMPLEMENTATION PLAN 2022

RECOMMENDATION 8					
In addition to recommendations 6 and 7, the Trust should consider whether there are sufficient safeguards in place to monitor clinical decisions made at MDT meetings and to ensure that recommendations are appropriately carried out.					
Comments	**Responsible Director**	**Action(s) Required to Deliver Recommendation(s)**	**Target Date**	**Status RAG**	**Evidence of Completion**
The Trust will review current and develop additional safeguard processes as required to ensure that clinical decisions made at MDT meetings are enacted and that processes are in place to monitor and audit the implementation of clinical decisions arising from the MDT.	Service Director	Process mapping of the MDT patient pathway has been completed. Additional resource is now in place to carry out audits of actions taken at MDT. Recognising the number of patients presented at MDTs each week and the number being actively tracked at any time, these audits will initially be spot checks across all local MDTs. Further resource will be put in place to increase the number of checks completed weekly. **Update 5/6/23** Sample of MDT prostate and bladder outcomes to check if management plan is as per NICE guidance Audit to be undertaken twice yearly **Update 03/10/23** Monthly MDT outcomes audit report i.e sample of 5 patients outcomes are audited on a monthly basis and reports of this are shared with Urology MDT Lead, Urology Service Management and Cancer services management teams. To date there have been no issues identified.	Jan 2023 August 2023		

RECOMMENDATIONS OF ROYAL COLLEGE OF SURGEONS UROLOGY SERVICES REVIEW IMPLEMENTATION PLAN 2022

RECOMMENDATION 9					
The Trust should consider whether there are sufficient safeguards in place within the electronic system to identify priority clinical decisions which needs escalation.					
Comments	**Responsible Director**	**Action(s) Required to Deliver Recommendation(s)**	**Target Date**	**Status RAG**	**Evidence of Completion**
Current NIECR development has been frozen due to implementation of Encompass, with implementation in the Trust scheduled for 2025. Any adjustments to current computerized systems will be either not possible or very challenging to implement.	Service Director	The Trust will review existing electronic systems (eg NIECR) to identify if sufficient safeguards are in place to identify priority clinical decisions and thereafter consider resolution of any deficiencies identified. As part of the review from recommendation 8, other systems will be put in place as required. **Update 5/6/23** RCS to clarify 'electronic system' – do they mean CaPPs? Clarify role of cancer Trackers for onward escalations/recording on CaPPs , escalation to oncology **Update 09/10/23** Cancer Trackers are in place to expedite care provided to individual patients – this only covers patients on cancer pathways. Further work to be progressed to address this more comprehensively.	Aug 2024		

RECOMMENDATIONS OF ROYAL COLLEGE OF SURGEONS UROLOGY SERVICES REVIEW IMPLEMENTATION PLAN 2022

RECOMMENDATION 10					
The Trust should review the adequacy of clinical correspondence following clinical decisions being made, and whether they are checked and followed up to ensure actions are subsequently carried out.					
Comments	**Responsible Director**	**Action(s) Required to Deliver Recommendation(s)**	**Target Date**	**Status RAG**	**Evidence of Completion**
No systems are currently in place to review all clinical correspondence and to check that all actions arising from clinical correspondence have been implemented, mainly due to manual paper based systems and lack of implementation of an EMR system in Northern Ireland. To provide such a system will require significant investment. The Encompass programme (full EMR) for NI is due to be implemented in the five HSC Trusts over the next 1-2 years coming to the Trust in 2025. This should facilitate better follow of actions arising from clinical correspondence as this will be built directly into the system.	Service Director	An audit of clinical correspondence and decisions arising from that correspondence will be undertaken. A phased audit approach will be developed to include three strands of audit in relation to multidisciplinary review actions as below: 1. Audit MDT recommendation implementation 2. Audit of Clinical correspondence 3. Audit of Discharge letters Standards to use as parameters to be agreed. **<u>Update 5/6/23</u>** It is standard practice that the Urology team dictate correspondence to GP / other Healthcare professional (HCP) after every MDT encounter. Their support teams ensure the actions are carried out	Dec 2023		

RECOMMENDATIONS OF ROYAL COLLEGE OF SURGEONS UROLOGY SERVICES REVIEW IMPLEMENTATION PLAN 2022

RECOMMENDATION 11					
The Trust should review the sufficiency of waiting list processes, ensuring that waiting lists are monitored and ideally shared by all consultants who do the same procedures. In addition, the Trust should review what priority is given to certain procedures, who checks waiting lists, and what the criteria is for assigning priority to operations.					
Comments	**Responsible Director**	**Action(s) Required to Deliver Recommendation(s)**	**Target Date**	**Status RAG**	**Evidence of Completion**
Prioritisation of operations in NI is undertaken by a regional system of categorization from P1 to P5 (similar to that used during Covid). Due to limited resources in NI and the Trust and across NI, patients are prioritised so that in effect only Priority 2 are being scheduled for surgery. Urological waiting lists are extensive in the Trust and regionally, only treating P2 patients on the elective theatre lists. Due to volume of patients waiting, it would be impractical to review each patient at the present time. A briefing paper to implement an Urology Scheduler is completed and is awaiting funding consideration.	Service Director	The Trust has developed a business case for an Urology Scheduler system to assist with waiting list management. This is awaiting consideration for funding. A review of scheduling and booking processes for surgery (and prioritisation) commencing with Urology will be undertaken in order to enhance administrative processes based on clinical priority. The Trust will explore development of pooled waiting lists within the wider urology surgical team. An audit of private practice patient change of status from the private sector to the HSC will be undertaken to provide assurance that appropriate priority placement of private patients on waiting lists is occurring. This will be incorporated into the Internal Audit work plan for 2024/25. Internal audit to be engaged in the annual Trust Internal Audit plan to undertake a comprehensive independent audit of processes for waiting lists and prioritisation of patients on waiting lists. **<u>Update 5/6/23</u>** The Urology Scheduler position is with finance for sign off, once approved then with BSO for recruitment **<u>Updated 2/10/23</u>** Urology Scheduler in post from 11/09/2023	Pending Funding August 2023 August 2023 April 2025 April 2025		

RECOMMENDATIONS OF ROYAL COLLEGE OF SURGEONS UROLOGY SERVICES REVIEW IMPLEMENTATION PLAN 2022

RECOMMENDATION 12					
The Trust should ensure immediate recognition amongst management and clinicians that no patient should wait for longer than a pre-agreed period for surgery and follow up. The management of each case should be consistent with the surgeon's own standards for how they would like to be treated.					
Comments	**Responsible Director**	**Action(s) Required to Deliver Recommendation(s)**	**Target Date**	**Status RAG**	**Evidence of Completion**
The Trust seeks to maintain safe care is maintained by ensuring patients do not wait longer than pre-agreed periods for surgery and follow-up however limited action can be taken due Northern Ireland's regional issues pertaining to waiting list management. In practice, this is unachievable due to capacity issues across Northern Ireland.	Service Director Medical Director	The commissioning system within N.I means that each speciality is commissioned to provide a level of service: beyond that level there is no funding or capacity to see and treat patients. This risk will be articulated clearly in the Trust Risk Register(s). **Update 5/6/23** No update due to resource issues **Update 9/10/23** No change in the current funding position in Northern Ireland. GIRFT Review of Urology services for Northern Ireland has taken place with opportunities identified for reconfiguration of care on a regional basis which should impact to some extent on waiting lists when implemented. The final GIRFT report remains awaited.	April 2023		

RECOMMENDATIONS OF ROYAL COLLEGE OF SURGEONS UROLOGY SERVICES REVIEW IMPLEMENTATION PLAN 2022

RECOMMENDATION 13					
The Trust should improve the quality of record keeping in clinical records. This should include but is not limited to: **(iii) More detail in clinic notes and letters, which should document the reasoning and evidence for clinical decisions. This should include details of MDT discussions;** **(vii) Clinical correspondence, radiology reports and investigation results.**					
Comments	**Responsible Director**	**Action(s) Required to Deliver Recommendation(s)**	**Target Date**	**Status RAG**	**Evidence of Completion**
Core standards for record keeping will be reviewed and additional guidance developed to incorporate the factors listed in this recommendation.	Medical Director	Regular audits of the quality of clinical notes will be undertaken using standardized tools (RCP tool). Implementation of Encompass will facilitate improved record keeping. **<u>Update 5/6/23</u>** Check with Fiona, Audit Manager re record keeping is on the Urology audit plan for 23/24 Action: Head of Service **<u>02/10/2023</u>** Record keeping is not on the urology audit plan for 23/24 - audit plan to be reviewed to ascertain if there is capacity to undertake audit	April 2024 Dec 2025		

RECOMMENDATIONS OF ROYAL COLLEGE OF SURGEONS UROLOGY SERVICES REVIEW IMPLEMENTATION PLAN 2022

RECOMMENDATION 14					
The Trust should audit the standard of clinical documentation to ensure there are contemporaneous and comprehensive notes of patient care at each stage of the surgical pathway.					
Comments	**Responsible Director**	**Action(s) Required to Deliver Recommendation(s)**	**Target Date**	**Status RAG**	**Evidence of Completion**
The Trust will under audit of the surgical urology patient pathway to assess the standard of clinical documentation using the *Surgery Tool for Auditing Records* (STAR) audit tool.	Service Director	Urology audits (as above) will be rolled out to other surgical specialities within the Trust. See Recommendation 13.	Aug 2024		

RECOMMENDATIONS OF ROYAL COLLEGE OF SURGEONS UROLOGY SERVICES REVIEW IMPLEMENTATION PLAN 2022

RECOMMENDATION 15					
The Trust should consider whether there are recurring issues within the electronic patient record system, and whether there are sufficient safeguards for administrative staff to					
Comments	**Responsible Director**	**Action(s) Required to Deliver Recommendation(s)**	**Target Date**	**Status RAG**	**Evidence of Completion**
The Trust to continue work with BSO to link dictation to electronic systems to increase safeguards. This will include system testing to ensure recommendation is met. During the implementation work for the NI encompass programme, work will be undertaken to ensure that audit of correspondence can be undertaken.	Performance Director	The Trust will consider current processes within medical records to identify and escalate missing correspondence. Implementation of Encompass will facilitate improved record keeping and tracking of correspondence. **<u>Update 5/6/23 & 5/10/23</u>** Monthly meeting with Urology Managers / administrative team when outstanding dictation is discussed and actions undertaken. SOP for administrative staff when dictation is not undertaken Southern Trust encompass implementation is estimated April 2025 Unable to update further until encompass is implemented**.**	April 2024 Dec 2025		

RECOMMENDATIONS OF ROYAL COLLEGE OF SURGEONS UROLOGY SERVICES REVIEW IMPLEMENTATION PLAN 2022

RECOMMENDATION 16					
The Trust should ensure there are safeguards in place to monitor decisions made during follow-up appointments and to identify and escalate missing correspondence from outpatient clinics.					
Comments	**Responsible Director**	**Action(s) Required to Deliver Recommendation(s)**	**Target Date**	**Status RAG**	**Evidence of Completion**
There is no timescale for the clinical staff re completion of dictation after OPD. There is currently no safe guarding process in place to monitor decisions made during follow up appointment. Further to this, there is a requirement to undertake an appropriate audit and action plan that can adequately provide assurance and monitoring that decisions made are adequately followed up.	Performance Director	**Update 5/6/23** **– see response to recommendation 15** In terms the escalation of missing correspondence, this will require testing of recent developments between BSO and IT department which looks to link the digital dictation/ system to patient administration system. This will aim to directly link outpatient attendance to creation of electronic document which would be approved and sent via electronic document transfer directly to GP practice. The Trust will review secretarial systems regarding secretarial responsibility for flagging that there is no dictation undertaken after outpatient clinic. A process to escalate missing correspondence from outpatient clinics will be required to be identified. Implementation of Encompass will facilitate improved record keeping and tracking of correspondence.	Aug 2024 Dec 2025		

RECOMMENDATIONS OF ROYAL COLLEGE OF SURGEONS UROLOGY SERVICES REVIEW IMPLEMENTATION PLAN 2022

RECOMMENDATION 17					
The Trust should ensure there are systems in place to monitor that letters are written and sent out to patients and their GPs after each clinic visit.					
Comments	**Responsible Director**	**Action(s) Required to Deliver Recommendation(s)**	**Target Date**	**Status RAG**	**Evidence of Completion**
The NICE Shared Decision Making Guideline NG197 highlights the issue of letters written to patients and GPs, particular section 1.2.20 which suggests writing to patients and copying to the relevant health professional. This is not standard practice within Northern Ireland.	Medical Director	Work is ongoing across the Trust to implement this aspect of NG197 (write to patients with copies sent to GPs). **Update 5/6/23** Expectation of standard that patients receive a letter following consultation **Update 9/10/23** Implementation of NICE NG 197 Shared Decision Making is proceeding in Southern Trust and across Northern Ireland. This incorporates specific guidance on writing to patients. Sending letters to patients is reviewed but work is ongoing to develop more robust systems in the Trust to improve monitoring.	April 2024		

The Regulation and Quality Improvement Authority

RQIA Review of the Urology Structured Case Record Review Southern Health and Social Care Trust

September 2022

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority (RQIA) is the independent body responsible for regulating, inspecting and reviewing the quality and availability of health and social care services in Northern Ireland. RQIA's reviews identify best practice, highlight gaps or shortfalls in services requiring improvement and protect the public interest. Reviews are supported by a core team of staff and by independent assessors, who are either experienced practitioners or experts by experience. Our reports are submitted to the Minister for Health and are available on our website at www.rqia.org.uk.

RQIA is committed to conducting inspections and reviews, taking into consideration our four key domains:

- Is care safe?
- Is care effective?
- Is care compassionate?
- Is the service well-led?

Membership of the Expert Review Team

Professor Aneez Esmail	Professor of General Practice (Emeritus), Centre for Primary Care and Health Services Research, University of Manchester
Mr Hall Graham	Professional Advisor, Regulation and Quality Improvement Authority
Dr Leanne Morgan	Clinical Lead, Regulation and Quality Improvement Authority
Mr Brian O'Hagan	Lay Representative and Independent Expert Advisor to the review

Membership of the Project Team

Mr Hall Graham	Professional Advisor, Regulation and Quality Improvement Authority
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Emer Hopkins	Interim Director of Improvement, RQIA
Dr Leanne Morgan	Clinical Lead, RQIA

Contents

Section 1 Introduction

1.1 Background and Context

On 31 July 2020, the Southern Health and Social Care Trust (SHSCT) contacted the Department of Health (DoH) to report an early alert concerning the clinical practice of a Urology Consultant (referred to in this report as Consultant A).

An initial review, which considered cases over an 18-month period of the consultant's work in SHSCT from 1 January 2019 to 30 June 2020, focussed 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 review 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[i]. The findings were significant and led the Minister for Health, Robin Swann MLA, to announce on 24 November 2020 that a statutory public inquiry would be established under the Inquiries Act 2005. The Urology Services Inquiry, which is currently ongoing, is chaired by Ms Christine Smith QC.

In parallel, yet separate, to the work of the public inquiry, SHSCT subsequently established a review group to assess the further findings of the initial review exercise and to explore the need for a further look-back review in the context of additional concerns.

Areas of concern were identified 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.

Nine cases were identified that met the threshold for a Serious Adverse Incident (SAI) review. Following the completion of these initial nine SAI reviews in 2021, the Trust was advised by DoH that the SAI process should not be used to review subsequent potential issues in care identified by the lookback process.

As a result, SHSCT developed a Structured Case Record Review (SCRR) process based on the Structured Judgement Review methodology as developed by the Royal College of Physicians. The aim of the SCRR process was to identify any areas of learning where patient safety could be improved.

In March 2022 SHSCT asked RQIA to undertake:

[i] Ministerial Statement by Health Minister to the Northern Ireland Assembly, 24th November 2020

- A review of the choice of Structured Judgement Review methodology to underpin their SCRR process.
- A review of the Trust SCRR process in relation to its effectiveness in identifying learning.

It was further agreed that, in the event that the SCRR process was not considered to be appropriate the Trust would like RQIA to suggest an alternative approach.

1.2 Terms of Reference

Although RQIA was requested to review the suitability of the Trust's SCRR process, we considered that the scope of the review should be wider. It would not be appropriate to only assess the tools involved but we should also assess the surrounding process within which the SCRR operates. Therefore the following Terms of Reference were agreed with SHSCT.

1. To assess the suitability of the Structured Judgement Review methodology as the basis for the Trust SCRR process.

2. To assess the specific Trust SCRR methodology in relation to its effectiveness in identifying learning.

3. To assess the overall trust process/framework for conduct of its record review.

4. To make recommendations in relation to the overall process and if the SCRR process is not considered to be appropriate suggest an alternative approach.

1.3 Review Methodology

RQIA used a PRINCE project management approach to underpin this review. The review utilised a range of methodologies to obtain supporting information to inform our assessment:

- We undertook a review of the literature around the use of the Structured Judgement Review Method to help identify key themes and areas of focus.
- We designed and issued structured questionnaires to the Southern Health and Social Care Trust.
- We analysed information returned to us and used this to develop Key Lines of Enquiry for meetings with the Trust.
- Our Expert Review Team (ERT) conducted focus groups and meetings with the independent panel of reviewers, senior staff and other relevant staff from the Trust.
- We analysed the information gathered through our structured pre review questionnaires, meetings, focus groups and staff questionnaire responses in order to determine our key findings and recommendations.

Section 2 Findings

In assessing the effectiveness of all aspects of the SCRR process we considered the overall process in respect of a number of component parts.

2.1 OVERALL TRUST PROCESS AND FRAMEWORK FOR SCRR

2.1.1 Background to the Structured Case Record Review

The provision of background and contextual information is vital to the understanding of the rationale and purpose of the Structured Clinical Records Review process. This information was provided by SHSCT, in conjunction with a Structured Case Review proposal document and was explored further by the Expert Review Team during fieldwork sessions with Trust representatives.

During fieldwork, the Expert Review Team heard how the Inquiry was announced unexpectedly in November 2020 during what was a difficult time for SHSCT, when it was grappling not just with the emerging issues within Urology Services but also with the COVID-19 pandemic and its associated pressures for service; this contextual information provided the Expert Review Team with a valuable insight into the challenges faced. At the point of announcement of the Inquiry Terms of Reference (see Appendix 1) SHSCT had already commenced a Lookback Review and through this had identified a significant number of patients meeting the threshold for an SAI review under the regional SAI procedure[1].

Due to the volume of patients identified, the time and resource required to progress SAI reviews, and the limited additional value of repeatedly reviewing the same type of incident via the SAI process, it was suggested that an alternative methodology is used to derive learning from these cases. The decision to use the SCRR approach, as an alternative to SAI methodology, was taken in conjunction with SPPG and DoH's Urology Assurance Group. The Expert Review Team considers that this decision was the correct one, and that Structured Judgement Reviews methodology, such as that developed by the Royal College of Physicians, is a robust method of assessing the quality of care and treatment of individual cases, when applied as intended. As such, the Expert Review Team endorses the decision to adopt an alternative approach to undertaking repeated SAI reviews in such circumstances.

Although the decision to proceed with the SCRR was taken prior to the announcement of the Public Inquiry, the Expert Review Team noted that SHSCT continually referenced the SCRR process within the context of their broader work to meet the requirements of the Inquiry. However, the Expert Review Team considers that the Inquiry and the SCRR are separate processes.

The Inquiry is an independent statutory process, supported by underpinning legislation, to deliver on its Terms of Reference; whereas the SCRR is a Trust and DoH-initiated process to establish themes of learning with a view to improving Trust systems to reduce the likelihood of similar incidents happening in the future. Whilst running in parallel to the Inquiry, the SCRR should not be influenced by the Inquiry's agenda or timescales, but instead should be focused on the need to derive learning and implement the necessary improvement.

During fieldwork, Trust representatives accurately described this distinction between the differing roles and purposes of the Inquiry and SCRR, the relationship between the differing processes and the arrangements for sharing information with the Inquiry Team. However, upon reviewing Trust documentation, although the rationale for the SCRR is clearly stated, the Expert Review Team identified a lack of clear documentation explaining the role, purpose and remit of the SCRR and, in particular, that it is an entirely separate process to the Inquiry.

Similarly, SHSCT SCRR documentation does not make clear whether the cases selected for SCRR are being reviewed on behalf of the Inquiry, or whether all or some of these cases could be subject to a second review by the Inquiry team, and whether patients and families are aware of the potential for conflicting findings. This is likely to cause confusion since the Inquiry Terms of Reference (ToR) include:

> (c) To examine the clinical aspect of the cases identified by the date of commencement of the Inquiry as meeting the threshold for a Serious Adverse Incident (SAI) and any further cases which the Inquiry considers appropriate, in order to provide a comprehensive report of findings related to the governance of patient care and safety within SHSCT's urology specialty.

The Expert Review Team considered that, although Trust representatives demonstrated a good understanding of the distinction between these two processes, which is further mitigated by the fact that at the time of drafting this report, the Inquiry methodology for ToR (c) has not yet been announced, and the patient / family information materials and Trust documentation require improvement. In the current format, the versions provided to the Expert Review Team do not fully and accurately inform patients and families and, thus, have the potential to inadvertently cause confusion and compound anxiety and distress.

We were informed that SHSCT, in light of recent criticism regarding factually inaccurate information contained in patient letters, regarding the Inquiry's purpose, has sought to improve the clarity and accuracy of documentation. The Expert Review Team was provided with a copy of a "Patient Letters Investigation" report which outline a thorough investigation undertaken by an experienced Director independent from the SHSCT and is accompanied by a number of sensible recommendations. The Expert Review Team commends this report and welcomes these improvement efforts. In addition to these, the Expert Review Team is of the view that SHSCT would benefit from improving their systems for developing and quality assuring patient / family information or indeed any documentation that is publicly accessible or likely to enter the public domain. Such arrangements should include the involvement of a lay person / service user representative and those with communications expertise within SHSCT. Where there is a pending or ongoing Public Inquiry, legal input should also be considered.

Recommendation 1

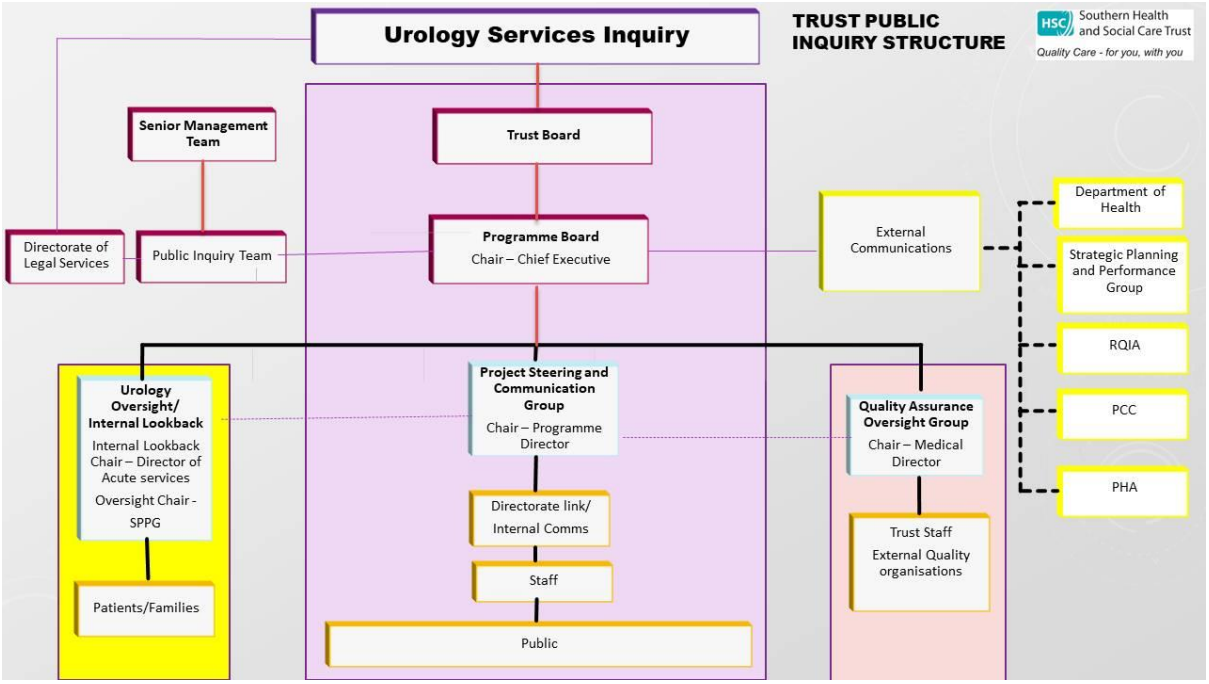
SHSCT should urgently update all relevant documentation to ensure that there is clarity regarding the SCRR including a description of the SCRR purpose, remit and process; explicitly stating that it is a separate process to any parallel Inquiries or investigations.

SHSCT should review their arrangements for developing and quality assuring patient / family information materials and publicly accessible information to ensure there is adequate lay / service user involvement, communications expertise and, where beneficial, legal input.

2.1.2 Review Structure

Robust structures are essential for ensuring effective delivery, assurance and accountability. SHSCT provided details of the Review Structure and advised that the SCRR process sits within its current Trust governance structures.

Figure 1. Current Review Structure



We were informed that the Review Structure is presently overseen by SHSCT Internal Urology Lookback Group. SHSCT Public Inquiry Programme Board is chaired by the Chief Executive. The Programme Board members act on behalf of SHSCT Board to oversee the work of the:

- Public Inquiry Response and Communications Group;
- Public Inquiry Urology Oversight / Lookback Steering Group; and
- Quality Assurance and Improvement Oversight Group

The Lookback Review is included on the Corporate and Acute Services Risk Registers. External oversight of the process is provided by the fortnightly Service

Planning and Performance Group (SPPG) Meeting and Department of Health led Urology Oversight Group.

ToR were provided for the Public Inquiry Programme Board, Trust Internal Urology Lookback Group and Health and Social Care Board[ii] (HSCB) Urology Group. The Expert Review Team noted the broad remit of oversight and co-ordination groups and considered that some of the committees were very large, with overlapping membership. The Expert Review Team noted that the composition of the Lookback Review Steering Group (referred to as the Urology Oversight / Internal Lookback Group) does not reflect the Regional Guidance for Implementing a Lookback Review Process (July 2021)[2] which suggests inclusion of:

> "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, representatives with expertise Public Health Agency (PHA) representative and an Health and Social Care Board (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."

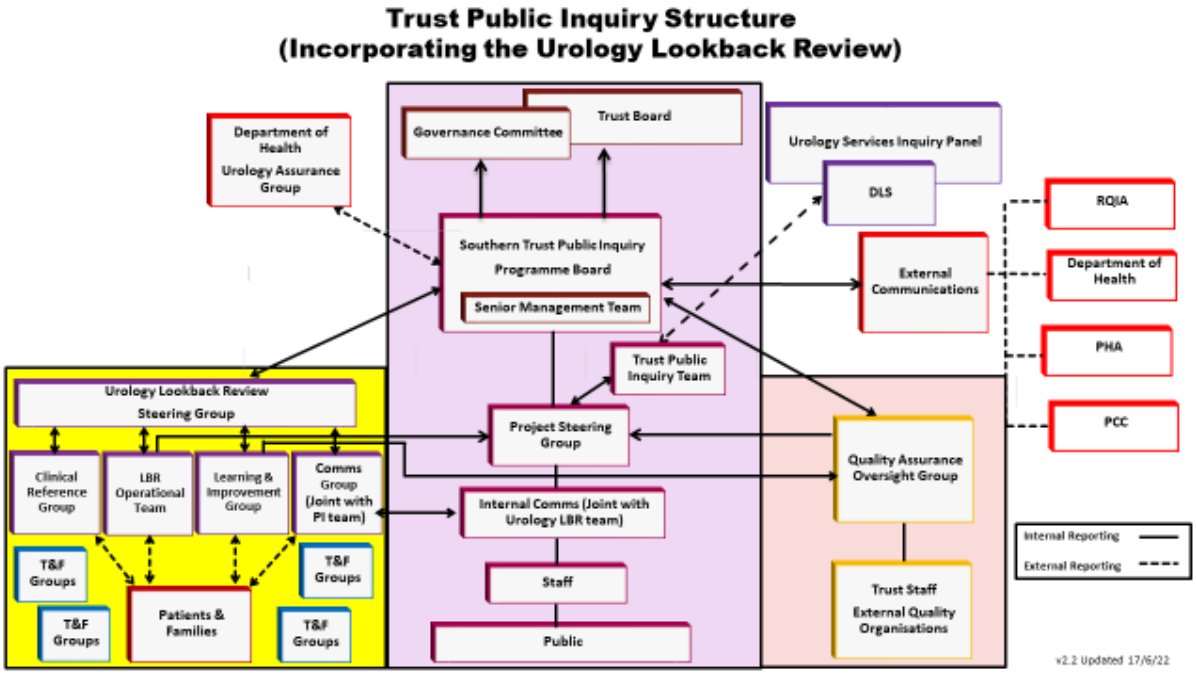
The Expert Review Team acknowledged the challenges and sensitivities of including a service user / advocacy representative who has been impacted by or has a vested interest in the matter of concern. However the inclusion of a lay member, not impacted by SHSCT Urology concerns, but nonetheless with previous experience of representing the interests of service users / the public on similar pieces of work, can be hugely valuable and should be considered by SHSCT. The benefits include enhanced public confidence in the process, improved adherence to the statutory duty of Personal Public Involvement (PPI), provision of advice on patient / family / public messaging and on the fulfilment of a duty of candour.

The Expert Review Team considered that there was a lack of clarity surrounding leadership / responsibility and arrangements for accountability and reporting. During fieldwork, we were advised that the Chief Executive has ultimate accountability for the SCRR and that recent work had been undertaken to improve oversight, reporting and ensure clear lines of accountability. This resulted in a proposed new structure for oversight of the SCRR process. The Expert Review Team is of the view that any new structure should also be designed to support SHSCT to fulfil its responsibilities in respect of all Urology work, to deliver on SCRR objectives and should avoid creating unnecessary duplication or complexity.

The Expert Review Team was informed that the new structure exists in shadow form at present with the Operational Team being chaired by the seconded Director in a holding position until the new Director responsible for surgery takes up post.

[ii]The Health and Social Care Board was replaced by the Service Planning and Performance Group (SPPG) April 2022.

Figure 2. Proposed New Review Structure (draft document at the time of the Review)



Although the Expert Review Team welcomes improvements to the overarching review structure, it is of the view that, given the sizeable undertaking and complexity of the work, the operational arrangements for management and co-ordination of the SCRR and potentially the Lookback Review itself, would benefit from the establishment of a dedicated project team. It was noted that one individual was seconded from another Trust to support SHSCT with its work and this was a welcome development; however, no other Trust representative attending the fieldwork sessions reported having experience of conducting Lookback Reviews. This represents a considerable lack of skill and experience, which can occur when there has been recent turnover or change within the management structures of an organisation. In light of this shortfall, the dedicated project team should include people with previous experience in undertaking similar work, who can draw upon a wide network of 'critical friends' to provide support, advice and guidance.

Recommendation 2

SHSCT should consider reviewing the composition of Lookback Review steering group to reflect that which is stated within Regional Guidance for Implementing a Lookback Review Process; in particular, consideration should be given to the inclusion of a lay representative.

SHSCT should establish a dedicated project team for the management and co-ordination of SCRR. SHSCT should recruit people with the skills and experience who, if required, can seek the advice and guidance of experts from across the region.

2.1.3 Project Management

Effective project management is crucial in ensuring a well-co-ordinated delivery of objectives within acceptable timescales; this is best implemented with the support of a project manager accredited in using validated project management methodology such as PRINCE / PRINCE 2.

SHSCT SCRR project is currently managed as a sub-workstream of SHSCT corporate lookback process rather than by an individual with project management expertise supported by dedicated project team. Furthermore, the process does not use a specific project management methodology and has followed an iterative approach in terms of its design, signoff and deployment.

To ensure identified project actions are undertaken, minutes are kept of screening and lookback meetings and these are carried forward into future meetings. Individual case records for SCRR are tracked to the relevant Expert Reviewer; ensuring updates can be sought on progress.

The Expert Review Team considered that, whilst these arrangements might suffice for small numbers of cases, they are not sufficiently robust for managing a large volume of work. The Expert Review Team is of the view that a dedicated project team for the co-ordination and management of the Lookback Review and SCRR process, should include a Project Manager; ideally such an individual should have previous experience in managing a Lookback Review or, in the absence of previous experience, should have an understanding of the process and should be supported by a network of people who have the requisite skills and expertise.

The Expert Review Team was advised that a proposal paper outlining an updated Lookback Review structure, process and accountability has been submitted to SHSCT Programme Board. In this paper it states that the Urology Lookback Review is a project and should be constructed as such in terms of purpose, ToRs, reporting lines, risk register etc., including the identification of / clarity on who is the Senior Reporting Officer (SRO) for the project; suggesting this should sit at Director level.

SHSCT further advised that this includes a review of the associated Project Management arrangements in order to ensure that the project progresses swiftly and with clear accountability. The Expert Review Team welcomes this approach.

Recommendation 3

Considering the need for dedicated co-ordination and management of the Lookback Review and the SCRR process; SHSCT should prioritise the appointment of a suitably qualified Project Manager.

2.1.4 Terms of Reference / Objectives of the SCRR

A clear Terms of Reference (ToR) or, in lieu of a ToR, a set of specific objectives serves to focus the minds of those undertaking the Structured Clinical Record Review process on the purpose, remit and what needs to be achieved during the

course of the process. Providing a framework for monitoring progress and accountability for delivery, it is also helpful in communicating the scope of work in a clear, open and transparent way; a Terms of Reference can also assist in conveying information about the process to interested parties, such as DoH, SPPG / PHA, Health and Social Care (HSC) Trusts, patients / families / carers and the public.

Unfortunately, there were no ToR / Objectives provided by SHSCT relating to the SCRR process itself. The Expert Review Team considers that a ToR should be drafted and agreed as soon as possible. Trust representatives were keen that this should adequately convey the clinical elements of the SCRR.

In light of this, a possible ToR could include:

1. To assess the quality of care and treatment provided by Consultant A, using Structured Judgement Review methodology which gives specific consideration to the following:

- Triage;
- Initial assessment;
- Diagnostic investigations;
- Outpatient care;
- Inpatient care;
- Perioperative care;
- Care during any medical or surgical procedure (excluding IV cannulation);
- Communication with colleagues, MDT and primary care;
- Communication with patient and families; and
- Discharge plan and follow-up arrangements.

2. To review the findings of the individual Structured Judgement Reviews and produce a thematic analysis report.

3. To identify learning and make recommendations for improvement.

The Expert Review Team also considered that it would helpful for SHSCT to explicitly state the purpose of the SCRR. It is referenced within the Review Methodology Section of the proposal document provided by SHSCT that “the objective of the SJR method is to look for strengths and weaknesses in the caring process, to provide information about what can be learnt about the hospital systems where care goes well and to identify points where there may be gaps, problems or difficulty in the care process”. This is closely aligned to the purpose of the SCRR, which is ultimately for SHSCT to define, but may best be described as serving “to assess the quality of care and treatment, in order to identify learning and implement improvement”. Clearly setting out the purpose in this way would also help to differentiate the SCRR from the Inquiry.

Recommendation 4

SHSCT should define and explicitly state the purpose of the SCRR process. Furthermore, a clear Terms of Reference / set of objectives should be agreed and referenced within the relevant Trust documentation.

2.1.5 Time period for inclusion of cases for SCRR

All cases reviewed as part of the current Lookback Review undergo screening for consideration for inclusion in the SCRR process; those meeting the SAI threshold are 'screened in'. The scope of the Lookback Review pertains to all patients that were under the care of Consultant A during the time period 1 January 2019 – 30 June 2020. The Expert Review Team explored the rationale for this time period with Trust representatives. When concerns first came to light, this period was chosen as it was believed that this was when patients were most at risk from aberrant clinical practice.

The Expert Review Team acknowledges that no lookback exercise can review all cases at once, that there has to be a starting point, and that a phased approach is preferable in order to expedite learning and facilitate reflection; furthermore, to start with those patients identified as being most at risk is sensible, justified and in keeping with regional guidance. However, the Expert Review Team was informed that since then, it has been identified, by examination of historical care through the Patient Casenote Review process, that patients treated by Consultant A prior to 2019 may also have received substandard care. This is unsurprising; it is the Expert Review Team's experience that problems with a clinician's practice tend to be longstanding and not restricted to a particular period of time. We were advised that in light of this finding, the Royal College of Surgeons (RCS) is currently undertaking a review of a sample of 100 cases from 2015 in order to identify whether there were problems present at this stage

The Expert Review Team is of the view that if there is already enough evidence to inform a risk assessment that patient groups receiving treatment prior to 2019 are at risk of harm, SHSCT should not wait for the RCS work to conclude and should proceed as a matter of urgency to extend their Lookback Review to identify and recall at risk patients under the care of Consultant A prior to 2019. This can be done using a phased, risk-stratified approach based on the learning gathered to date. It can then be extended and scaled up further, following receipt of the RCS findings, should this be required. However, regardless of the approach adopted, given the risk posed to live patients, it is imperative that a further phase of the Lookback is commenced as a matter of priority.

Since this is likely to be a considerable undertaking, requiring suitable expertise to offer advice and guidance, it is vital that SHSCT is adequately supported by its partners across the HSC system, including DoH/ Urology Assurance Group / SPPG and PHA. As this work is scaled up, an independent assessment of the current Urology Lookback Review arrangements would serve to provide assurance regarding its effectiveness and identify any areas that need strengthened; this assessment could be undertaken by RQIA as a 'Part 2' to this review of the SCRR. Assurance of the current lookback arrangements would serve to strengthen the

foundations in place for extending the time period and scaling up to include additional patient subgroups.

Recommendation 5

SHSCT should give urgent consideration to extending their Lookback Review to identify and recall further groups of patients. DoH / Urology Assurance Group / SPPG, PHA and RQIA should work together to support SHSCT with the Lookback Review.

RQIA should consider undertaking an independent assessment of Trust arrangements for the Urology Lookback Review in order to provide assurance on its effectiveness and identify any areas for improvement.

As there is a need to prioritise the Lookback Review, to ensure that patients at risk are promptly reviewed and that ongoing care and treatment is arranged, it may be preferable for an external body, such as the Royal College of Physicians, to undertake the SCRR on behalf of SHSCT. Not only would this allow Trust teams to focus on the Lookback Review whilst maintaining a safe level of care provision for its current and new patients, it would mean that the SCRR is conducted by an independent organisation that has the requisite expertise, governance structures, well tested processes and quality assurance mechanisms in place to support this type of work; consequently, the output may be more expedient and performed to a higher standard. However, the Expert Review Team acknowledges that commissioning an independent body may not be possible either due to a lack of agreement, resources or time, in which case the recommendations outlined in this report should support SHSCT itself to facilitate the SCRR.

Recommendation 6

SHSCT should consider commissioning an independent body to undertake the SCRR process on its behalf.

2.1.6 Case selection

Appropriate case selection is important to ensure effective use of time and resources, which should be prioritised towards cases where there is likely to be learning.

During fieldwork, Trust representatives outlined the process for case selection. All service users who were under the care of Consultant A between January 2019 and June 2020 were reviewed using a 10-question Patient Review form either internally by SHSCT or an external consultant urologist commissioned for this purpose. This 10-question Patient Review Form explored current as well as historical care. At a point in time, this list of questions was shortened to 4 questions which explored current care, following discussions with SPPG (formerly HSCB) who were keen that it mirror the approach used by the Belfast HSC Trust Neurology recall. It reverted back to 10 questions at the request of the Trust (and with agreement by SPPG) with all relevant case notes being assessed retrospectively to ensure consistency.

Where concerns regarding the quality of care are identified, these cases are then considered at a screening meeting, attended by the Trust's acute directorate governance and clinical staff, to establish if the concerns meet the threshold set out in the regional SAI procedure. Where the case meets the criteria for an SAI, it is progressed as an SCRR.

The Expert Review Team considered that if the aim is to identify all cases where there is likely to be learning, the use of SAI thresholds may not be the most effective method. This was explored with Trust representatives who were in agreement. We were advised that cases considered for inclusion in the SCRR included the following:

1. SAI threshold met; concerns around the care and treatment in keeping with a theme already identified
2. SAI threshold met; concerns around the care and treatment in keeping with an emerging theme, not previously identified
3. SAI threshold not met; nonetheless, learning identified
4. SAI threshold not met; care and treatment "reasonable"

The Expert Review Team is of the view that it is acceptable to include cases from Group 3. Although a case may not meet the criteria for an SAI review, it may still contain valuable learning from a patient experience or service quality perspective.

To date, 53 cases have been identified that meet the criteria for SCRR. This number is likely to increase further, particularly if the care and treatment of additional patient groups is going to be subject to an extension of the Lookback Review; a total in excess of 90 cases is expected to be identified from this phase alone.

During fieldwork the Expert Review Team heard that of the 53 SCRRs passed to the external SCRR urologists between February and May this year only 20 have been returned to date. This prolonged process poses challenges for the Trust as they are keen to establish the full extent of learning in relation to these cases.

Given time constraints and limited availability of expert reviewers, the Expert Review Team was keen to explore whether a sampling approach had been considered by SHSCT. Such an approach would seek to maximise learning within the constraints of available resources and may lead to improvements being implemented at an earlier stage.

During fieldwork, Trust representatives remarked on the similarity of themes across the cases that have already been reviewed. We were informed that there was very similar learning arising from 19 out of 20 cases reviewed to date. This supports an argument that a point of saturation might be reached and there may be limited additional benefit to reviewing all cases, as was initially intended.

The Expert Review Team recognises that a pragmatic approach to sampling would mark a departure from the original intention and direction of the SCRR. It would be the Expert Review Team's view that such a departure requires a clear rationale to be agreed by the DoH; this would require the purpose, scope and Terms of Reference for the SCRR review to be clearly articulated and defined. DoH should ensure that such an approach is justified when taking into consideration the wider context,

including the planned work and emergent findings of the Public Inquiry. The Expert Review Team's view is that a sampling approach would expedite learning and would allow an opportunity for earlier improvement to be implemented. However, there are ethical considerations and SHSCT should take steps to ensure that the sampling framework is robust and should be open and honest with patients and families about the approach and its rationale.

Understanding that some patients and families may be disappointed that their case is no longer going to be reviewed, SHSCT may wish to include an option for patients and families to request inclusion in the SCRR. If it is not feasible or reasonable to grant such a request, then the patient or family should be informed of the alternatives available to them, such as submitting a concern to the Urology Public Inquiry, SHSCT Complaints Department, GMC, PSNI or any redress scheme. It would be helpful at this stage for DoH / Urology Assurance Group / SHSCT to liaise with the Urology Public Inquiry to ascertain their intended approach to case identification and proposed methodology for delivering on Inquiry ToR (c). Should the inquiry intend to review all cases for those patients / families approaching the Inquiry Team, this would lessen the expectations on SHSCT, enabling the SCRR work stream to focus on applying a sampling framework with a view to deriving system learning and implementing improvement.

Recommendation 7

SHSCT should consider implementing a sampling approach to case selection for SCRR. Such an approach should be agreed with DoH / Urology Assurance Group / SPPG. SHSCT should be clear on the rationale, its benefits and limitations and ensure that there is openness and transparency in communication with patients, families and the public. SHSCT should engage the Clinical Ethics Committee to consider any ethical issues arising from such an approach which can then be addressed and mitigated by SHSCT.

2.1.7 Ethical Considerations

The application of ethical principles when conducting reviews of a complex and sensitive nature is invaluable to guide decision-making and ensure that the review is conducted in an open, transparent, fair and sensitive way. It can be helpful in ensuring a rigorous approach, adherence to a duty of candour, respect for confidentiality but also autonomy (i.e. right not to know) and in ensuring that specific patient groups are not inadvertently disadvantaged. It is also helpful when considering specific ethical issues that may arise from the process of reviewing patient cases, such as circumstances where previously undiagnosed or undisclosed hereditary conditions are identified.

SHSCT advised that no Clinical Ethics issues were identified for discussion with SHSCT Clinical Ethics Committee. The Expert Review Team is of the firm view that given the scale and sensitivity of the work involved, and the potential for inadvertent harm to be caused by the process, SHSCT would benefit from giving due consideration to the application of Ethical Principles. Advice from SHSCT Clinical Ethics Committee should be urgently sought and, if deemed necessary, this could be assisted by the HSC Regional Clinical Ethics Committee.

We refer SHSCT to a recently issued Ethical Framework[3], developed specifically for RQIA's Expert Review of Deceased Patients of Dr Watt, which contains overarching themes that are applicable to any lookback or review of this nature:

1. Respect for Persons (which includes Privacy, Confidentiality and Data Protection, and the Right to Know and the Right Not to Know)
2. Transparency and Candour
3. Fairness
4. Responsibility

It was RQIA's experience that the process of discussing ethical principles and deliberating the potential for ethical issues is as valuable as the end product of any framework or ethical paper. In the context of the Expert Review of Deceased Patients of Dr Watt, it had wider benefits beyond ensuring that the methodology and the approach were ethically rigorous, and greatly assisted with the drafting of correspondence to families, and in the interactions with families by the RQIA Family Liaison Team.

Recommendation 8

SHSCT should request SHSCT Clinical Ethics Committee to review both current and proposed arrangements for the Lookback Review and SCRR. Where ethical issues are identified, SHSCT should give this due consideration and, where required, adapt the methodology and approach for the review.

2.1.8 Legal Considerations

A legal perspective on review proposals and arrangements is prudent when undertaking work of this nature.

The Expert Review Team's experience is that it can be helpful across a number of areas including:

- Identifying previously unconsidered pitfalls in relation to correspondence with interested parties, proposed review methodology and approach;
- Ensuring there is appropriate indemnity for reviewers undertaking the SCRR;
- Managing data protection issues;
- Managing legal challenges from solicitors acting on behalf of patients / relatives;
- Managing legal challenges from Consultant A's legal team; and
- Requesting clinical records of patients reviewed by Consultant A in a private a capacity

Trust representatives advised that the Directorate of Legal Services (DLS) is supporting SHSCT with the Inquiry and that an opinion could be sought if required. However, SHSCT advised that legal advice had not been sought as the SCRR is being utilised as an alternative of SAI to establish learning from the situation. The Expert Review Team considered that legal input would be required in order to make this determination and also to consider the potential for future legal ramifications.

It is the Expert Review Team's view that given the significance and scale of concerns, the likelihood of negligence and that this is a departure from the regional SAI process, a legal perspective should be sought in relation to the arrangements for SCRR.

Recommendation 9

SHSCT should engage with Trust legal representation to obtain a legal perspective on the arrangements for the SCRR.

2.2 METHODOLOGY AND IDENTIFICATION OF LEARNING

2.2.1 Patient and Family Engagement

There is a statutory duty of Personal Public Involvement as set out in the Health and Social Care (Reform) Act (Northern Ireland) 2009[4]. Best practice in involvement is to seek the input of service users and families to help shape the review process, particularly around sensitive person-centred communication, the provision of support and a mechanism for sharing concerns. There may be additional valuable information from affected service users / families that will not be evident in the clinical documentation of the clinician under investigation; information from families and carers is particularly vital in those cases where a patient has sadly deceased. Importantly, effective patient and family engagement is crucial in order to adhere to the principles of candour and 'being open'.

The regional SAI procedure stipulates the requirements for patient and family engagement. On 7 July 2022, the report of the RQIA Review of the Systems and Processes for Learning from Serious Adverse Incidents in Northern Ireland[5] was published; this has relevant findings on effective engagement and involvement of families and recommendations for strengthening the regional approach and procedure. Furthermore, a draft 'Statement of Rights' as an output of the O'Hara Inquiry may be helpful in focussing HSC Trusts on the importance of appropriate and sensitive interaction with patients and their families.

Although the SCRR is not an SAI process, the Expert Review Team is of the view that, as a minimum, patients and families should be informed of the purpose of the SCRR, and that those affected should have an opportunity to provide additional information about their care and treatment. SHSCT outlined their process for engaging and involving families. The Expert Review Team is impressed with and commends the significant efforts SHSCT has made in contacting all impacted families, which, given the scale, is a huge undertaking. However, we note recent issues arising regarding the quality of patient information and consider that the arrangements for patient and family involvement in both shaping the process and sharing concerns require improvement.

The Expert Review Team considers that SHSCT PPI team and those external to SHSCT, such as the PHA and Patient Client Council, have been underutilised in ensuring that there are robust arrangements for PPI as part of the Lookback Review and SCRR.

Recommendation 10

SHSCT should review their arrangements for the involvement of patients and families to ensure that it fulfils its statutory duty of Personal Public Involvement. SHSCT should consider engaging those with Personal Public Involvement expertise and external partners such as the PHA who have PPI training resources for staff and the PCC who could provide advice and support in the involvement of patients and families as part of the Lookback Review and SCRR.

SHSCT outlined its arrangements for following up and sharing the findings of the SCRR with patients and family members. Although there is a Family Liaison Officer (FLO) available to support patients and families, the findings are primarily shared through postal correspondence. Whilst this may be the preference of a large number of families, many may require additional support to understand and emotionally cope with the findings.

The Expert Review Team consider the following to represent good practice[6,7,8]:

- As far as possible, reports should be quality assured, checked for factual accuracy, and should be written in easy to understand lay language;
- Patients / families should be provided with a range of options on how they wish to receive the report; one option should be a face to face meeting. They also have a right “not to know” the findings;
- The Family Liaison Officer should be accompanied by a medical doctor in relaying the findings of the report;
- Psychological support should be made available to those impacted by the process and findings of the SCRR;
- If further medical follow-up is required by patients or relatives, there should be Trust arrangements in place to facilitate this in a timely manner; and
- There should be opportunities for the FLO to debrief with colleagues and timely access to psychological support for the FLO and any others involved in family engagement.
- Independent advocacy should be considered for patients or families, particularly when cases are complex. The PCC have extensive experience in this area through previous work on SAIs and other Inquiries.

During fieldwork, the Expert Review Team explored the support available for those staff members involved in the review and, in particular, the patient and family engagement. SHSCT described effective provision of support including: senior and peer support, psychological support and access to Inspire Wellbeing Counselling service. The Expert Review Team is content that the arrangements for support appear sufficient but cautions that a substantial proportion of the work appears to be undertaken by one FLO. Given the large number of cases identified, it may be beneficial to increase the capacity of the Family Liaison Team to provide support to those impacted by the Lookback Review and SCRR.

Recommendation 11

SHSCT should review their arrangements for sharing SCRR findings with patients and families giving consideration to good practice as outlined by the Expert Review Team in this report.

2.2.2 Methodology & Tool

Structured Judgement Review methodology is a reliable, well validated tool that has been developed by the Royal College of Physicians. It allows for the blending of traditional, clinical-judgement based, review methods with a standard format. The approach requires reviewers to make safety and quality judgements on particulars of care, to make explicit written comments, and to assign a score for the quality of care at each phase. This produces a rich set of information about each case in a form that can be aggregated to produce knowledge about clinical services and systems. SHSCT discussed the use of this tool with the Royal College of Physicians and opted for this methodology to underpin the SCRR process.

The Structured Judgement Review methodology was adapted for the SCRR in order to take into consideration the relevant phases of care. The phases of care assessed are:

- Triage;
- Initial assessment or review;
- Review of Diagnostics;
- Ongoing Outpatient Care;
- Admission and Initial Management;
- Ongoing Inpatient Care;
- Care during a procedure (excluding IV cannulation);
- Perioperative care; and
- Discharge plan of care.

The Expert Review Team is not privy to all the specific clinical concerns therefore cannot be certain that the tool adequately scrutinises all relevant aspects of care. With this caveat in mind, the SCRR tool generally appears reasonable. However, the Expert Review Team did note some areas that SHSCT may wish to address. There is some divergence from the RCP methodology in terms of the data collection instrument. There is no section to assess:

- Quality of documentation in the records;
- Communication between Consultant A and the patient / carer / family; and
- Communication between colleagues, MDT and primary care.

Whilst we were advised that deceased patients are included in the review, there are no sections outlining a review of the death certification or whether a referral to the coroner's service was required.

Of particular value in relation to deceased patients, but of great value for all cases, is the consideration of patient and family concerns. In general, there is a lack of patient

and family input into the SCRR process. Patients and families were not engaged with in order to shape the review. Equally, there is no consistent mechanism to proactively seek the concerns of patients and families for consideration as part of the individual SCRR. This marks a considerable deficit in the information available to formulate findings. The experience of the Expert Review Team is that, where concerns from patients and families are taken into account, this greatly enhances the learning process and provides information and context that is often not present in the notes. RCP has successfully incorporated patient / family concerns into its review process by asking expert reviewers to review the notes firstly without knowledge of the patient / family concerns and then a second time taking the patient / family concerns into consideration. The complaint can then be judged to be 'upheld', 'partially upheld' or 'not upheld'.

RQIA's experience from the Expert Review of Deceased Patients of Dr Watt is that there is a close correlation between the views of family members and the judgement of the structured judgement tool (SJR), strengthening the argument that there is great benefit in attaining patient and family input. Where there is little or no correlation between the patient / family story and the clinical picture documented in the records, the Review Panel may determine that the family concern is 'not upheld'; of note, this only occurred for two (out of 44) patients included in Phase 2 of the Expert Review of Deceased Patients of Dr Watt.

Recommendation 12

SHSCT should liaise with RCP and consider amending the Structured Clinical Record Review tool to include an assessment of the quality of documentation and an assessment of the documented communication with patients and families; the clinical team, MDT and primary care. SHSCT should consider facilitating the consideration of patient / family concerns as part of the SCRR to mirror the approach undertaken by RCP.

Whilst Structured Judgement Tools provide an objective assessment of the care and treatment documented within the clinical records, it can only allow for a partial systems perspective. For example, it may tell a story of care and treatment according to the national standards of the time, of the standard and quality of documentation, multidisciplinary involvement, communication between colleagues and communication with family members. Of direct relevance, it will not examine factors such as caseload, working relationships and peer review.

Furthermore, it will not tell us about the governance systems within Urology Services or within SHSCT as a whole. It will not examine the role of external bodies and the wider system in providing oversight and assurance of quality and safety of care.
With this in mind, DoH or SHSCT Board may wish to commission RQIA to undertake a Review of Governance within Urology in Southern Health and Social Care Trust. This would provide an opportunity to identify and remedy any deficits, and to share learning within SHSCT and across the system so that governance systems may be strengthened and future harm prevented.

Recommendation 13

DoH should commission RQIA to undertake a Review of Governance Arrangements within Urology Services in Southern HSC Trust.

2.2.3 Expert Reviewers

Each case is reviewed independently by a 'Subject Matter Expert' (or Expert Reviewer) utilising the SCRR methodology. SHSCT provided details of Expert Reviewers, including a description of the job role and a copy of the guidance provided to reviewers at the outset of the work. The Expert Reviewers are nominated via the British Association of Urological Surgeons (BAUS) for their subject matter expertise. SHSCT ensures that each reviewer is appropriately registered and of good standing with their professional regulator, the General Medical Council (GMC). The Expert Review Team is content that reviewers appeared suitably independent and qualified.

In total, SHSCT approached 13 reviewers of which four Expert Reviewers have been recruited to support this work. Given the difficulty recruiting Consultant Urologists and the time consuming nature of the SCRR process, the Expert Review Team considered whether specialist nurse reviewers or urologists in training could be used instead. A clearly defined protocol with consultant oversight of the process would facilitate this. It was considered that a hierarchical culture within HSC, associated with perceptions amongst the Northern Ireland public that attaches particular significance to reviews undertaken by a consultant, may be a barrier to implementing a non-consultant review process. Therefore, if the work cannot supported by specialist nurses or trainee urologists, consideration should be given to the use of doctors working outside the specialty of urology.

The Expert Review Team noted that no training was provided to Expert Reviewers, who instead were stated to be familiar with SJR tool methodology. In addition, there was no specific manual provided to reviewers; albeit the following guidance was provided:

- Using the Structured Judgement Review method - A guide for reviewers; National Mortality Case Record Review Programme 2019[9]; and
- Structured Judgement Review - Frequently Asked Questions 2019.

Additionally, the process had not been piloted and there was no method of calibration between reviewers to ensure inter-reviewer reliability and consistency. Importantly there is no mechanism for quality assuring the work of reviewers, either by assigning two reviewers to each case or by second-reviewing a sample of the cases.

The Expert Review Team notes that 20 SCRRs had been completed at the time of fieldwork; and while we understand the challenges in delivering quality assurance of reviews within the current limited pool of reviewers it may be beneficial to conduct an independent review by a second expert reviewer to ascertain the degree of reliability and consistency in assessing the quality of care. A panel should then be convened

to discuss any significant discrepancies in judgement, to gain consensus and provide expert reviewers with an opportunity to standardise their approach.

Even in the absence of discrepancies, it can be helpful for clinical reviewers to have a forum to discuss cases, debrief and avail of emotional or psychological support. Although it was reported that each reviewer can contact SHSCT Deputy Medical Director for Quality and Safety if issues arise, the Expert Review Team is of the view that SHSCT is missing an opportunity to proactively support reviewers, seek feedback on the process and seek reviewers' views on the learning arising.

Recommendation 14

SHSCT should not be limited to consultant urologists when recruiting clinical reviewers to undertake the SCRR process. All Expert Reviewers should be provided with guidance and support, including an opportunity to debrief, feed back and avail of emotional / psychological support if required.

A document should be drafted specific to this particular piece of work to guide reviewers through the process of conducting the SCRR; this should include a defined protocol for the assessment of the quality of care and treatment.

A sample of cases already reviewed using the SCRR methodology should undergo a second review to ensure inter-reviewer reliability and consistency. Consideration should be given to quality assurance of a defined sample of cases for the remainder of the SCRR.

2.2.4 Review Panel

Good practice dictates that in undertaking a review, an expert panel to deliberate findings and attain consensus on recommendations is preferable to the judgement of one individual expert. A forum for discussion between panel members allows for a sharing of expertise and perspective, brings a deeper and broader understanding of issues, mitigates bias and derives learning more effectively.

SHSCT stated that there is no specific review panel for the SCRR; however, the Trust Lookback Group oversees the overall lookback process that includes the SCRR. On completion of the initial batch of SCRRs, an independent Consultant Urologist will develop a thematic report on the findings.

The Expert Review Team considered that, as SHSCT has rightly identified that a key outcome of the SCRR is a thematic analysis in order to identify learning and inform system improvements, the process would benefit from a dedicated review panel rather than relying on the professional judgement of one individual to collate findings, identify themes and make recommendations. This was explored with Trust representatives during fieldwork, who advised that the RCS and BAUS had both been approached to undertake an independent quality assurance of the SCRR but SHSCT had not been able to secure agreement from either of these bodies. Subsequently SHSCT considered convening a multidisciplinary panel comprising eight individuals but due to limited resource and availability of staff this had not progressed. The Expert Review Team considers that a smaller panel, including

urology, governance and lay expertise would suffice; encouragingly, Trust representatives were amenable to this model.

The Expert Review Team is of the view that any learning and evidence-based recommendations made by the review panel would require a commitment from SHSCT to implement a clear prioritised action plan within acceptable timescales.

Recommendation 15

A review panel should be constituted, for the specific purposes of identifying learning and determining recommendations arising from the SCRR process. This panel should include individuals with expertise in urology and governance, and include a lay member.

2.2.5 Identification and Dissemination of Learning

Dissemination of learning is crucial in order to improve systems for delivery of care both within SHSCT and across the region. Any strategy for the dissemination of lessons learned should be supported by DoH / SPPG / PHA and should incorporate an action log of the system improvements required, along with timescales for follow up and review.

SHSCT stated that each SCRR report will be reviewed by a Trust clinician who will identify if there is any previously unidentified learning. The thematic analysis report will also be considered by SHSCT in respect of broader system issues.

SHSCT advised that returned SCRRs are reviewed by a Trust clinician who will decide on the appropriateness of sharing learning more widely; this includes learning that should be shared beyond Trust boundaries. Mechanisms for sharing learning were stated to include:

- Using SHSCT local shared learning template;
- Regional shared learning template;
- Morbidity and Mortality Meetings (Patient Safety Meetings);
- Acute Governance Meetings (Directorate wide); and
- Urology and Cancer Services team meetings.

The Expert Review Team considered that the arrangements for identifying, implementing and disseminating learning required strengthening. The reliance on the professional judgement of one clinician to undertake a thematic analysis, in the absence of a mechanism for the reviewers to discuss and feedback, compounded by the lack of quality assurance of individual reports, risks that important system issues may go unidentified. Similarly, the reliance on a Trust clinician to determine whether learning should be shared wider, lacks independence, and runs the risk that one person acts as a gatekeeper to the implementation of improvement and dissemination of lessons learned.

As stated previously, a review panel with representation from urology, governance and a lay member would serve to ensure that there is a robust mechanism for deriving, implementing and making determinations on the dissemination of learning.

Where learning is derived, the Expert Review Team would expect that recommendations are made and clear prioritised time-specific action plans are put in place with arrangements for monitoring and accountability. A follow-up review, with defined parameters for assessment around implementation, would provide assurance around the implementation of sustainable improvements.

The information provided by SHSCT indicates that the consideration of dissemination of learning is confined to within Trust boundaries; although a regional shared learning template is referenced, it is not clear whether this in itself would be sufficiently robust to disseminate learning to the relevant stakeholders across the system. SHSCT representatives were of the view that the previous HSCB process for sharing learning from SAIs needs to be adapted or replicated for the SCRR process but that this had not yet commenced. The Expert Review Team is of the view that the mechanisms for sharing learning should be discussed urgently with DoH / SPPG / Urology Assurance Group. Recipients should include Public Inquiry, SHSCT Board, Urology Assurance Group, DoH / SPPG, PHA, and RQIA; under duty of candour principles, it should be considered whether there is an onus to share learning with the public. In any case, an effective strategy for communication with stakeholders would serve to underpin arrangements for the effective dissemination of learning.

Recommendation 16

SHSCT should work with DoH / SPPG / PHA to develop an effective dissemination strategy for the Lookback Review and SCRR so that learning is shared regionally with all relevant stakeholders and the public is effectively informed under duty of candour principles.

2.3 GOVERNANCE OF THE SCRR

2.3.1 Risk Management

Effective risk management relies on the identification, assessment, mitigation and monitoring of risk. All projects incur risks, such as risks associated with timescales, available expertise, budgetary constraints and data protection vulnerabilities. However, projects of this nature can carry considerable additional risk, such as the risk of causing harm to patients / families / public and reputational risk to the health service. It is vital that the structures, systems and processes in place support effective recognition and management of such risk.

The Expert Review Team was advised that the project does not keep a formal risk log; however, risks are recorded and discussed through meetings. At the time of review, there were three risks identified with mitigation actions identified for each.

When the Expert Review Team explored the issue of risk it was advised that the risks associated with the SCRR had progressed to both the directorate risk register for Acute Services and to the Corporate Risk Register.

The Regional Guidance for Implementing a Lookback Review Process (July 2021) states that:

> "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 Expert Review Team was further advised that SHSCT is currently transitioning to a revised organisational structure, designed to fully support SHSCT to fulfil its function in respect of the SCRR objectives; this is currently operating in in shadow form. As a consequence, the project will operate under more robust governance structures with a live risk register maintained specifically for the Lookback Review. Issues of risk will also be included in the ToR for the new Urology Lookback Review Steering Group and SHSCT Public Inquiry Programme Board (note these are working titles which may change when the new structure is finalised). The Expert Review Team welcomed these improvements which will serve to strengthen the current arrangements for risk management.

2.3.2 Records Management

Effective management of clinical records requires protocols for retrieving, scanning and sharing records, underpinned by strong governance arrangements. SHSCT described robust arrangements for accessing and sharing of clinical records, which was in keeping with good information governance.

A list of patient names and health and care numbers of those cases identified for SCRR is shared with a dedicated administrator. When a decision is made to proceed with SCRR, the relevant patient records are obtained through normal hospital processes by request of hardcopy notes via the medical records team. Notes in patient charts which are not available on NIECR are copied, scanned and uploaded to Egress Secure Workspace, an electronic platform, for sharing with expert reviewers. Expert reviewers also have secure access to NIECR.

There is a dedicated member of the clinical governance team assigned to support the SCRR process, who is responsible for obtaining the charts, extracting the records for scanning and who also uploads to Egress Secure workplace and notifies and liaises with the external expert reviewers. The Expert Review Team considered this approach to be acceptable.

2.3.3 Data Considerations

SHSCT outlined their arrangements for data protection. Document transfer is managed via SHSCT Egress document sharing platform and also via secure VPN access to NIECR records. Each Expert Reviewer is required to complete a Trust confidentiality agreement and Data protection agreement prior to accessing records.

The Expert Review Team identified a potential General Data Protection Regulation (GDPR) issue with the arrangements for contacting families. SHSCT would benefit

from further consideration of information governance, and in particular, data protection issues in relation to SCRR.

Given the sizeable number of patients involved, a database is beneficial to track progress of the Lookback Review / SCRR, to analyse demographic and clinical information, and to monitor outcomes. SHSCT is presently developing a new database to store and analyse information in relation to the selected cases. Unlike the previous database which relied on manual population, the new database allows for automatic population, reducing the risk of input error. The Expert Review Team welcomes this development and advises that a statement of purpose should be drafted for the new database, outlining the rationale for transferring data; a copy of the old redundant file should be retained in case it needs to be examined at a later stage. If deemed to be helpful, SHSCT could be signposted to regional experts who recently developed a database as part of the neurology live patient recall.

Recommendation 17

SHSCT should draft a statement of purpose for the new database, outlining the rationale for transferring data and should retain a copy of the redundant file on record.

2.3.4 Communication with Stakeholders

Effective communication with stakeholders ensures that there is clear, consistent messaging on the purpose, remit, progress and findings of any review. It also facilitates liaison and co-operation regarding specific aspects of the work where external input is required in order to achieve a particular outcome. The need for robust stakeholder communication is referenced within the Regional Guidance for Implementation of a Lookback Review which highlights that the principle of 'no surprises' should be adopted and outlines that there should be:

- An agreed communication plan/liaison plan for other HSC organisations or independent/private providers which might be affected;
- An agreed media/communications management plan if required, that aims to be proactive in disclosure to the general public and considers responses to media enquiries; and
- Engagement with PSNI and coroner's service in line with standard procedures.

In addition to the above stakeholders, there should also be a channel of communication established with the GMC via the HSC Trust's Responsible Officer. All these elements are best considered as part of a comprehensive Communications Strategy developed for the specific Lookback Review.

SHSCT advised that when completed, the SCRRs are planned to be shared with the Urology Public Inquiry along with the thematic review of cases. Additionally, DoH will be provided with updates on the process via the Urology Assurance Group. SHSCT advised that the Coroner will be notified if there is a potential issue identified via the SCRR processes which has not previously been identified via Trust processes.

The Expert Review Team considers that there is an absence of an overall communication and stakeholder engagement strategy. It is also noted that there is no channel of communication established between SHSCT and PSNI or GMC. The GMC is likely to be interested in the findings, which will be relevant to the Fitness to Practice (FTP) investigation of the consultant concerned. In addition, there is a possibility that the harm found could be of PSNI interest in terms of possible assault, gross negligence, or in extreme cases, manslaughter. The Expert Review Team considers that a Communications Strategy should be developed and examples from recent lookback exercises or similar review work across the region may assist SHSCT in expediting this.

Recommendation 18

SHSCT should urgently develop and implement a communication strategy specific to the Lookback Review and including the SCRR process.

A channel of communication specific to Urology work streams should be established between SHSCT, PSNI, GMC and Coroner's office; SHSCT should ascertain the thresholds for referral in respect of specific concerns arising out of cases reviewed as part of the SCRR.

Section 3 Conclusion and Recommendations

3.1 Conclusion

RQIA acknowledges the commitment of SHSCT to ensuring that this work is undertaken a manner that is robust and effective in deriving learning and informing improvements. This was evident, not only by the fact that SHSCT approached RQIA to request this review, with the aim of providing assurance, but also in the Expert Review Team's engagement with Trust representatives and staff during fieldwork. We acknowledge the amount of time and effort that SHSCT staff have given to this piece of work and commend their openness, candour and willingness to learn from the expertise of the Expert Review Team. This positive engagement and 'buy in' will assist SHSCT in implementing the necessary improvements.

RQIA was initially approached to provide independent assurance of the SCRR methodology. During preliminary discussions with SHSCT, we determined that this assurance should be broadened to include the wider process, governance and framework surrounding the SCRR process. This was felt to be particularly important given that the SCRR arose as a result of a significant number of SAIs which were identified through SHSCT Lookback Review, at which point the decision was made to adopt alternative methodology to the SAI process. The Expert Review Team endorses this decision. Structured Judgement Methodology, when applied appropriately, is a reliable, validated methodology which offers an effective means of deriving learning and implementing improvements.

However, when examining the SCRR process within the context of the Lookback Review, it was apparent to the Expert Review Team, that the Lookback in itself is not only a significant undertaking for SHSCT but its progression is a matter of urgent priority. An assessment of the historical care of patients, whose cases had undergone the screening process for SCRR, identified deficits in care and treatment prior to 2019. SHSCT is presently conducting a risk assessment and has commissioned RCS to undertake a review of cases relating to 2015 which should assist SHSCT in determining the future scope and scale of their Lookback. The Expert Review Team is of the firm view that SHSCT should not wait until this work concludes, and based on the evidence SHSCT has gathered to date should proceed to review and recall further groups of patients which it has identified to be at risk of harm.

Understanding that this is a considerable undertaking and that issues have already been identified regarding the availability of expertise and resource to support the Lookback Review, SHSCT will require significant support from the wider HSC system: DoH, SPPG, PHA and RQIA. A dedicated, appropriately resourced and experienced project team should be established as soon as possible to support this work. This may require secondment of additional individuals with the relevant skills and experience to SHSCT. RQIA recognises the efforts SHSCT has already undertaken to improve its lookback arrangements and is keen to support SHSCT with further improvements. As RQIA is best placed to provide assurance on the current arrangements to ensure strong foundations for scaling up and extending the Lookback time period, we recommend that RQIA undertakes a follow-up piece of assurance work looking specifically at the Lookback Review. Going forward, in order

to allow SHSCT to focus on the Lookback Review, ideally the SCRR should be undertaken by an independent body. The Expert Review Team understands that SHSCT may not be able to secure the support of an external organisation; therefore, we make a number of recommendations to strengthen the existing SCRR process and arrangements.

SHSCT should explicitly state the purpose of the SCRR and draft a Terms of Reference as soon as possible. Caveated with the fact the Expert Review Team is not privy to all specific clinical concerns, the tool itself appears reasonable, but it does deviate from the tool used by RCP and leaves a number of areas unexamined such as quality of documentation. In addition, given that a proportion of patients are deceased, it would be judicious to update the tool to take into consideration death certification and the need for coronial referral. The Expert Review Team advises that SHSCT liaise with RCP to ensure the tool is appropriately aligned and that SHSCT mirrors RCP's approach to considering patient and family concerns as part of the SCRR process.

The arrangements for patient and family involvement require significant strengthening. Inclusion of lay membership on the relevant project groups would ensure SHSCT meets its statutory duty of patient and public involvement. The Expert Review Team also provides advice on best practice in involving, listening to and supporting patients and families through processes such as these in a way that reduces the potential for further harm and serves to restore faith in the health service. Given the scale, complexity and sensitivity of the work involved, due consideration should be given to seeking an ethical perspective on arrangements through SHSCT Clinical Ethics Committee.

RQIA notes the large number of cases that have been identified for SCRR and the difficulty this poses in terms of conducting SCRRs within reasonable timescales, compounded by the limited number of expert reviewers. A sampling approach is pragmatic and effective in deriving learning within the constraints of time and resource. However, this requires a clear purpose; ToR; agreement with DoH / Urology Assurance Group; due consideration of ethical considerations; and considered and sensitive engagement with patients and families. Importantly, where cases are selected for review, this should be done to a high standard.

A document should be developed to guide reviewers through the SCRR process and there should be a mechanism for calibration between reviewers to ensure consistency and inter-reviewer reliability. Additionally, a sample of the cases should be subject to second review for quality assurance. Understanding that this is challenging to achieve within reasonable timescales with a limited number of reviewers, the Expert Review Team recommends that SHSCT considers recruiting non-urology consultants to review the cases, guided by a defined protocol and with appropriate expert oversight.

Whilst the outcome of individual case reviews will be valuable to patients and families in terms of understanding what went wrong and why, it is the overall learning derived from the SCRR process that will assist SHSCT and the region in improving its systems. Therefore, it is vitally important that SHSCT strengthens its arrangements for identification and dissemination of learning. A review panel

comprising members with expertise in urology and governance, and a lay representative should be established to deliberate findings, derive learning and make evidence-based recommendations. Equally, the mechanisms for sharing learning require an effective dissemination strategy to be agreed with DoH / SPPG and PHA. Underpinning this, communication with stakeholders including GMC, Coroner's Service and PSNI requires to be underpinned by a Communication Strategy and established channels of communication. Furthermore, the arrangements for sharing information with the public under a duty of candour and for developing patient and family information require considerable strengthening. Encouragingly this is already being explored by SHSCT in light of concerns surrounding factual accuracy of previously issued patient correspondence.

On the whole, the challenges facing SHSCT are considerable, complex and require a concerted effort with appropriate involvement of a number of organisations; DoH / SPPG, PHA and RQIA. Retaining the focus on patient safety, the Lookback Review requires urgent support and upscaling. Whilst SCRR will be valuable in establishing deficits within the care and treatment of this patient population, it is limited in terms of deriving systems and governance learning. As such, RQIA advises that a Review of Governance of Urology Services would be crucial in terms of providing assurance around the current service. RQIA is committed to providing both independent assurance and improvement support to SHSCT as it continues its efforts to urgently address deficits in care whilst improving the quality and safety of SHSCT urology services.

3.2 Summary of Recommendations

Recommendation 1

SHSCT should urgently update all relevant documentation to ensure that there is clarity regarding the SCRR including a description of the SCRR purpose, remit and process; explicitly stating that it is a separate process to any parallel Inquiries or investigations.

SHSCT should review their arrangements for developing and quality assuring patient / family information materials and publicly accessible information to ensure there is adequate lay / service user involvement, communications expertise and, where beneficial, legal input.

Recommendation 2

SHSCT should consider reviewing the composition of Lookback Review steering group to reflect that which is stated within Regional Guidance for Implementing a Lookback Review Process; in particular, consideration should be given to the inclusion of a lay representative.

SHSCT should establish a dedicated project team for the management and co-ordination of SCRR. SHSCT should recruit people with the skills and experience who, if required, can seek the advice and guidance of experts from across the region.

Recommendation 3

Considering the need for dedicated co-ordination and management of the Lookback Review and the SCRR process; SHSCT should prioritise the appointment of a suitably qualified Project Manager.

Recommendation 4

SHSCT should define and explicitly state the purpose of the SCRR process. Furthermore, a clear Terms of Reference / set of objectives should be agreed and referenced within the relevant Trust documentation.

Recommendation 5

SHSCT should give urgent consideration to extending their Lookback Review to identify and recall further groups of patients. DoH / Urology Assurance Group / SPPG, PHA and RQIA should work together to support SHSCT with the Lookback Review.

RQIA should consider undertaking an independent assessment of Trust arrangements for the Urology Lookback Review in order to provide assurance on its effectiveness and identify any areas for improvement.

Recommendation 6

SHSCT should consider commissioning an independent body to undertake the SCRR process on its behalf.

Recommendation 7

SHSCT should consider implementing a sampling approach to case selection for SCRR. Such an approach should be agreed with DoH / Urology Assurance Group / SPPG. SHSCT should be clear on the rationale, its benefits and limitations and ensure that there is openness and transparency in communication with patients, families and the public. SHSCT should engage the Clinical Ethics Committee to consider any ethical issues arising from such an approach which can then be addressed and mitigated by SHSCT.

Recommendation 8

SHSCT should request SHSCT Clinical Ethics Committee to review both current and proposed arrangements for the Lookback Review and SCRR. Where ethical issues are identified, SHSCT should give this due consideration and, where required, adapt the methodology and approach for the review.

Recommendation 9

SHSCT should engage with Trust legal representation to obtain a legal perspective on the arrangements for the SCRR.

Recommendation 10

SHSCT should review their arrangements for the involvement of patients and families to ensure that it fulfils its statutory duty of Personal Public Involvement. SHSCT should consider engaging those with Personal Public Involvement expertise and external partners such as the PHA who have PPI training resources for staff and the PCC who could provide advice and support in the involvement of patients and families as part of the Lookback Review and SCRR.

Recommendation 11

SHSCT should review their arrangements for sharing SCRR findings with patients and families giving consideration to good practice as outlined by the Expert Review Team in this report.

Recommendation 12

SHSCT should liaise with RCP and consider amending the Structured Clinical Record Review tool to include an assessment of the quality of documentation and an assessment of the documented communication with patients and families; the clinical team, MDT and primary care. SHSCT should consider facilitating the consideration of patient / family concerns as part of the SCRR to mirror the approach undertaken by RCP.

Recommendation 13

DoH should commission RQIA to undertake a Review of Governance Arrangements within Urology Services in Southern HSC Trust.

Recommendation 14

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A document should be drafted specific to this particular piece of work to guide reviewers through the process of conducting the SCRR; this should include a defined protocol for the assessment of the quality of care and treatment.

A sample of cases already reviewed using the SCRR methodology should undergo a second review to ensure inter-reviewer reliability and consistency. Consideration should be given to quality assurance of a defined sample of cases for the remainder of the SCRR.

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should include individuals with expertise in urology and governance, and include a lay member.

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A channel of communication specific to Urology work streams should be established between SHSCT, PSNI, GMC and Coroner's office; SHSCT should ascertain the thresholds for referral in respect of specific concerns arising out of cases reviewed as part of the SCRR.

Appendix 1: Terms of Reference for the Statutory Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust

(a) To review the Southern Health and Social Care Trust's (the Trust) handling of relevant complaints or concerns identified or received prior to May 2020 and its participation in processes to maintain standards of professional practice. The Inquiry shall determine whether there were any related concerns or circumstances which should have alerted the Southern Trust to instigate an earlier and more thorough investigation over and above the extant arrangements for raising concerns and making complaints.

(b) To evaluate the corporate and clinical governance procedures and arrangements within the Trust in relation to the circumstances which led to the Trust conducting a "lookback review" of patients seen by the urology consultant Mr Aidan O'Brien (for the period from January 2019 until May 2020). This includes the communication and escalation of the reporting of issues related to potential concerns about patient care and safety within and between the Trust, the Health and Social Care Board, Public Health Agency and the Department. It also includes any other areas which directly bear on patient care and safety and an assessment of the role of the Board of the Trust.

(c) To examine the clinical aspect of the cases identified by the date of commencement of the Inquiry as meeting the threshold for a Serious Adverse Incident (SAI) and any further cases which the Inquiry considers appropriate, in order to provide a comprehensive report of findings related to the governance of patient care and safety within the Trust's urology specialty.

(d) To afford those patients affected, and/or their immediate families, an opportunity to report their experiences to the Inquiry.

(e) To review the implementation of the Department of Health's "Maintaining High Professional Standards Policy" by the Trust in relation to the investigation related to Mr O'Brien. The Inquiry is asked to determine whether the application of this Policy by the Trust was effective and to make recommendations, if required, to strengthen the Policy.

(f) To identify any learning points and make appropriate recommendations as to whether the framework for clinical and social care governance and its application are fit for purpose.

(g) To examine and report on any other matters which the Chairman considers arise in connection with the Inquiry's investigations in fulfilment of these Terms of Reference.

The clinical practice of Mr O'Brien is being investigated by the General Medical Council (GMC) and it would, therefore, be inappropriate for the Inquiry to encroach on the GMC's remit. The Inquiry shall submit a report as soon as practicable to the Minister for Health. Should the Inquiry as part of its investigation establish any issue of concern which it believes needs to be brought to the Minister's immediate attention, then this will be done.

Appendix 2: Structured Judgement Review[10]

Case note review remains a prime means of retrospectively assessing quality of patient care. Implicit review is based on clinical judgement and is judged to be effective in identifying and recording the detail and nuance of care (both unsatisfactory and good).

Unstructured implicit review was criticised for low inter-rater reliability (high variability) and for potential reviewer bias. Structured implicit review methods require reviewers to use a judgement based structured explicit scale to rate quality of care from very poor to excellent. However, this form of review only provides a scale based quantitative result giving no indication of why a reviewer made a particular judgement. This means that it is useful for large scale monitoring or epidemiological studies of adverse events but is less effective for more detailed review at ward or hospital level of why an event occurred.

To increase the value of structured review in reviewing the whole spectrum of care quality, rather than focussing only on adverse event rates, a methodology was developed where reviewers were required to provide implicit clinical judgements and to write explicit comments to support judgement based quality of care scores: this forms the basis of Structured Judgement Review.

Structured Judgement Review requires reviewers to make safety and quality judgements over phases of care, to make written comments about care for each phase and to score care for each phase.

The objective of this review method is to look for strengths and weaknesses in the caring process, to provide information about what can be learnt about hospital systems where care goes well and to identify areas where there may be gaps, problems or difficulties with the care process. It can be used for a wide range of hospital based safety and quality reviews across services and specialties and not only for those cases where patients die in hospital. The quality and safety of care may be judged and recorded whatever the outcome of the case and good care is judged and recorded in the same detail as care that may have been problematic.

There are two stages to the review process.

Stage One

Carried out by ‘front line’ reviewers who are trained in the method and who undertake reviews within their own services, for example in Morbidity and Mortality Reviews.

Phases of care – the ‘structure’ part of the process.

Phases of care are shown below but may be varied depending on the type of care or service being reviewed:

- Admission and initial care – first 24 hours
- Ongoing care

- Care during a procedure
- Perioperative/procedure care
- End of life care (or discharge care)
- Overall assessment of care

Explicit Judgement Comments

Explicit judgement commentaries provide:

- The means for the reviewer to concisely describe how and why they assess the safety and quality of care provided.
- A commentary that other health professionals can really understand if they subsequently look at the completed review.

Phase of Care Scores

Care scores are recorded after judgement comments have been written and the score is itself an overall judgement of the reviewer. Scores range from excellent to very poor.

1. Very poor care
2. Poor care
3. Adequate care
4. Good care
5. Excellent care

Judging the quality of recording in the case notes.

As part of the overall assessment, the reviewer is also asked to record their judgement on the quality and legibility of the records again using a score of 1-5.

Second Stage Review

A score of 1 or 2 is given when the reviewer assesses that care has been poor or very poor. A score at this level should trigger a second stage review through the hospital governance process.

A second stage review also uses the structured judgement method and takes place if a patient has died. If the second stage reviewer broadly agrees with the initial case review a decision may be taken to carry out a further assessment concerning the potential avoidability of the patient's death.

The judgement is framed by a 6 point scale. A score of 1,2 or 3 on the avoidability scale would indicate a governance 'cause for concern'.

1. Definitely avoidable
2. Strong evidence of avoidability
3. Probably avoidable (more then 50:50)
4. Possibly avoidable, but not very likely (less than 50:50)
5. Slight evidence of avoidability

6. Definitely not avoidable.

Structured Judgement Review can produce learning at two levels:

- The detail captured can identify both poor practice and good practice of individual clinicians.
- When multiple reviews are undertaken within a clinical area or a hospital, a thematic analysis can be performed that may highlight systemic issues in a system.

Quantitative data identify very poor to excellent care in a number of care phases. Qualitative data from explicit judgements may be analysed, for example using word detection software, to identify recurrent themes.

References

[1] Procedure for the Reporting and Follow up of Serious Adverse Incidents 2016. Available at https://hscboard.hscni.net/download/PUBLICATIONS/policies-protocols-and-guidelines/Procedure-for-the-reporting-and-follow-up-of-SAIs-2016.pdf Cited July 2022

[2] Regional Guidance for Implementing a Lookback Review Process (July 2021). Available at https://www.health-ni.gov.uk/sites/default/files/publications/health/doh-reg-guide-lookback-reveiw.pdf Cited July 2022

[3] Ethical Framework to Inform Phase Two of the Expert Review of Records of Deceased Patients of Dr Watt April 2021. Available at b996b934-f707-4206-b1c9-1e7d706bd5ec.pdf (rqia.org.uk) Cited July 2022

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[5] RQIA Review of the Systems and Processes for Learning from Serious Adverse Incidents In Northern Ireland (June 2022). Available at RQIA Review of Systems and processes | Department of Health (health-ni.gov.uk) Cited July 2022

[6] IHRD Workstream 5: What you should expect in relation to a Serious Adverse Incident Review in a Health and Social Care setting (Version 2: February 2019). Available at IHRD Workstream 5 - Serious Adverse Incidents - What to Expect irt SAI Review.pdf (health-ni.gov.uk) Cited July 2022

[7] NHS Resolution: Saying Sorry (June 2017) Available at NHS-Resolution-Saying-Sorry.pdf Cited July 2022

[8] Involvement Tools and Guides. Available at Involvement Tools and Guides - Engage (hscni.net) Cited July 2022

[9] Using the structured judgement review method. Guide for reviewers (England). 2019. Available at INMCRR guide England_0.pdf (rcplondon.ac.uk) Cited July 2022

[10] Information taken from the Royal College of Physicians: Using the structured judgement review method. Guide for reviewers (England). Available at https://www.rcplondon.ac.uk/sites/default/files/media/Documents/NMCRR%20guide%20England_0.pdf Cited July 2022

The **Regulation** and **Quality Improvement** Authority

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RQIA SCRR REVIEW RECOMMENDATIONS

IMPLEMENTATION PLAN

RECOMMENDATION 1				
1 (a) SHSCT should urgently update all relevant documentation to ensure that there is clarity regarding the SCRR including a description of the SCRR purpose, remit and process; explicitly stating that it is a separate process to any parallel Inquiries or investigations.				
Action Required to Deliver Recommendation(s)	**Responsible Officer[1]?**	**Update**	**Status RAG**	**Evidence pf Completion**
Update PID – with detail and purpose of SCRR,	LBR Project Manager (LE)	**20/10/22** – work commenced on this	Ongoing	
Draft a "stand-alone" summary of the background, purpose, objectives and process of SCRR	LBR Project Manager (LE)	**20/10/22** – work commenced	Ongoing	
1(b) SHSCT should review their arrangements for developing and quality assuring patient / family information materials and publicly accessible information to ensure there is adequate lay / service user involvement, communications expertise and, where beneficial, legal input.				
Add lay representation to the Urology Lookback Review steering and operational group.	Head of the Lookback Review (SW)	**20/10/22** – Lay representation sought via PPI team in Trust	Ongoing	
Patient / family information materials required for Phase 2 to be activity considered by Lay representatives and tested within other PPI forums either internal or external to Trust.	This is an action for the future – will be addressed and evidenced in phase 2			

[1] Responsibility for delivery this action plan sits with the SRO for the LBR who is chair of the LBR Steering Group (MOH)

RECOMMENDATION 2				
2(a) SHSCT should consider reviewing the composition of Lookback Review steering group to reflect that which is stated within Regional Guidance for				
Action Required to Deliver Recommendation(s)	**Responsible Officer?**	**Update**	**Status RAG**	**Evidence pf Completion**
Reorganise structures for the LBR process and reset role and function of steering group including membership	Chair of Steering Group (MOH)	**20/10/22** – complete	Closed	- Terms of Reference for Steering Group - Diagram of new structure
2(b) SHSCT should establish a dedicated project team for the management and co-ordination of SCRR. SHSCT should recruit people with the skills and experience who, if required, can seek the advice and guidance of experts from across the region.				
Lookback Review in line with project management principles and processes. Draft PID to summaries the LBR process	Chair of Steering Group (MOH)	20/10/22 – complete – new structure and process	Closed	- PID - New structure and process in place to include clarity on reporting and accountability

RECOMMENDATION 3				
Considering the need for dedicated co-ordination and management of the Lookback Review and the SCRR process; SHSCT should prioritise the appointment of a suitably qualified Project Manager.				
Action Required to Deliver Recommendation(s)	**Responsible Officer?**	**Update**	**Status RAG**	**Evidence pf Completion**
Appoint project manager to oversee the implementation of the Lookback Review in line with project management principles and processes	Chair of Steering Group (MOH)	20/10/22 – complete LE in post from 1 September 2022	Closed	- Staff in post

RECOMMENDATION 4				
4(a) SHSCT should define and explicitly state the purpose of the SCRR process. Furthermore, a clear Terms of Reference / set of objectives should be agreed and referenced within the relevant Trust documentation.				
Action Required to Deliver Recommendation(s)	**Responsible Officer?**	**Update**	**Status RAG**	**Evidence of Completion**
Same as per recommendation 1(a) above	See recommendation 1(a) above	**20/10/22** – work commenced	Ongoing	

RECOMMENDATION 5				
5(a) SHSCT should give urgent consideration to extending their Lookback Review to identify and recall further groups of patients. DoH / Urology				
Action Required to Deliver Recommendation(s)	**Responsible Officer?**	**Update**	**Status RAG**	**Evidence of Completion**
Draft options paper for extending the Urology Lookback Review and progress with option agreed by UAG.	Chair of Steering Group (MOH)	**20/10/22** – work commenced	Ongoing	
5(b) RQIA should consider undertaking an independent assessment of Trust arrangements for the Urology Lookback Review in order to provide assurance on its effectiveness and identify any areas for improvement.				
RQIA to action not Trust				

RSC requested – not accepted SCRR process is currently outsourced to individual external urologists accessed via BAUS. Request to be made to RCP	Dep MD (DG)	**20/10/22** – unable to secure RCS to undertake this work, IS also considered but unable to secure capacity to do this work. Awaiting feedback from RCP		Emails from RSC Emails with BAUS

RECOMMENDATION 7				
SHSCT should consider implementing a sampling approach to case selection for SCRR. Such an approach should be agreed with DoH / Urology Assurance Group / SPPG. SHSCT should be clear on the rationale, its benefits and limitations and ensure that there is openness and transparency in communication with patients, families and the public. SHSCT should engage the Clinical Ethics Committee to consider any ethical issues arising from				
Action Required to Deliver Recommendation(s)	**Responsible Officer?**	**Update**	**Status RAG**	**Evidence of Completion**
Sampling approach to case selection for SCRR to be included in the options paper on progressing with the SCRR process for consideration by UAG	Chair of Steering Group (MOH)	**20/10/22** – work commenced – document to be ready for UAG in November (no date)	Ongoing	

RECOMMENDATION 8				
SHSCT should request SHSCT Clinical Ethics Committee to review both current and proposed arrangements for the Lookback Review and SCRR. Where ethical issues are identified, SHSCT should give this due consideration and, where required, adapt the methodology and approach for the review.				
Action Required to Deliver Recommendation(s)	**Responsible Officer?**	**Update**	**Status RAG**	**Evidence of Completion**
Papers on SCRR and extending the Lookback Review to be shared with Trust ethic committee when complete	TBA	**20/10/22** - Not yet commenced – to discuss with new Medical Director when he takes up post	Not started	

RECOMMENDATION 9				
SHSCT should engage with Trust legal representation to obtain a legal perspective on the arrangements for the SCRR.				
Action(s) Required to Deliver Recommendation(s)	**Responsible Officer?**	**Update**	**Status RAG**	**Evidence pf Completion**
Share SCRR related papers with DLS	Chair of Steering Group (MOH)	**20/10/22** - Current SCRR process arrangement shared with DLS. The options paper on the way forward re SCRR will be shared with DLS when complete and prior to discussion with UAG.	Ongoing	

RECOMMENDATION 10				
SHSCT should review their arrangements for the involvement of patients and families to ensure that it fulfils its statutory duty of Personal Public Involvement. SHSCT should consider engaging those with Personal Public Involvement expertise and external partners such as the PHA who have PPI training resources for staff and the PCC who could provide advice and support in the involvement of patients and families as part of the Lookback				
Action(s) Required to Deliver Recommendation(s)	**Responsible Officer?**	**Update**	**Status RAG**	**Evidence pf Completion**
As per recommendation 1(b) add Lay representation to the Urology Lookback Review steering and operational group. Provide information and bespoke induction of new Lay representatives to assist in contributing to the Lookback Review	Head of the Lookback Review (SW)	**20/10/22** – Lay representation sought via PPI team in Trust	Ongoing	

RECOMMENDATION 11				
SHSCT should review their arrangements for sharing SCRR findings with patients and families giving consideration to good practice as outlined by the				
Action(s) Required to Deliver Recommendation(s)	**Responsible Officer?**	**Update**	**Status RAG**	**Evidence pf Completion**
Share current process for communicating with patients / families re SCRR outcomes with DLS for feedback and advice.	Chair of Steering Group (MOH)	**20/10/22** – As per DLS advice for an individual patient –patients to be offered either report in full or summary from section 2.11. Letter also includes opportunity to discuss the finding with clinical team face to face and separately an offer of a clinical appointment with consultant urologist. Also includes an unreserved apology from the CX on behalf of the Trust	Completed & Closed	Email from DLS (21/7/22)

RECOMMENDATION 12				
SHSCT should liaise with RCP and consider amending the Structured Clinical Record Review tool to include an assessment of the quality of documentation and an assessment of the documented communication with patients and families; the clinical team, MDT and primary care. SHSCT				
Action(s) Required to Deliver Recommendation(s)	**Responsible Officer?**	**Update**	**Status RAG**	**Evidence pf Completion**
Consider the above recommendation	Chair of Steering Group (MOH)	**20/10/22** – recommendation considered and decision taken not to change SCRR inter-process as calls into question the validity the work done previously.	Closed see below re next phase of LBR	
SCRR process to be reviewed - if being utilised for the extended cohort of patients. This recommendation to be applies at that time.	This is an action for the future – will be addressed and evidenced in phase 2			

RECOMMENDATION 13				
DoH should commission RQIA to undertake a Review of Governance Arrangements within Urology Services in Southern HSC Trust.				
Action(s) Required to Deliver Recommendation(s)	**Responsible Officer?**	**Update**	**Status RAG**	**Evidence pf Completion**
DOH to action not Trust				

RECOMMENDATION 14				
14(a) SHSCT should not be limited to consultant urologists when recruiting clinical reviewers to undertake the SCRR process. All Expert Reviewers should be provided with guidance and support, including an opportunity to debrief, feedback and avail of emotional / psychological support if required.				
Action(s) Required to Deliver Recommendation(s)	**Responsible Officer?**	**Update**	**Status RAG**	**Evidence pf Completion**
Establish if RCP can facilitate the SCRR process	DMD (DG)	**20/10/22** – await feedback from RCP	Ongoing	
SCRR process to be reviewed - if being utilised for the extended cohort of patients. This recommendation to be applies at that time.	This is an action for the future – will be addressed and evidenced in phase 2			
14(b) A document should be drafted specific to this particular piece of work to guide reviewers through the process of conducting the SCRR; this should include a defined protocol for the assessment of the quality of care and treatment.				
Action(s) Required to Deliver Recommendation(s)	**Responsible Officer?**	**Update**	**Status RAG**	**Evidence pf Completion**
Review the document that currently exists for the SCRR reviewers and update it in terms of good practice identified in RQIA review document as the basis for further review should SCRR continue to be utilised in the extended Lookback Review.	Project Manager (LE)	**20/10/22** – This work has commenced	Ongoing	

14 (c) A sample of cases already reviewed using the SCRR methodology should undergo a second review to ensure inter-reviewer reliability and				
Action(s) Required to Deliver Recommendation(s)	**Responsible Officer?**	**Update**	**Status RAG**	**Evidence pf Completion**
Consider this action	Chair of Steering Group (MOH)	**20/10/22** – recommendation considered – due to lack of SCRR reviewers it is not possible to undertake a second review of a sample of the returned SCRR reports. For this cohort of patients a comparative analysis of reasons for SCRR verse findings from SCRR has been undertaken and both align	Closed see below re next phase of LBR	SCRR theming analysis
SCRR process to be reviewed - if being utilised for the extended cohort of patients. This recommendation to be applied at that time.	This is an action for the future – will be addressed and evidenced in phase 2			

RECOMMENDATION 15				
A review panel should be constituted, for the specific purposes of identifying learning and determining recommendations arising from the SCRR process. This panel should include individuals with expertise in urology and governance, and include a lay member.				
Action(s) Required to Deliver Recommendation(s)	**Responsible Officer?**	**Update**	**Status RAG**	**Evidence pf Completion**
Commission a "Thematic Review" undertaken when all 53 SCRR reports and complete.	Medical Director	**20/10/22** – an external urologist identified to complete this work when the report are returned. Currently on 24 of the 53 reports have been returned.	Not started	
Provide an analysis of the themes identified by Trust senior doctors through the internal "SCRR Screening" process and complete to themes identified external SCRR urologists	Head of the Lookback Review (SW)	**20/10/22** – Complete and will be kept up to date as reports are returned	Closed	Report available

RECOMMENDATION 16				
SHSCT should work with DoH / SPPG / PHA to develop an effective dissemination strategy for the Lookback Review and SCRR so that learning is				
Action(s) Required to Deliver Recommendation(s)	**Responsible Officer?**	**Update**	**Status RAG**	**Evidence pf Completion**
Agree and document the process(s) for disseminating regional learning following the Lookback Review for consideration by UAG	Head of the Lookback Review (SW)	**20/10/22** – work commenced	Ongoing	
Update Communication plan to include this aspect of communication	Project Manager (LE)	**20/10/22** – cannot commence until above action completed	Not started	

RECOMMENDATION 17				
SHSCT should draft a statement of purpose for the new database, outlining the rationale for transferring data and should retain a copy of the redundant				
Action(s) Required to Deliver Recommendation(s)	**Responsible Officer?**	**Update**	**Status RAG**	**Evidence pf Completion**
Draft a "Statement of Purpose"	Project Manager (LE)	**20/10/22** – Copy in draft awaiting review and sign-off	Ongoing	

RECOMMENDATION 18				
18(a) SHSCT should urgently develop and implement a communication strategy specific to the Lookback Review and including the SCRR process.				
Action(s) Required to Deliver Recommendation(s)	**Responsible Officer?**	**Update**	**Status RAG**	**Evidence pf Completion**
Draft communications strategy including communication plan for each stage of the Lookback exercise	Communications Manager (PT)	**20/10/22** – draft plan complete – awaiting review and sign-off	Ongoing	
18(b) A channel of communication specific to Urology work streams should be established between SHSCT, PSNI, GMC and Coroner's office; SHSCT should ascertain the thresholds for referral in respect of specific concerns arising out of cases reviewed as part of the SCRR.				
Action(s) Required to Deliver Recommendation(s)	**Responsible Officer?**	**Update**	**Status RAG**	**Evidence pf Completion**
Consider above recommendation		**20/10/22** – channel of communication currently exists with GMC and USI. Communication with PSNI and / or coroner not warranted at this time – this will be established if required in the future.	Closed	Emails and documents shared with GMC and USI.

RQIA SCRR Review Recommendations

Action Plan

Summary

Total Number of Trust Actions Required = 25

Date	RAG Rating	Number
24/10/22		8
		14
		3
18/11/22		9 ↑
		13 ↑
		3 =
16/12/22		18 ↑
		5 ↓
		2 ↓
03/02/23		18 =
		6 ↑
		1 ↓
20/03/23		20↑
		4↓
		1=
24/04/23		22↑
		2↓
		1=

RQIA SCRR REVIEW RECOMMENDATIONS IMPLEMENTATION PLAN

RECOMMENDATION 1				
1 (a) SHSCT should urgently update all relevant documentation to ensure that there is clarity regarding the SCRR including a description of the SCRR purpose, remit and process; explicitly stating that it is a separate process to any parallel Inquiries or investigations.				
Action Required to Deliver Recommendation(s)	**Responsible Officer[1]?**	**Update**	**Status RAG**	**Evidence pf Completion**
Update PID – with detail and purpose of SCRR,	LBR Project Manager (LE)	**20/10/22** – work commenced on this **18/11/22** - draft complete being reviewed prior to being finalised **16/12/22 -** Complete	Complete	Report
Draft a "stand-alone" summary of the background, purpose, objectives and process of SCRR	LBR Project Manager (LE)	**20/10/22** – work commenced **18/11/22** - draft complete being reviewed prior to being finalised **16/12/22 -** Complete	Complete	Report
1(b) SHSCT should review their arrangements for developing and quality assuring patient / family information materials and publicly accessible information to ensure there is adequate lay / service user involvement, communications expertise and, where beneficial, legal input.				
Add lay representation to the Urology Lookback Review steering and operational group.	Head of the Lookback Review (SW)	**20/10/22** – Lay representation sought via PPI team in Trust **18/11/22** - no further progress **16/12/22** – Two lay reps identified and joining Operational & Steering Groups	Complete	Emails confirming TOR
Patient / family information materials required for Phase 2 to be activity considered by Lay representatives and tested within other PPI forums either internal or external to Trust.	This is an action for the future – will be addressed and evidenced in phase 2			

[1] Responsibility for delivery this action plan sits with the SRO for the LBR who is chair of the LBR Steering Group (MOH)

RECOMMENDATION 2				
2(a) SHSCT should consider reviewing the composition of Lookback Review steering group to reflect that which is stated within Regional Guidance for				
Action Required to Deliver Recommendation(s)	**Responsible Officer?**	**Update**	**Status RAG**	**Evidence pf Completion**
Reorganise structures for the LBR process and reset role and function of steering group including membership	Chair of Steering Group (MOH)	**20/10/22** – complete	Closed	- Terms of Reference for Steering Group - Diagram of new structure
2(b) SHSCT should establish a dedicated project team for the management and co-ordination of SCRR. SHSCT should recruit people with the skills and experience who, if required, can seek the advice and guidance of experts from across the region.				
Lookback Review in line with project management principles and processes. Draft PID to summaries the LBR process	Chair of Steering Group (MOH)	**20/10/22** – complete – new structure and process	Closed	- PID - New structure and process in place to include clarity on reporting and accountability

RECOMMENDATION 3				
Considering the need for dedicated co-ordination and management of the Lookback Review and the SCRR process; SHSCT should prioritise the appointment of a suitably qualified Project Manager.				
Action Required to Deliver Recommendation(s)	**Responsible Officer?**	**Update**	**Status RAG**	**Evidence pf Completion**
Appoint project manager to oversee the implementation of the Lookback Review in line with project management principles and processes	Chair of Steering Group (MOH)	**20/10/22** – complete LE in post from 1 September 2022 **27/02/2022** – LE completed PRINCE2 Foundation and Practitioner Training	Closed	- Staff in post - Certificate of P2 completion

RECOMMENDATION 4				
4(a) SHSCT should define and explicitly state the purpose of the SCRR process. Furthermore, a clear Terms of Reference / set of objectives should be				
Action Required to Deliver Recommendation(s)	**Responsible Officer?**	**Update**	**Status RAG**	**Evidence of Completion**
Same as per recommendation 1(a) above	See recommendation 1(a) above	**20/10/22** – work commenced **18/11/22** - draft complete being reviewed prior to being finalised **16/12/22 -** Complete	Complete	Report

RECOMMENDATION 5				
5(a) SHSCT should give urgent consideration to extending their Lookback Review to identify and recall further groups of patients. DoH / Urology Assurance Group / SPPG, PHA and RQIA should work together to support SHSCT with the Lookback Review.				
Action Required to Deliver Recommendation(s)	**Responsible Officer?**	**Update**	**Status RAG**	**Evidence of Completion**
Draft options paper for extending the Urology Lookback Review and progress with option agreed by UAG.	Chair of Steering Group (MOH)	**20/10/22** – work commenced **18/11/22 –** Options paper shared with UAG on 17 November	Complete	Options paper
5(b) RQIA should consider undertaking an independent assessment of Trust arrangements for the Urology Lookback Review in order to provide assurance on its effectiveness and identify any areas for improvement.				
RQIA to action not Trust				

RSC requested – not accepted SCRR process is currently outsourced to individual external urologists accessed via BAUS. Request to be made to RCP	Dep MD (DG)	**20/10/22** – unable to secure RCS to undertake this work, **18/11/22 –** IS (3FiveTwo) sourced – IS contract being urgently drawn up to commission this work **16/12/22 –** IS now being utilised		Emails from RSC Emails with BAUS First tranche (14 cases) passed to IS on 13 December

RECOMMENDATION 7				
SHSCT should consider implementing a sampling approach to case selection for SCRR. Such an approach should be agreed with DoH / Urology Assurance Group / SPPG. SHSCT should be clear on the rationale, its benefits and limitations and ensure that there is openness and transparency in communication with patients, families and the public. SHSCT should engage the Clinical Ethics Committee to consider any ethical issues arising from such an approach which can then be addressed and mitigated by SHSCT				
Action Required to Deliver Recommendation(s)	**Responsible Officer?**	**Update**	**Status RAG**	**Evidence of Completion**
Sampling approach to case selection for SCRR to be included in the options paper on progressing with the SCRR process for consideration by UAG	Chair of Steering Group (MOH)	**20/10/22** – work commenced – **18/11/22** – to be further clarified when IS contract in place **16/12/22** – All of the outstanding cases (29) of the original 53 cases will be passed to IS. Consideration will be given to sampling the remaining 38 plus any new SCRRs added at screening in the NY **03/02/23** – Now 125 SCRR in total (potential for up to a further 9 which are	Closed	

		planned for screening – which when compete finishes screening for cohort 1. A paper to be drafted for UAG to consider sampling of the current outstanding 72 SCRR cases. **20/03/23 –** All original 53 index SCRR cases are now completed. Comparative review has been completed. Direction from UAG as of 13.02.23 is to move to a "targeted" approach to the remaining SCRR cases. LBR Team currently assessing those remaining cases for determination of issue and if this is a new theme.		

RECOMMENDATION 8				
SHSCT should request SHSCT Clinical Ethics Committee to review both current and proposed arrangements for the Lookback Review and SCRR. Where ethical issues are identified, SHSCT should give this due consideration and, where required, adapt the methodology and approach for the review.				
Action Required to Deliver Recommendation(s)	**Responsible Officer?**	**Update**	**Status RAG**	**Evidence of Completion**
Papers on SCRR and extending the Lookback Review to be shared with Trust ethic committee when complete	TBA	**20/10/22** - Not yet commenced – to discuss with new Medical Director when he takes up post **18/11/22 –** no update **16/12/22** – no update **03/02/23** – a seating of the ethic committee to be arranged to consider ethical considerations of Cohort 2 **24/04/23** – not considered necessary as both agreed by UAG.	Closed	Minutes of UAG from 7 March 2023

Share SCRR related papers with DLS	Chair of Steering Group (MOH)	**20/10/22** - Current SCRR process arrangement shared with DLS. The options paper on the way forward re SCRR will be shared with DLS when complete and prior to discussion with UAG. **18/11/22** – to be further considered if SCRR to change when IS contract in place. **16/12/22** – unchanged **03/02/23** – paper referred to above under recommendation 7 to be shared with DLS when complete **23/3/23** – shared with DLS and USI		Email to DLS dated 23/3/23 & in document in USI discovery folder

RECOMMENDATION 10				
SHSCT should review their arrangements for the involvement of patients and families to ensure that it fulfils its statutory duty of Personal Public Involvement. SHSCT should consider engaging those with Personal Public Involvement expertise and external partners such as the PHA who have PPI training resources for staff and the PCC who could provide advice and support in the involvement of patients and families as part of the Lookback Review and SCRR.				
Action(s) Required to Deliver Recommendation(s)	**Responsible Officer?**	**Update**	**Status RAG**	**Evidence pf Completion**
As per recommendation 1(b) add Lay representation to the Urology Lookback Review steering and operational group.	Head of the Lookback Review (SW)	**20/10/22** – Lay representation sought via PPI team in Trust	Complete	Meeting with Head of LBR and 2 lay reps

Provide information and bespoke induction of new Lay representatives to assist in contributing to the Lookback Review		**18/11/22 –** no update while Head of LBR is unavailable **16/12/22** – Two lay reps identified and joining Operational & Steering Groups		Information pack

RECOMMENDATION 11				
SHSCT should review their arrangements for sharing SCRR findings with patients and families giving consideration to good practice as outlined by the				
Action(s) Required to Deliver Recommendation(s)	**Responsible Officer?**	**Update**	**Status RAG**	**Evidence pf Completion**
Share current process for communicating with patients / families re SCRR outcomes with DLS for feedback and advice.	Chair of Steering Group (MOH)	**20/10/22** – As per DLS advice for an individual patient –patients to be offered either report in full or summary from section 2.11. Letter also includes opportunity to discuss the finding with clinical team face to face and separately an offer of a clinical appointment with consultant urologist. Also includes an unreserved apology from the CX on behalf of the Trust	Completed & Closed	Email from DLS (21/7/22)

RECOMMENDATION 12				
SHSCT should liaise with RCP and consider amending the Structured Clinical Record Review tool to include an assessment of the quality of documentation and an assessment of the documented communication with patients and families; the clinical team, MDT and primary care. SHSCT				
Action(s) Required to Deliver Recommendation(s)	**Responsible Officer?**	**Update**	**Status RAG**	**Evidence pf Completion**
Consider the above recommendation	Chair of Steering Group (MOH)	**20/10/22** – recommendation considered and decision taken not to change SCRR inter-process as calls into question the validity the work done previously.	Closed see below re next phase of LBR	
SCRR process to be reviewed - if being utilised for the extended cohort of patients. This recommendation to be applies at that time.	This is an action for the future – will be addressed and evidenced in phase 2			

RECOMMENDATION 13				
DoH should commission RQIA to undertake a Review of Governance Arrangements within Urology Services in Southern HSC Trust.				
Action(s) Required to Deliver Recommendation(s)	**Responsible Officer?**	**Update**	**Status RAG**	**Evidence pf Completion**
DOH to action not Trust				

RECOMMENDATION 14				
14(a) SHSCT should not be limited to consultant urologists when recruiting clinical reviewers to undertake the SCRR process. All Expert Reviewers should be provided with guidance and support, including an opportunity to debrief, feedback and avail of emotional / psychological support if required.				
Action(s) Required to Deliver Recommendation(s)	**Responsible Officer?**	**Update**	**Status RAG**	**Evidence pf Completion**
Establish if RCP can facilitate the SCRR process	DMD (DG)	**20/10/22** – await feedback from RCP **18/11/22 –** no further feedback – response chased **16/12/22 –** Complete – IS contract in place	Complete	Contract Returned reports from IS
SCRR process to be reviewed - if being utilised for the extended cohort of patients. This recommendation to be applies at that time.	This is an action for the future – will be addressed and evidenced in phase 2			
14(b) A document should be drafted specific to this particular piece of work to guide reviewers through the process of conducting the SCRR; this should include a defined protocol for the assessment of the quality of care and treatment.				
Action(s) Required to Deliver Recommendation(s)	**Responsible Officer?**	**Update**	**Status RAG**	**Evidence pf Completion**
Review the document that currently exists for the SCRR reviewers and update it in terms of good practice identified in RQIA review document as the basis for further review should SCRR continue to be utilised in the extended Lookback Review.	Project Manager (LE)	**20/10/22** – This work has commenced **18/11/22 –** Being prepared to support IS contract **16/12/22** – draft guideline shared with IS as part of contracting process	Closed	IS Contract Contract monitoring notes

14 (c) A sample of cases already reviewed using the SCRR methodology should undergo a second review to ensure inter-reviewer reliability and				
Action(s) Required to Deliver Recommendation(s)	**Responsible Officer?**	**Update**	**Status RAG**	**Evidence pf Completion**
Consider this action	Chair of Steering Group (MOH)	**20/10/22** – recommendation considered – due to lack of SCRR reviewers it is not possible to undertake a second review of a sample of the returned SCRR reports. For this cohort of patients a comparative analysis of reasons for SCRR verse findings from SCRR has been undertaken and both align	Closed see below re next phase of LBR	SCRR theming analysis
SCRR process to be reviewed - if being utilised for the extended cohort of patients. This recommendation to be applied at that time.	This is an action for the future – will be addressed and evidenced in phase 2			

RECOMMENDATION 15				
A review panel should be constituted, for the specific purposes of identifying learning and determining recommendations arising from the SCRR				
Action(s) Required to Deliver Recommendation(s)	**Responsible Officer?**	**Update**	**Status RAG**	**Evidence pf Completion**
Commission a "Thematic Review" undertaken when all 53 SCRR reports and complete.	Medical Director	**20/10/22** – an external urologist identified to complete this work when the report are returned. Currently on 24 of the 53 reports have been returned. **18/11/22 –** no further SCRR returned **16/11/22** – Meeting with Dr Sally Williams on 13/12 – Dr William agreed to coordinate a thematic Review when SCRR complete **03/02/23** – five outstand SCRR returns. Dr Williams to be contacted to start process for undertaking a thematic review **20/03/23-** Contract pending with Dr Sally Williams with support of the IS SME's who undertook the completion of the SCRR reports. **24/04/23** – DAC being drafted – delayed due to checking if an external urologist would complete negating need for a DAC	Ongoing	
Provide an analysis of the themes identified by Trust senior doctors through the internal "SCRR Screening" process and complete to themes identified external SCRR urologists	Head of the Lookback Review (SW)	**20/10/22** – Complete and will be kept up to date as reports are returned	Closed	Up to date report available

RECOMMENDATION 16				
SHSCT should work with DoH / SPPG / PHA to develop an effective dissemination strategy for the Lookback Review and SCRR so that learning is				
Action(s) Required to Deliver Recommendation(s)	**Responsible Officer?**	**Update**	**Status RAG**	**Evidence pf Completion**
Agree and document the process(s) for disseminating regional learning following the Lookback Review for consideration by UAG	Head of the Lookback Review (SW)	**20/10/22** – work commenced **18/11/22 –** no update to report **16/12/22** – no further progress **03/02/23** – no further progress as cohort 1 still to complete. **20/03/23 –** date agreed for Learning and Development Group this month. HOS will attend to disseminate from LBR Process. (Update from meeting will be reflected in next action plan update) **24/04/23** – learning to be shared following completion of Cohort 1 outcomes report.	Ongoing	
Update Communication plan to include this aspect of communication	Project Manager (LE)	**20/10/22** – cannot commence until above action completed **16/12/22** – no change **03/02/23** – no change **20/03/23** – no change **24/04/23** – no change – Outcomes report due end May for discussion and agreement at UAG on 7 June 23	Not started	

RECOMMENDATION 17				
SHSCT should draft a statement of purpose for the new database, outlining the rationale for transferring data and should retain a copy of the redundant				
Action(s) Required to Deliver Recommendation(s)	**Responsible Officer?**	**Update**	**Status RAG**	**Evidence pf Completion**
Draft a "Statement of Purpose"	Project Manager (LE)	**20/10/22** – Copy in draft awaiting review and sign-off **18/11/22** – no update to report **16/12/22** – not signed off until cross-reference against template requested from BOH (via RQIA) – not yet received **03/02/22** – database developer completing – request made for draft to be shared **20/03/23** – Document Finalised	Complete	Statement of Purpose document

RECOMMENDATION 18				
18(a) SHSCT should urgently develop and implement a communication strategy specific to the Lookback Review and including the SCRR process				
Action(s) Required to Deliver Recommendation(s)	**Responsible Officer?**	**Update**	**Status RAG**	**Evidence pf Completion**
Draft communications strategy including communication plan	Communications Manager (PT)	**20/10/22** – draft plan complete – awaiting review and sign-off **18/11/22 –** no update to report **16/11/22** – Phase 1 plan complete – will be revised for Phase 2	Complete and closed	PID including phase 1 comms plan
18(b) A channel of communication specific to Urology work streams should be established between SHSCT, PSNI, GMC and Coroner's office; SHSCT should ascertain the thresholds for referral in respect of specific concerns arising out of cases reviewed as part of the SCRR.				

Action(s) Required to Deliver Recommendation(s)	Responsible Officer?	Update	Status RAG	Evidence pf Completion
Consider above recommendation		**20/10/22** – channel of communication currently exists with GMC and USI. Communication with PSNI and / or coroner not warranted at this time – this will be established if required in the future.	Complete and Closed	Emails and documents shared with GMC and USI.

Getting it Right First Time

Urology across Northern Ireland

October 2023

This report has been produced by the Getting It Right First Time (GIRFT) Project Team at the Royal National Orthopaedic Hospital (RNOH/GIRFT). It aims to enable the urgent restoration of elective urological services and the adoption of the HVLC/GIRFT principles to ensure best outcomes for patients, by reducing unwarranted variation and maximising the use of existing resources and assets.

Written by:

Kieran O'Flynn: GIRFT Joint National Urology Clinical Lead, Consultant Urological Surgeon, Northern Care Alliance.

John McGrath: GIRFT Joint National Urology Clinical Lead, Consultant Urological Surgeon, Royal Devon University Healthcare NHS Foundation Trust

Foreword

Getting It Right First Time (GIRFT) is a national Programme in England developed by the GIRFT National Team under the Chairmanship of Professor Tim Briggs. GIRFT has been designed to improve patient care, by reducing unwarranted variations in clinical practice. It helps identify clinical outliers and best practice amongst providers, highlights changes that will improve patient care and outcomes and delivers efficiencies (such as the reduction of unnecessary procedures) and cost savings.

Working to the principle that a patient should expect to receive equally timely and effective investigations, treatment and outcomes wherever care is delivered, irrespective of who delivers that care, GIRFT aims to identify approaches from across the NHS that improve outcomes and patient experience.

The High Volume Low Complexity (HVLC) programme is a priority data-led transformation programme supporting the recovery of elective care services post COVID-19 pandemic. It aims to reduce the backlog of patients waiting for planned operations, improve clinical outcomes and access to services through standardised clinical pathways (HVLC programme - Getting It Right First Time - GIRFT).

The GIRFT Projects Directorate at the Royal National Orthopaedic Hospital (RNOH/GIRFT), also under the Chairmanship of Professor Tim Briggs, was approached by the Northern Ireland Department of Health Elective and Cancer Services team to conduct a review of Urology across Northern Ireland using the GIRFT methodology and HVLC principles.

This report describes the findings and recommendations from the review, as well as laying out the objectives and the approach followed by the RNOH GIRFT team.

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Contents

1. Executive Summary

This report is based on the data and observations from RNOH/GIRFT's face to face visits to all the Trusts in Northern Ireland to review their urology services. **Figure 1** shows the schedule of the visits. **Annex A** provides a full list of hospitals included in this review.

Figure 1: Schedule of visits

Trust	Visit Date
South Eastern Trust	Tuesday 16th May and Wednesday 17th May 2023
Belfast Trust	Wednesday 17th May 2023
Northern Trust	Thursday 18th May 2023
Southern Trust	Thursday 18th May 2023
Western Trust	Friday 19th May 2023

We have made a series of recommendations in this report which aim to tackle waiting lists, improve structures and ways of working and improve the quality of care. Consideration is given to other cross-cutting areas to improve performance, awareness and the governance of urology services across Northern Ireland.

It is now essential that the recommendations made in this report are immediately taken forward to improve care for patients and to put in place a structure and ways of working across Northern Ireland to deliver them. This will involve the Trusts working together and a blurring of their historical boundaries. Furthermore, it is essential that the changes introduced to increase elective surgery are resilient during the winter months; and must deliver elective care for 48 weeks per annum. We can no longer accept "shut down" of elective care during winter; it is not in the best interest of patients and will not reduce waiting lists.

We have made a total of **40 national recommendations** in this report. These include recommendations for the Department of Health to take forward nationally **(Section 2.1)** and recommendations where the Department of Health should encourage the implementation of over-arching recommendations to all Trusts, as many improvements apply to all providers **(Section 2.2)**.

Through a combination of Trust meetings and a review of the data provided, we observed variation in practice within Trusts, between Trusts and also when compared to NHS England urology metrics; some of the variation is unwarranted. Where we have observed this, we have challenged the Urology Teams and provide appropriate recommendations. Separate recommendations for each of the Trusts are detailed in **Annex B-F.**

We have provided a number of useful links to GIRFT Urology pathways and good practice guidance in **Annex G** along with a glossary of terms and abbreviations in **Annex H.**

The review team met with senior clinicians, managers and members of the trust executives at each of the five trusts providing services across Northern Ireland. There was an overwhelming sense amongst the people that we spoke with that provision of urological services across the Province had deteriorated over the past decade and that long-term planning was hampered by the absence of a functioning administration at Stormont and the current political vacuum.

The direct consequence of this is that budgetary planning is difficult, with in-year budgeting becoming the norm. Nevertheless, the RNOH/GIRFT team were very impressed with the

strides that colleagues had made in discussions about how service should evolve in the specialty of Urology.

Given the population in Northern Ireland of 1.86 million, it is neither possible nor desirable that all elements of the specialty can be delivered to a high standard in each hospital. Rationalisation and delivery of high-quality services are essential to ensure that clinicians with the requisite experience and skills are available to manage routine and complex care. While this principle has been accepted in urological oncology (provision of surgery for prostate, bladder, kidney and penile malignancies) and surgical andrology, there is a general acceptance across the British Isles that surgery of bladder outflow obstruction, complex stone disease, female and functional / neuro-urology should also move in this direction. It is to the immense credit of the Urologists in Northern Ireland that planning for this scenario is well advanced. Implementation should be the next step to ensure a vibrant and sustainable service for Northern Ireland's population.

2. Recommendations

2.1 General Recommendations for Northern Ireland Urology

No.	Department of Health Recommendations
1	DoH should establish a group of relevant stakeholders to lead on the development of an action plan to implement the GIRFT recommendations, allocating responsibilities to relevant people to share the workload. The group will need to align with existing regional and local structures to ensure no duplication.
2	The DoH should continue to encourage and support Trusts to strengthen clinical coding processes, including the routine sharing of data with clinical teams.
3	The DoH should ensure that good governance arrangements are in place to enable patients to have timely access to investigations and ensure that all clinicians seeing outpatient referrals have access to Northern Ireland Electronic Care Record (NIERC), thereby avoiding duplication of imaging and unnecessary repeat appointments. This predominantly relates to the use of 'outsourcing'; there should be a focus on long term provision of outpatient care in order to obviate the need for this short-term support. This should be explored with the rollout of Encompass.
4	The DoH should support Trusts to strengthen clinical networking to further promote mutual aid, where differences in waiting access times and or differences in the volumes of backlogs exist.
5	The DoH needs to urgently work with providers to address the under-provision of theatre capacity in regard to the provision of major urological cancer surgery, including cystectomy, radical prostatectomy and renal surgery. In the first instance, Belfast Trust should also work to ensure the full delivery of commissioned theatre list for the urology service within the Belfast Trust.
6	DoH should consider supporting a formal renal surgery network at sites outside of Belfast City Hospital (BCH) that currently offer this surgery; this could help to de-pressurise other major urological cancer pathways at the City site.
7	The Public Health Agency (PHA), in conjunction with BHSCT, should initiate a strategic review of the provision of robotic assisted surgery for Northern Ireland in Urology and other specialties, recognising the likely developments in robotic surgery in the next decade.
8	The DoH should promote and enable further examples of cross-site working between clinical teams for the delivery of both benign and cancer urological services.
9	The DoH should consider initiating a review into the funding mechanisms for trusts providing specialist care in both oncology and sub specialist urology practice, ensuring that trusts are not disadvantaged by undertaking specialist work.
10	The DoH should continue to ensure that Trusts are actively working to reduce the reliance on external outsourcing of clinical care; this can be achieved through implementation of the GIRFT recommendations and principles
11	The DoH should formalise the plans for the long-term provision of surgical andrology for Northern Ireland.

12	The DoH should formalise plans for the long-term provision of female and functional urology for Northern Ireland in conjunction with recommendations made in the GIRFT Uro-gynaecology report.
13	The DoH, in association with the Northern Ireland Medical and Dental Training Authority (NIMDTA), should undertake a review to ensure the national selection in Urology is the right model for recruitment into the specialty.
14	The DoH, in association with NIMDTA, to review the distribution of Urology trainees across NI, ensuring equity and access to training opportunities.
15	DoH, in partnership with trusts, should ensure robust processes/pathways and audit particularly of sub-specialty services to ensure they meet minimum quality standards, e.g. prostate cancer diagnostic pathways/ RARP/Cystectomy/ penile cancer etc. Quality standards should be agreed by subspecialist urologists in each area but already available for many subspecialty areas.

2.2 General Recommendations for the NI Department of Health and all Trusts

Northern Ireland Urology General Recommendations	
Outpatient Care	
1	As a priority, The DoH should support and encourage each Trust to plan for and establish a Urology Investigation Unit, where such a facility does not already exist (GIRFT Urology Investigation Units Guidance), to maximise the efficiency of elective outpatient services.
2	The DoH should ensure that Trusts strengthen the Advice and Guidance services and all referrals should undergo robust clinical triage by a senior clinician (medical or nursing), with downgrading of inappropriate red flag referrals (GIRFT Urology Outpatient Guidance).
3	As a matter of urgency, The DoH must support and encourage Trust Urology Teams to redesign and enhance their capacity to provide single-visit outpatient consulting and assessment (diagnostic) services for patients, with pre investigation imaging, where indicated arranged at triage prior to attendance.
4	The DoH should ensure that Trusts review their outpatient practice with a view to reducing the number of unnecessary review appointments, aspiring to a new to follow-up ratio of 1:2.
5	The DoH should promote greater adoption of virtual reviews as well as further nurse specialist input into outpatient pathways.
6	The DoH should ensure that Trusts are offering patient-initiated follow-up (PIFU) rather than routine clinical review to suitable patients. Trusts should ensure that there are robust mechanisms in place for such patients to gain timely access back into secondary care.
7	The DoH should ensure that outpatient pathways are standardised across all Trusts to ensure there is consistency nationally for patient undergoing outpatient investigation or treatment.
8	Trusts should rapidly implement a flexible cystoscopy and transurethral laser ablation (TULA) service for 'red patches' and recurrent superficial bladder cancer in the outpatient setting.
Inpatient Urology and HVLC	
9	Trusts should ensure that suitable procedures (flexible cystoscopy, flexible cystoscopy and Botox, transperineal biopsy procedures, urodynamics etc.) are **not** routinely

	performed in Trust theatres. These should be performed in an outpatient procedure room by default, not inpatient theatres '**Right procedure, right place' approach**'.
10	The PIG should ensure that there is continuous improvement work on moving existing in-patient pathways to daycase pathways and moving daycase pathways to an outpatient setting, where appropriate.
11	Trust management should ensure that Trusts are optimising their theatre capacity in order that each urologist has, as a minimum, 2 sessions of theatre activity for 42 weeks of the year, when not Consultant of the Week.
12	Trusts to implement the GIRFT guidance on theatre productivity, with appropriate listing and maximising theatre efficiency with SPPG oversight.
13	Where not already done, The DoH should ensure that Trusts implement an action plan for increasing the percentage of elective operations undertaken as day surgery, using the BADS guidance (Day case surgery - Getting It Right First Time - GIRFT).
14	The DoH should continue to ensure that Trusts have access to and efficiently utilise 'cold' HVLC sites, thereby ensuring that protected elective capacity is maintained regardless of winter or acute care pressures.
15	The Department of Health should continue to encourage Trusts to collaborate ensuring that there is equitable access across Northern Ireland for patients in regard to more specialist services for example: bladder outflow obstruction surgery, Percutaneous nephrolithotomy (PCNL), Extra-corporeal shock wave lithotripsy (ESWL) and Sacral nerve stimulation (SNM).
Urgent and Emergency Care (UEC)	
16	As an immediate action, Urologists (in collaboration with general surgery and emergency department colleagues) should develop contemporary, clear protocols for patients with urological conditions requiring urgent and emergency care (UEC). This is of particular importance for the Northern HSC where re-configuration of the current service is advised.
17	The Department of Health should ensure that Trusts offering on-site UEC services in urology should urgently develop ambulatory assessment facilities, where they do not already exist.
18	The Department of Health should ensure that Trusts offering on-site acute urological care should support clinical teams in developing a fully staffed 24/7 middle grade rota – these can comprise of an extended workforce, including doctors, nurse practitioners and or physicians' associates.
19	Each Trust must ensure there is a clear protocol and service-level agreement in place with an IR provider for the provision of interventional radiology, including out-of-hours cover.
20	Trusts must ensure there are established pathways for the provision of urgent ureteroscopy, extra-corporeal shockwave lithotripsy (ESWL) and bladder outflow surgery after acute presentation.
Specialist Urological Provision	
21	Performance Implementation Group to develop an approach for the delivery of Bladder Outlet Obstruction surgery (BOO) predicated on the use of two HVLC sites in Lagan Valley and Omagh Hospitals with agreed regional pathways.
22	The DoH should ensure that percutaneous nephro-lithotomy (PCNL) surgery for Northern Ireland should be centralised at Craigavon Area Hospital with agreed regional pathways.
23	The DoH should ensure that provision of extra-corporeal shockwave lithotripsy (ESWL) for Northern Ireland should be centralised at Craigavon Area Hospital, providing a timely service for urgent referrals.
24	The DoH should continue to ensure a co-ordinated approach to waiting list validation for outpatient and admitted pathways, with regular reporting of the clinical backlogs.

25	The DoH should continue to actively work to reduce the reliance on external outsourcing of clinical care through implementation of the GIRFT recommendations and principles

3. Project Objectives

The aim of this review was to:

- Identify areas of improvement to help the Department of Health to have a better understanding about how Urology services are being delivered across the country with the ultimate aim of improving patient outcomes.
- Ensure Urology services are being delivered in line with the Elective Care Framework and the Department of Health's strategic direction on the expansion of the elective care centres regional model.
- Identify recommendations to improve the patient pathways for Urology in all Trusts in Northern Ireland through production of a final report.

4. Our Methodology and Approach

We followed the GIRFT methodology, structured as follows:

- **Data gathering** and structuring shared ahead of the deep dive visits
- **RNOH communication** about the programme (including HVLC)
- **Deep dive engagements** for each Trust, with relevant stakeholders present
- **National level report** explaining findings and recommendations.

Prior to each visit we issued a questionnaire to each Trust which asked for information on the workforce; on call arrangements; recruitment and the provision of urology services.

We examined the data looking for unwarranted variation e.g. differences between hospitals in areas such as:

- **Overall Activity Metrics** (Urology elective inpatient spells, day case spells, Virtual outpatient Attendance, RTT Pathways)
- **Emergency Urological Care** (Urology emergency admissions, Emergency stone admissions, Urinary retention, Urinary tract infection /Urosepsis, Testicular torsion)
- **High Volume Low Complexity (HVLC) Procedures** (Transurethral resection of bladder tumour (TURBT) procedures, bladder outflow obstruction procedures, ureteroscopy and stent management procedures)
- **Oncology (Kidney and Ureter)** (radical nephrectomy for cancer procedures, nephrectomy for benign disease procedures, partial nephrectomy procedures)
- **Oncology Prostate** (Radical prostatectomy procedures)
- **Stone management** (PCNL procedures, extracorporeal shockwave lithotripsy (ESWL))
- **Female and Functional** (stress urinary incontinence, colposuspensions, autologous fascial sling procedures, paraurethral bulking agents for incontinence, cystoscopy and botox procedures sacral neuromodulation)
- **Andrology** (Peyronnies disease, Urethroplasty procedures).

The deep dive engagements took place from Tuesday 16th May to Friday 19th May and were led by Kieran O'Flynn and John McGrath. Each deep dive was an opportunity for the Trust to provide an overview of their Urology services and current issues; this was followed by a review of the GIRFT data and a detailed discussion. All the meetings were well attended by a mixture

of colleagues in Urology roles (clinicians, theatre staff, senior managers and allied health professionals) and colleagues from the Department of Health, all of whom contributed to the excellent discussions. This allowed the review team to gain a good understanding of the issues facing each Trust and their hospitals and to suggest improvements.

5. Urology Services Overview

Urology services are provided at four of the five Trusts. There is limited urological provision in the Northern Health and Social Care Trust. Patients requiring urological care are referred, depending on their postcode, to either Belfast Trust or Western Health and Social Care Service based at Altnagelvin. Similar arrangements apply for patients needing urgent and emergency care.

Urology is a broad specialty encompassing diseases of the kidney, bladder, prostate and genitalia. Approximately 40% of referrals are to establish a potential diagnosis of cancer (most commonly prostate or bladder cancer). These referrals are 'red flagged' and, due to their number, pose particular challenges in the arrangements for early assessment and management. Other common reasons for referral are lower urinary tract symptoms in older men and recurrent Urinary tract infections (UTI's - predominantly in women). All Trusts provide routine urological care, but each has encountered different challenges in relation to the timeliness of the care provided and for most patients unfortunately experience significant delays in getting access to both a timely diagnosis and/or treatment. The underlying reasons are explored further in the report.

The provision of specialist urological care is disparate throughout the province and is detailed in **Figure 2**. Most urological oncology (with the exception of penile cancer) is provided at Belfast Trust, with nephrectomy also being performed at Altnagelvin Area Hospital, Craigavon Area Hospital and the Ulster Hospital.

As can be seen from **Figure 2**, many elements of subspecialist practice in Urology are delivered at more than one trust. This has largely developed for historical reasons or due to the interests of a particular surgeon. For many elements of subspecialty practice, the numbers of procedures performed are small and this mitigates against developing a genuine expertise. The ability to deliver such services has also been hampered by the Covid pandemic, when much specialist non-oncological surgery was deferred, leading to de-skilling of surgeons. It is now opportune to consider how these services should be delivered in the future, ensuring that patients get access to high quality care, irrespective of their postcode.

In urological practice, transurethral prostatectomy (TURP) was considered the sentinel operation for the specialty. While bladder outflow obstruction surgery is currently delivered at all trusts, development in this area of urological practice mean that there are a number of newer treatment modalities available, many of which can be delivered safely as daycase procedure. Given the numbers of procedures performed in Northern Ireland each year, it is neither practicable nor financially viable for all newer modalities to be delivered at all trusts. Consolidation of these services is recommended and further discussed in **Section 8** of this report.

Figure 2: Provision of Specialist Services in NI

	Belfast HSC	Northern HSC	South Eastern HSC	Southern HSC	Western HSC
Oncology					
Radical Nephrectomy	Y	N	Lap-nephrectomy only	Y	Y
Partial Nephrectomy	Y	N	Referred to Belfast City Hospital	Referred to Belfast City Hospital	Referred to Belfast City Hospital
Nephro-ureterectomy	Y	N	N	Y	Y
Cystectomy	Y	N	Referred to Belfast City Hospital	Y	Referred to Belfast City Hospital
Radical prostatectomy	Y	N	Referred to Belfast City Hospital	Referred to Belfast City Hospital	Referred to Belfast City Hospital
Penile Cancer	Referred to Altnagelvin Area Hospital	N	Referred to Altnagelvin Area Hospital	Referred to Altnagelvin Area Hospital	Y
Stone disease					
PCNL	Y	N	Y	Y	Y
ESWL	Y	N	N	Y	Y
Female and Functional					
Stress Incontinence	Y	N	N	Y	Y
Bladder reconstruction	Y	N	N	N	Y
SNM	Y	N	N	N	Y
Andrology					
Urethroplasty	N	N	Y	N	Y
Peyronnies surgery	N	N	N	N	Y
Surgery for male stress incontinence	N	N	N	N	N

6. Workforce and Training

The Urology workforce for Northern Ireland is detailed in **Figure 3**. The ratio of urologists per head of the population is one of the lowest in Europe and lags behind that in England.

There are a number of factors that contribute towards Northern Ireland's difficulty in recruiting and retaining a workforce in the specialty. These include geography, national trainee selection, remuneration, onerous on-call rotas and limitations in the ability to develop sub-specialist practice in the specialty. Given the current working conditions with a significant on-call burden, currently limited subspecialty practice and the failure to develop specialist nursing, it is difficult to see how the hospitals in Northern Ireland can continue to attract high calibre consultant Urologists in the future.

Across the four home nations, it is estimated that there are approximately 120 unfilled consultant posts in the specialty. As only 50 National training number's (NTN's) exit training each year with a Certificate of Completion of Training (CCT) in Urology, there is an undersupply of trainees and consultant recruitment for many trusts is challenging. Units with fewer than 8 consultants have particular difficulty attracting new consultants, again largely because of onerous on-call arrangements and a limited subspecialty practice.

Northern Ireland and its constituent hospitals are approaching a tipping point with its over-reliance on a locum workforce and the anticipated retirement and relocation of consultants in the near future. The Department of Health will need to explore methods to incentivise recruitment into units where there have been repeated attempts to appoint substantive consultants but no suitable applicants found. On the mainland, there have been measures such as enhanced salary, improved re-location packages and negotiation on the starting salary point for new appointees. Other measures, such as networked on-call to reduce overall frequency, can enhance a consultant's working life and remove the current disincentives.

Whereas each trust would like to support the development of new consultant appointments in Urology, development of a functioning Urology Area Network model was effectively paused at the onset of the Covid pandemic; in the interim, much discussion has taken place and there is a renewed interest in inter-hospital working. Good progress has been made in developing plans for the provision of specialist services across Northern Ireland and these are discussed elsewhere in the report.

Figure 3: Current medical workforce

Trust	Funded Consultant Urologists	Consultant Urologists WTE	Trainees WTE	Trust doctors WTE	Physician Associate	Comments
Belfast HSC	8.8	8	5 StR (Funded = 5.0wte; 4.4wte in post) and 1 CT Doctor (Funded = 1.0wte)	1 (Funded = 3.0wte; 2 in post inc. 1 agency)	0	2x Trust (Specialty Grade) Doctors recruited Sept 2023 to take up positions before December 2023. In addition, there are, 2x temporary Clinical Fellows and 1x temporary LAS Doctors in post.
Northern HSC	0	0	0	0	0	
South Eastern HSC	7	6(1 on mat leave)	1	3	2	1 consultant post vacancy 1 locum consultant currently covering maternity leave
Southern HSC	6	4.41	3 (4.5 funded)	0.87 (1.1 funded)	0.5 (0.5 funded)	Current advertisement for 3 urologists Includes 1 long term agency locum 1 works half time at Belfast City
Western HSC	9	7.6	3 (0 funded)			2 vacant posts consultant posts

Each unit remains understaffed with respect to Urology Clinical Nurse Specialist (CNS) support, detailed in **Figure 4**, and this has a major impact on the functioning of the unit. There is a paucity of CNS provision in diagnostics, with CNS provision of prostate biopsy, flexible cystoscopy, flexible cystoscopy and Botox limited to Craigavon Area Hospital.

Figure 4: Current Whole Time Equivalent (WTE) clinical nurse specialist (CNS) and physician associate (PA) provision in Urology in NI

Role	Belfast HSC	Northern HSC	South Eastern HSC	Southern HSC	Western HSC
Band> 8c and above	-	-	-	-	-
Band 8b	-	-	-	-	-
Band 8a	1.00	-	1.00	2.42	-
Band 7	2.00	-	1.00	4	6.27
Band 6	3.00	-	2.00	0	3.52
Band 5	0	-	-	0	0
Physician Associate	-	-	2	0.5	-

As shown in **Figure 5,** there is currently no provision of flexible cystoscopy and laser ablation for recurrent superficial bladder cancer across NI; this is frequently delivered by nurse specialists in England (see section on outpatient provision). Such arrangements are standard elsewhere in the UK, where these services are provided in a dedicated outpatient setting / Urology Investigation Unit (UIU).

Figure 5: Provision of clinical nurse specialist roles by Trust

Role	Belfast HSC	Northern HSC	South Eastern HSC	Southern HSC	Western HSC
Flexible Cystoscopy	N	N	Y	Y	N
Flexi Cystoscopy and TULA	N	N	N	N	N
Flexible cystoscopy and botox	N	N	N	Y	N
Male lower urinary tract symptoms	Y		Y	Y	Y
Transperineal prostate biopsy	N	N	N	Y	N
Prostate cancer surveillance	Y	N	Y	Y	Y
Renal cancer surveillance	Y	N	Y	Y	Y
Stone clinic	Y	N	Y	Y	Y
Andrology	N	N	Y	N	Y
Continence	Y	N	N	N	Y

There needs to be rapid expansion in terms of numbers of specialist nurses but also a rapid upskilling of the workforce. The latter may be accelerated using an academy style model at one or more Trusts, where there could be a focused effort on training lists and mentors.

7. Outpatients and diagnostics

The facilities for outpatient assessment in Urology vary considerably across Northern Ireland. Each of the sites are highly constrained by the lack of space and suitable consultation and treatment rooms. The average waits by Health and Social Care Trust and the facilities available are shown in **Figures 6 and 7**. The consequence of this is that patients cannot be seen at the same time by members of the Urology team (doctors, nurses and Physician Associates); as a direct consequence, patients often have repeat appointments to see different staff members and outcomes are delayed. The constraints almost certainly contribute to the heavy reliance on ‘outsourcing’ for outpatient referrals and diagnostics.

Figure 6: Average waits by Health and Social Care Trust Northern Ireland[1] Accessed 16/6/23

	Belfast HSC	Northern HSC	South Eastern HSC	Southern HSC	Western HSC
Red flag*	2	N/A	2	5	1
Urgent**	14	N/A	17	30	7
Routine	68	N/A	87	155	16
Outsourcing arrangements	A percentage of routine appointments.	N/A	A percentage of red flag cystoscopies and TP biopsies.	A majority of red flag and urgent appointments.	A percentage of no-red flag patients and cystoscopies related to COVID backlog.

**Red Flag:* *These appointments are allocated to patients with suspected Cancer diagnosis and are the highest priority.*
***Urgent:* *These appointments are allocated to patients with urgent care needs other than Cancer.*

Trust Urology Teams must, as a matter of urgency, redesign and enhance their capacity to provide single-visit outpatient consulting and assessment (diagnostic) services for patients, avoiding the necessity for outsourcing and repeat attendances.

The most glaring example is at Altnagelvin Area Hospital, where some urology activity is delivered in the ground floor outpatients department, but patients have other elements of outpatient care delivered in rooms adjacent to the ward using rooms and facilities that are cramped and ill-suited for the assigned roles. This is compounded by the fact that neither the nursing offices nor the consultant offices are located close by. Co-location of facilities would enhance team working and greatly facilitate throughput. The lack of dedicated space means that it is not possible to provide a contemporary transperineal prostate cancer diagnostic service as the allocated room is required for flexible cystoscopy and haematuria / recurrent bladder tumour assessments. The direct result is long waiting time for prostate and bladder cancer diagnostics due to inadequate facilities and understaffing.

Craigavon Area Hospital does have a co-located investigation unit though it is currently shared with other services when not required by the Urology service. There is a compelling case to use this area exclusively for urology, given the volume of outpatient and diagnostic work that will need to be delivered. This will be particularly pertinent when outsourcing of outpatient referrals ceases and additional capacity will be needed, which may include a need to expand the current unit to provide additional consulting / procedure rooms.

Relatively low staffing levels in the urology departments of Northern Irelands Hospitals are undoubtedly a source of real pressure when considering the ability to meet the outpatient demand.

The number of clinical nurse specialists is particularly low, given Northern Ireland's size and population. The nurses work exceptionally hard, largely concentrating their work on oncology provision with little dedicated CNS provision for 'benign urology'. At Altnagelvin Area Hospital, the oncology nurses are part of the Oncology directorate and hence lack the flexibility to cover both oncology and functional urology to meet the demands of the service. As discussed in

[1] My Waiting Times NI - DOH/HSCNI Strategic Planning and Performance Group (SPPG) – formerly HSCB

Section 6, there is an urgent need to extend the role of specialist nurses and practitioners to meet the demand of the outpatient workload. Expansion of the medical workforce alone is not a sustainable long-term solution.

There is a definite sense across all units that both the nursing and medical urology team feel under-supported in the provision of contemporary facilities for the delivery of outpatient care. The current models do not serve the specialty well, as most units nationally have or are in the process of transitioning to a Urology Investigation Unit (UIU) type model. A UIU means that flexible cystoscopy, laser ablation, urodynamics and local anaesthetic prostate biopsy can be provided in one location by the extended Urology team, comprising medics and CNS's with a special interest. By co-locating facilities into one place, there is greater scope for one-stop models of care, as well as improved interaction and flexibility within the clinical team. Throughout the country, Urology has largely morphed into an outpatient specialty where, with appropriate and modern practices, patients can be rapidly seen and assessed without recourse to day-case or inpatient attendance. If implemented effectively, a functioning UIU can have a dramatic effect on the number of patients requiring day-case procedures or overnight stays. It is estimated that only 1:12-14 patients seen in UIU will then require some form of admission. One of the highest priorities for redesign of urological care in Northern Ireland should be the delivery of UIUs at all the urology units, scoped to provide a level of future-proofing in regard to the expected growth in demand for urological services, as the population ages. The recommendations are in line with the Richards Report[2] on development of diagnostic facilities.

Figure 7: Availability of outpatient facilities by Trust

Trust	Site	Urology Investigation Unit	Comment
Belfast HSC	Royal Victoria	No	Emergency care only
	Belfast City Hospital	No	Space available on level 3 for development of investigation unit delivering flexi cystoscopy and TPB
Northern HSC	Antrim Area Hospital	No	Limited in-reach model by visiting Urologist. BHSCT provides two clinics a week in Mid Ulster Hospital. SNS follow-up is delivered (nurse led with support from Medtronic)
	Causeway Hospital	No	Outreach OP clinics and flexible cystoscopy (Altnagelvin team)
	Whiteabbey	No	Flexible cystoscopy (delivered by Belfast Trust)
South Eastern HSC	Ulster Hospital	No	Flexible cystoscopy and TPB done in inpatient facility
	Lagan Valley	No	Daycase facilities only at present

[2] NHS England » Diagnostics: Recovery and Renewal – Report of the Independent Review of Diagnostic Services for NHS England

	Downpatrick	No	Limited capacity to deliver flexi cystoscopy
Southern HSC	Craigavon Area Hospital	Yes	Flexible cystoscopy and TPB delivered but facilities shared with other services if rooms not being utilised by the urology team at present
	Daisy Hill Hospital	No	Outpatient activity commenced August 2023, Day case and 23 hours stay facilities only at present
Western HSC	Altnagelvin Area Hospital	No	Disparate facilities across the hospital site
	South West Acute Hospital	No	No outpatient activity
	Omagh Hospital	No	Flexible cystoscopy in daycase theatre

None of Northern Ireland's Urology units offer transurethral ablation of bladder lesions (TULA). Investment in a dedicated handheld laser at each of the sites would enable access to flexible cystoscopy and laser ablation of small bladder tumours, avoiding the necessity for repeat visits or a daycase procedure. Many units nationally have found this investment be worthwhile with significant cost savings. The development of a TULA service has the potential to significantly reduce the requirement for day case cystoscopy and biopsies and treatment of small bladder lesions. The capital outlay is small, and the learning curve is short, with very rapid release of theatre capacity at all sites. As services nationally transition from day case to outpatient delivery, it's important that mechanisms are in place to record this significant activity.

There remain significant pressures with the 'trial without catheter' (TWOC) service in outpatients. Improving this element of the service, with timely access would enable more patients to be put on day surgery pathways and avoid long lengths of stay. A properly resourced TWOC service with a Standard Operating Model (SOP) across the Trusts should be seen as a priority for the Urology teams.

The diagnostic pathway for patients suspected of having prostate cancer is not optimal. Patients referred with a high Prostate Specific Antigen (PSA) and suspected prostate cancer are generally first seen in outpatients and then referred for a prostate MRI scan. Most units in England have adopted a straight to test model, subject to satisfactorily completed pro-forma from the GP. This approach is endorsed by NHS England NHS England Prostate Cancer Timed Diagnostic Pathway. Due to litigation fears, some consultants in NI prefer to see patients in outpatients before ordering an MRI scan. The pathway is also delayed due to limited access to MRI, delays in reporting and frequently delays in accessing transperineal biopsy (LATP) in outpatients and delays in pathology reporting. Without improvements to diagnostic resources in Northern Ireland, it will not be possible to deliver these pathways at the pace that is required for rapid diagnosis. It is noted that the NICAN Urology CRG are currently undertaking a pathway project relating to this and reflecting the approach advocated in the NHS England pathway document. It is recommended that the rapid role of this pathway following the initial pilot is supported across all trusts.

Prostate biopsy services have generally morphed from transrectal to transperineal biopsy, with the majority of services now being delivered in outpatients. The appointment of a prostate

cancer navigator and a nationally agreed pathway has the potential to shorten the pathway and enable an upfront MRI, prior to first appointment, for those patients who meet the criteria. The NICAN Urology Clinical reference group should take this forward.

8. Elective Care

Based on the returned data from each of the Health and Social Trusts, it is difficult to make a direct comparison between the provision of the sentinel procedures in NI compared with England where Model Hospital[3] statistics are collected for 170 different metrics in the specialty. Some general observations can, however, be made. Each clinical team expressed concerns that the data collected did not reflect actual case volumes and while the data provides some insight, it cannot always be relied upon for capacity planning.

There is certainly scope nationally for significant improvement with day-case rates across the 'sentinel' procedures referred to in the GIRFT data pack (exemplars being TURBT and bladder outlet surgery), which should help relieve the pressure on in-patient beds. Further improvement should now be possible if the right facilities are provided and the philosophy regarding 'daycase as default' is built into the booking rules for these procedures and the pathways are supported by a dedicated nursing team. The development of the Daycase Unit at Lagan Valley Hospital has shown that it is possible to deliver TURBT, bladder outflow obstruction and ureteroscopy safely as a day case and this initiative is warmly applauded and should be replicated elsewhere. An important principle has been the concept that it is a system resource that can be used by multiple units, working to common standards. Single Patient Tracking List (PTL) waiting lists will be vital to eliminate inequities in access times between Trusts. This will necessitate consistent approaches to the evaluation and listing of patients for the respective procedures.

When compared to Model Hospital, the daycase rate for TURBT is likely to be below the England average at 19%. The current English national benchmark performance is 44% with examples in exemplar units of 80%. Barriers in NI include the limited availability of daycase facilities, a culture of admitting the patients anticipating an overnight stay although not required, surgeon and patient preference and the limited opening hours of daycase facilities where they exist.

Intravesical Mitomycin instillation is a vital component of TURBT and should be done in theatre at the end of the procedure, followed by a trial without catheter in the recovery area ahead of discharge. Although this is done in some units (for example, WHCST) there were no data available on Mitomycin instillation in the individual units, it was acknowledged that there are difficulties in delivering this effectively across all of NI. Reasons cited include lack of personnel, lack of training and resistance from pharmacy and theatre staff as well as disruption of the day-case pathway.

Urology Units in NI are encouraged to use 'day case as default' for the majority (60-70% at least) of bladder tumour resections and evidence nationally suggests that the *routine* use of post-operative catheterisation is not necessary. There are significant pressures on the delivery of TURBT at the City Hospital, largely due to constraints on access to theatre slots. This issue could potentially be addressed by provision of daycase facilities at either the Mater Hospital or Lagan Valley Hospital. Trans-urethral laser ablation (TULA) for small recurrent bladder lesions, provided in an outpatient setting also has the potential to free up theatre space. All units should implement a TULA service as a matter of priority.

[3] NHS England - Model Hospital

The current provision of surgery for bladder outflow obstruction (BOO), **shown in Figure 8**, is poor, both in terms of treatment options and unacceptably long waiting times. At the time of writing, over 300 patients from across Northern Ireland have been waiting for bladder outflow surgery for more than four years. Whereas most BOO surgery in NI is delivered as an in-patient procedure, daycase surgery for BOO is uncommon but ripe for development. Many units in England now offer daycase surgery for BOO, with the current benchmark for England being 26% and exemplar units achieving a daycase rate in excess of 80%.

Excluding the backlog caused by Covid, men awaiting bladder outlet surgery represents the largest patient cohort nationally on the urology waiting list. Approximately 750 men require BOO surgery on an annual basis in NI. This need is not currently being met with patients experiencing long delays. As a consequence, some patients have been referred to Dublin for their treatment. Men with larger prostates, who have developed urinary retention, do particularly badly as they are not suitable for some of the newer available modalities and cannot currently access Holmium Enucleation of the Prostate (HoLEP) which would be the current standard of care.

Figure 8: Available surgical options for the treatment of male bladder outflow obstruction, by hospital.

Trust	Site	Available options for surgical treatment of BOO	Comment
Belfast HSC	Royal Victoria	Nil	
	Belfast City	TURiS and Prostate artery embolisation (PAE)	
Northern HSC	Antrim Area	None	Mid Ulster Hospital Magheraflt-Urolift
	Causeway	TURiS	
South Eastern HSC	Ulster Hospital	TURiS	HOLEP cases have commenced with mentoring to be completed by September 2023
	Lagan Valley	TURiS, REZUM and Greenlight laser	Urolift in development. Rezum and greenlight at LVH is utilised by other trust surgeons (e.g. Southern)
	Downpatrick	None	
Southern HSC	Craigavon	TURiS, Greenlight	
	Daisy Hill	TURiS	
Western HSC	Altnagelvin	TURiS	
	Omagh	Daycase TURiS	

Bladder outlet obstruction (BOO) surgery is now recognised an area of sub-specialist expertise and there is an emerging consensus that patients should have access to all suitable options,

including Trans Urethral Resection in Saline (TURiS), Greenlight laser, Urolift, REZUM and HoLEP. There should be a two-centre model for the majority of BOO surgery in Northern Ireland, predicated on the nominated, protected elective capacity sites in Lagan Valley Hospital and Omagh Hospital. Holmium laser enucleation of the prostate poses a particular challenge as it is ideal for men with larger prostates but is not currently available at any sites. The service is being developed with mentoring of 2 consultants at the Ulster Hospital. There are 2 Surgeons in Southern Trust are also trained to deliver HoLEP with plans currently in place to utilise the Daisy Hill 23 hour stay elective unit to deliver this

There should be regional pathways in place for patients requiring BOO surgery and ideally there would be nurse-led assessment of these men and nurse-led consent for each of the procedures that form part of a regional pathway. This was explored at each of the deep dive visits and there was broad agreement for nurse-led consent and development of single PTL waiting lists for each of the BOO procedures.

Given the significant pressures on theatre access at inpatient sites, it will be important for patients, nurse specialists and urologists to be aware that a day case option should always be explored first as this will result in more timely care. The GIRFT Academy guide provides an algorithm for patient suitability for each of the procedure types: GIRFT Urology Guidance - Bladder Outlet Obstruction.

The practice of ureteroscopy appears to have changed over the past few years with more hospitals delivering the procedures as day case. 78% of ureteroscopies performed in South Eastern Trust are currently being delivered as day cases in line with contemporary practice in England, undoubtedly aided by the daycentre at Lagan Valley, this is being delivered by surgeons from South Eastern, Belfast and Southern Trusts. Trusts should aim to deliver the same day case rates across NI for all patients undergoing ureteroscopy, recognising that with the move of suitable patients to HVLC centres those patients undergoing ureteroscopy in inpatient setting are inevitably complex and will have a longer LOS.

9. Urgent and Emergency Care (UEC)

The current provision of urgent and emergency care in shown in **Figure 9**. In common with other regions in England, Trusts in Northern Ireland have seen an increase in the number of patients admitted with urological conditions. The true demand for urological care is likely to be under-represented as most patients with a urological diagnosis are coded under General Surgery at the time of initial admission.

There is an overwhelming impression that the pathways for patients with urological diagnoses requiring urgent or emergency care do not function satisfactorily, and a post code lottery exists with regard to adequacy of emergency care provision. There needs to be an urgent addressing of the issues described below.

The underlying problems with UEC relate to poorly designed and functioning pathways, a fragmented middle-tier emergency care urology service and inadequate provision of acute beds for those patients requiring onward admission from Northern Health and Social Care Trust to either Altnagelvin or the Belfast Trust. At the heart of the issue are communication problems between the trusts and a lack of formal dialogue in agreeing these clear and standardised protocols.

Antrim Area Hospital and Causeway Area Hospital have no urological cover on-site and rely on inter-hospital transfer for patients requiring on-going urological care, based on postcode. Surgeons, ED clinicians and medical staff report significant problems referring patients to both Belfast City and Altnagelvin Hospital, with delays and at times a reluctance to transfer certain

patients. There was a specific issue highlighted with deployment of non-specific advice from the on-call urology team ('admit locally' was the term entered in patient notes) and then difficulty getting consistent advice from the neighbouring urology unit the following day. Patients experience delays at Antrim Area Hospital and Causeway Area Hospital and spend an unreasonable length of time, either in the ED department or on a ward, without adequate consultant supervision. Criticism can be levelled both ways. 20-30% of admissions in the generality of surgery have a urological component. Working in a hospital with a functioning ED unit and no urology cover means that the staff will have to engage with urological problems and cannot abrogate responsibility for patients who require admission and stabilisation. There is an urgent need for co-designed urgent and emergency pathways for the common acute urological conditions that outline standards of care for patients and the responsibilities of the referring and the admitting units.

Figure 9: Provision of urgent and emergency care, by hospital.

Trust	Site	Emergency admissions	Inpatient Urology
Belfast HSC	Royal Victoria	Y	Y
	Belfast City	N	Y
Northern HSC	Antrim	Transfer	N
	Causeway	Transfer	N
South Eastern HSC	Ulster Hospital	Y	Y
	Lagan Valley	Transfer	N
	Downpatrick	Transfer	N
Southern HSC	Craigavon	Y	Y
	Daisy Hill	Transfer	Some 23hr stay
Western HSC	Altnagelvin	Y	Y
	SWAH	Transfer	N

It is our recommendation that the current postcode-based system is removed and the arrangements between Trusts simplified in the interests of safe patient care. All patients attending Antrim Area Hospital who require onward care should be directed to Belfast Trust and those attending the Causeway Area Hospital directed to Altnagelvin.

Arrangements at the Royal Victoria for the reception of emergency urological admissions are inadequate. By default, patients are admitted through the ED department as a Urology Assessment Unit does not exist. From ED, patients are then admitted to ward 4 (an orthopaedic ward), which has little dedicated urological nursing and is perceived as having a

lesser interest in the urological patients by comparison to its base specialty of orthopaedics. For a hospital of this size, there should be provision of an ambulatory assessment unit, either as a stand-alone clinical area or within a generic surgical assessment unit. Referrals from general practice or surrounding hospitals would then be sent directly to the assessment unit, allowing more rapid access to urological care and relieving the pressure of inappropriate routing through ED.

Due to service pressures, Urologists have difficulty accessing confidential enquiry into Peri-operative deaths (CEPOD) theatre lists for the acute management of haematuria or emergency ureteroscopy for stones. Under these circumstances, patients are more likely to get a ureteric stent (rather than primary ureteroscopy and laser lithotripsy) with inevitable delays in their long-term management. This contrasts with efficient pathways for emergency cholecystectomy in general surgery. Access for category one cases, such as acute testicular torsion, was reported to be good and there was no sense that these more urgent cases were delayed. The same was true of percutaneous drainage of the kidney in interventional radiology at BCH but this was not the case in other sites.

Whereas most patients with urinary retention do not require admission, patients do require a timely trial without catheter following ED attendance. In many Trusts, the arrangements appear to be haphazard: patients sometimes get a TWOC in the community or at the admitting hospital, but if that fails they are then re-catheterised and referred for consideration of onward surgical treatment. Patients then wait months or years for an appointment and definitive surgical treatment. It is well accepted that patients with indwelling catheters experience greater morbidity with recurrent Urinary tract infections (UTIs), haematuria and urosepsis. The inability to provide a timely service for these patients results in more emergency and unscheduled care. Given the elective backlogs, there is an urgent need to streamline the pathway for men who present with urinary retention and fail a subsequent TWOC. Such measures could include dedicated, rapid-access outpatient slots or a TWOC service based in the setting of a UIU (where there is clinical expertise on-site to support a same-day, shared-decision on the need for bladder outlet surgery).

The situation with regard to patients presenting with ureteric colic varies across the province. There appears to be no up to date pathway in the Northern area for the onward referral of patients needing emergency stone treatment. Clinicians at Antrim and Causeway were unclear as to the modalities of treatment that might be offered for a patient presenting with acute ureteric colic (either ESWL or acute ureteroscopy). Despite NICE guidance supporting its use, acute ESWL is rarely used across the province and provision of acute ureteroscopy is generally poor at all sites. There needs to be a clear pathway in place to ensure that patients can easily be referred from all sites for acute onward ESWL and this should be built into the plans for the fixed-site lithotripsy service at Craigavon Area Hospital. In terms of acute ureteroscopy, pathways should also be developed for either surgery at the time of initial admission (reliant on CEPOD access) or a ‘book and return’ model of care. The latter can also work well in protected elective care sites, such as Lagan Valley.

Access to interventional radiology by trust is detailed in Figure 10 and is essentially limited onsite to normal working hours in most Trusts, with the exception of the Royal Victoria Hospital. Given the current workforce issues in interventional radiology, access to these services will inevitably be constrained; a functioning SOP with service level agreements at each Trust is required to ensure timely access to the service, with a guaranteed repatriation once the immediate crisis is resolved.

10. Specialist Care

10.1 Oncology

The current arrangements for major oncological surgery are shown in **Figure 10** and are derived from the pre-visit questionnaire. The estimated figures for the uro-oncological surgery requirement are shown in **Figure 11** below.

The majority of operative uro-oncology is provided for at Belfast City Hospital, but there are significant capacity challenges in delivering a timely service. At present, Belfast City Hospital has seven theatres, two of which are undergoing refurbishment on a rolling basis. It is estimated that this process will not be completed for the next 18-24 months. Although there is a DaVinci Robot in place, it is underused and even if it was operated at full capacity it is unlikely that an operative programme based on a single robot would be sufficient to meet NI needs. This is particularly true as the provision of radical cystectomy and radical nephrectomy has now moved towards robotically-assisted surgery as the approach of choice.

Figure 10: Provision of Oncology by Health Board in Northern Ireland

	Belfast HSC	South East HSC	Southern HSC	Western HSC
Laparoscopic nephrectomy	Y	Y	Y	Y
Partial nephrectomy	Y	N	N	N
Nephroureterectomy	Y	N	Y	Y
Cystectomy	Y	N	N	N
Radical prostatectomy*	Y	N	N	N
Penile Cancer	N	N	N	Y

**Majority of patients requiring radical prostatectomy are transferred to the Mater Private Hospital in Dublin.*

With appropriate investment and recruitment, there are sufficient volumes of work in NI to justify a second robotic surgery programme at Altnagelvin Hospital. Ideally, it would be implemented as part of a cross-specialty platform, given that colorectal surgery and gynaecological surgery is beginning to transition at pace towards a robotic approach. Recruitment of surgeons with the necessary skills will be the major barrier to expansion of the robotic provision but establishing a second, high-volume robotic service at the Western Trust would appeal to certain individuals and would likely make Western Trust a more attractive place to deliver urology.

Radical prostatectomy; Provision of robotically assisted radical prostatectomy (RARP) is currently predicated on three surgeons operating at Belfast City Hospital. Approximately 56 procedures were performed in 2022 (internal data) with an average length of stay of 1.68 days (England average 1.7 days). Patients requiring RARP from across NI are currently managed on a central register. Because of the numbers involved and constraints on the service, a

majority of patients requiring RARP are then referred to the Mater Hospital in Dublin for their treatment.

Based on the RARP rate of 150 procedures per million of the population in England, it is estimated that the true requirement for RARP on an annual basis in NI is approximately 270 procedures. It is likely that many patients who are eligible for surgery do not currently choose RARP, either in Belfast or Dublin, and instead opt for active surveillance or radiotherapy as a result of the long waits for the procedure or the need to travel. This is a phenomenon that has been observed in more rural parts of England or where access times are poor.

The average specialist unit in England delivers 150 cases per year with each operating surgeon performing an average of 50 cases per annum. Given NI's requirements, supplying the service would require 6 surgeons in the fullness of time, with back-up support from properly staffed nursing and administrative teams. Based on a two-session day, and two RARP being delivered per list, 120 lists would need to be provided across the network to meet the demand.

The Department of Health needs to urgently work with providers to address the under-provision of theatre capacity for the provision of major urological cancer surgery, thereby addressing delays to treatment. In doing so, there should also be a clear commitment to re-patriate pathways for patients who are currently required to travel out of Northern Ireland for specialist cancer surgery

Cancer Nephrectomy; The majority of renal surgery is also likely to become robotically-assisted in the near future, in keeping with this change of practice on the mainland and this will further increase the need for robotic surgery provision.

Both open and laparoscopic nephrectomy are provided at 4 Health and Social Care Trusts in NI. Outside Belfast, laparoscopic nephrectomy is the most commonly performed renal operation. Patients with small renal lesions are referred to Belfast for robotically-assisted partial nephrectomy (RAPN) or ablative treatments. The practice is changing rapidly in England. Robotically-assisted nephrectomy and robotically-assisted partial nephrectomy are becoming established as the standard operative techniques, with the more specialised units providing robotic partial nephrectomy and robotic nephroureterectomy. It is likely that nephroureterectomy followed by radical nephrectomy will transition to a robotically-assisted approach as standard in the future, further decreasing the requirement for open surgery. The ratio for partial nephrectomy to total nephrectomy is approximately 70:30.

Based on the available data, NI has a requirement for approximately 180 nephrectomies per year. In a contemporary practice, approximately 125 will be partial nephrectomies and 55 either laparoscopic or open. Partial nephrectomy (RAPN) surgery should only be on a single site, with IR availability. There is a compelling need to improve the provision of nephrectomy across NI (approximately 180 procedures per annum) and robotically-assisted partial nephrectomy at Belfast City Hospital. This should include a networked service for renal surgery as outlined above.

Within the Department of Health, a discussion should be initiated and a strategy will need to be developed regarding the current viability and future provision of the nephrectomy service across NI. Ideally, there should be provision of total nephrectomy across the Province with a single, virtual service linked by a single MDT, so that sickness and holiday leave can be covered. The minimum requirement in the future should be based on at least six trained surgeons providing the range of robotic and open procedures with appropriate governance and oversight.

Cystectomy; Open cystectomy is currently provided at Belfast City Hospital by three surgeons. There were no data available from the data pack between April 2019 and March 2020, but it is estimated that the annual requirement for cystectomy in NI is a minimum of 56 procedures per year though could be higher depending on disease characteristics. The practice of cystectomy is rapidly changing in the UK and a robotically assisted approach has become the commonest modality in England. By necessity, this change in practice will again need to be factored into a strategic plan for the service; as new consultants take up their posts, most will have completed a robotics fellowship. Radical cystectomy, in common with RAPN, should only be delivered on a single site due to its complexity and lower-case volumes.

There were no concerns expressed in relation to the pathway across NI with respect to cystectomy. Although there is no concrete evidence, there is anecdotal evidence that patients experience significant delays in accessing surgery due to inadequate list availability. Cystectomy is the most time critical pathway in urological oncology and every effort should be made to ensure that patients receive their surgery in a timely fashion (ideally no longer than 30 days from decision to treat). Generally speaking, there will be two patients a week requiring radical cystectomy (when other indications such as pelvic exenteration are included) and the team at BCH should make every effort to regularly provide this capacity and minimise delays in treatment.

There needs to be improved capacity for the provision of radical cystectomy surgery, with adequate and timely theatre access for the delivery of approximately 70-90 procedures per year (based at Belfast City Hospital). Consideration should be given to developing a robotically-assisted approach for this procedure.

Figure 11: Estimated number of urological oncology procedures requiring to be delivered per year in Northern Ireland

Procedure		Estimated number of procedures required /year	Comment
Nephrectomy		180	Based on approximately 70% patient being suitable for partial nephrectomy
	Laparoscopic or open nephrectomy	55	
	Partial nephrectomy	125	
Cystectomy		60-70 (for bladder cancer)	
Radical prostatectomy*		270	
Penile Cancer		25	Many patients will require multiple procedures

Penile Cancer; the penile cancer service is currently based at Altnagelvin Hospital and is essentially staffed by a single consultant with support from an experienced, retired and returned colleague. While this arrangement works well at present there are obvious concerns regarding the resilience of the service in the event of unplanned leave and or sickness. Although the numbers of new penile cancers are relatively small (approx. 30-40 per year), many will require multiple diagnostic and therapeutic procedures. It is important that this service remains linked to a designated penile cancer centre either in North West of England

or in Eire, both to ensure resilience for this single-handed service and peer support for more complex patients. There is currently a MDT in place with the Christie Hospital, Manchester.

Provision of penile cancer surgery should ideally be based on service delivery by two trained surgeons, ensuring the resilience of the service.

10.2 Stone Management

The current provision of stone service in NI can be shown in **Figure 12.** The advancements in both our understanding of the natural history of stone disease allied with developments in technology over the past decade mean that much stone surgery can be delivered endoscopically using suitably powered lasers; all trusts provide ureteroscopy with the exception of the Northern Health and Social Care Board, which are reliant on an in-reach model at Causeway Hospital, supported by the Urology team from Altnagelvin. Extracorporeal shockwave lithotripsy (ESWL) and the provision of percutaneous nephrolithotomy (PCNL) remain important elements of a contemporary service. In England the numbers of PCNLs performed annually have steadily decreased as better technology means that more patients can be treated endoscopically. ESWL retains an important role in the management of renal calculi and the urgent treatment of patients presenting with ureteric colic. Its' use is supported by NICE guidance, both on efficacy and cost comparison.

Figure 12: Current provision of stone services in Northern Ireland

	Belfast HSC	Northern HSC	South Eastern HSC	Southern HSC	Western HSC
Site(s)	Royal Victoria and Belfast City	Causeway	Ulster and Lagan Valley	Craigavon and Daisy Hill	Altnagelvin
Ureteroscopy and laser fragmentation	Y	Y	Y	Y (CAH + DHH)	Y
PCNL	Y	N	Y	Y (CAH)	Y
ESWL	Y	N	N	Y (CAH)	Y

The provision of PCNL is dependent on securing a suitable access track with radiological screening, either performed by the operating surgeon or more commonly an interventional radiologist. The number of patients requiring PCNL in Northern Ireland is small and it is generally agreed that the service should be placed in one hospital, helping to free up theatre time in other units. The agreed model is that centralisation of PCNL surgery and more complex endourological procedures should take place at Craigavon Area Hospital, led by the Southern team. This will require the provision of an all-day operating list for PCNL, supported and funded for a minimum of 42 weeks of the year with two PCNLs on each list. Case volumes for the more complex endourological procedures will also need to be assessed as these will require additional theatre capacity within the unit.

Centralisation of static ESWL should also take place at Craigavon Area Hospital; this will require the provision of ESWL 5 days a week, supported by trained radiographers and clinical staff (including a dedicated clinical nurse specialist). There should be a single referral system in place for all Trusts to enable timely access to both acute and elective ESWL. Such an arrangement will enable the Department of Health to disinvest in mobile lithotripsy services.

Each trust providing an emergency service must ensure there are established pathways for the provision of urgent ureteroscopy and/ or ESWL. Such models of care work well elsewhere in England. For ureteroscopy and laser lithotripsy, this can include a 'book and return' model to the acute site or a HVLC hub site.

10.3 Female and Functional urology

Due to the pressures on core urology, emergency care and limited theatre access, the provision of female and functional urology has struggled for in NI for many years. The Covid pandemic has exacerbated poor access to care for these patients and many women with stress urinary incontinence and other functional issues have had difficulty accessing appropriate surgery.

Figure 13: Current provision of female and functional procedures in Northern Ireland

Procedure /Condition	Current provision(Urology)	Comment
Surgical management of urinary stress incontinence	Belfast City, Craigavon and Altnagelvin	Element of this service should be provided in association with urogynaecology at designated sites
Vesicovaginal repair (VVF)	Altnagelvin and Belfast City and Craigavon	Altnagelvin
Ureteric injury **(Trauma and iatrogenic)**	All centres	Constraints in theatre access at BCH and long waits hamper the service
Bladder augmentation	Altnagelvin and Belfast (in-reach)	As above
Urethral reconstruction*	Altnagelvin	As above
Insertion of artificial urinary sphincter	Not currently commissioned or provided in N Ireland	Service could be provided in a 23-hour surgical unit. Altnagelvin may be best placed to consider this.
Congenital and acquired neuropathic bladder management	Belfast City, Altnagelvin and Craigavon	Provision of services for these patients (including those with MS) occurs on an ad hoc basis
Videourodynamics	Altnagelvin and Belfast City	New facilities developed at Belfast City

*Linkage to sub-specialty MDT

There have, however, been pockets of good care and positive developments in Northern Ireland. The best developments have been at Altnagelvin where video-urodynamics (used to establish a diagnosis with bladder pressure monitoring, combined with radiological imaging) and sacral nerve stimulation (SNS) have been commissioned and are providing a good service for the region. As seen in **Figure 13**, provision of surgery for urinary stress incontinence

(provided by a Urology service) is delivered at Belfast, Craigavon and Altnagelvin. Surgery for Genuine Stress Incontinence (GSI) is also provided by urogynaecologists across Northern Ireland and it is difficult to get precise estimates about how much is being done by each specialty.

Surgery for female and functional problems unfortunately occupies a low priority for many busy hospitals. This is evidenced by the situation at Belfast City and Craigavon where, despite having an Urologist trained in this area of practice, access to theatre is constrained by the unmet demand of the oncology service. This situation is unlikely to be resolved for the foreseeable future. Patients continue to be referred to Belfast City Hospital without a realistic timeframe for surgery.

Compounding this issue is the requirement to deal with other aspects of functional urology which can have a profound effect on patients' lives. These include the surgical management of intractable incontinence, and the long-term management of patients with congenital neuropathic bladder and other neurological issues which affect bladder function (e.g. iatrogenic trauma, MS, stroke, spinal cord injury and vesico-vaginal fistula). Belfast Health and Social Care Trust is the designated Mesh Centre for management of patients with vaginal tape erosions, which requires a combined urogynaecology, urology and pelvic surgery input. While the clinical expertise is available, surgical facilities underpinning activities in functional urology are inadequate to meet current demands. Surgical techniques have developed significantly over the past decade and internationally more of these patients are being managed using robotic techniques, which are destined to become standard management in the next decade. They should be equally available to patients from Northern Ireland. Currently the robot is only commissioned for radical prostatectomy and partial nephrectomy.

Due to the small numbers involved, elements of female and functional urology for NI should be properly commissioned and resourced. Options include limiting investigative and surgical options to one or two centres in the province or considering disinvesting from some elements of the subspecialty (e.g. urethral reconstruction, mitrofanoff procedures). There is little or no prospect of this service being delivered at the City Hospital in Belfast and alternative site(s) must be identified for the provision of care within six months.

10.4 Andrology (including Urethral Reconstruction)

Access to benign andrology and urethral reconstruction surgery in Northern Ireland has been extremely limited over the past few years due to the huge pressures elsewhere in the service, including the long cancer waits, the Covid pandemic and limited theatre access. Northern Ireland has one trained andrologist for the region who is fully committed to delivering a high quality penile cancer.

Figure 14: Estimated Andrology Requirements for Northern Ireland

Procedure	Rates per 100,000 in UK practice*	Anticipated requirement per year in NI (based on population of 1.868 million)
Artificial urinary sphincter insertion	0.63	12
Penile prosthesis insertion (new)	0.44	8
Urethral surgery (including hypospadias repair)	4.2	79
Urethral surgery (excluding hypospadias repair	1.08	20
Penile cancer procedures	0.66	13
Corporoplasty	0.77	15
Male Infertility procedures	0.69	13

The projected andrology requirements for Northern Ireland are shown in **Figure 14**, based on current UK data. In Northern Ireland, at present, two consultants provide urethral reconstruction, but the bulk of their work is in the provision of core urology, stones and emergency care. As a consequence, patients with urethral stricture disease can wait significant periods of time for definitive treatment.

In the England, andrology services are largely predicated on a population of 7 million and the number of surgeons with a low volume practice in the subspecialty has declined significantly over the past few years.

At a minimum, andrology services for NI should be properly commissioned and limited to single centre. However, the anticipated volume of procedures is low and does not lend itself to the development of genuine subspecialty expertise. The Department of Health should commission a review of surgical andrology for NI. Options for the service might include:

1. Centralise the provision of surgical andrology at Altnagelvin hospital. This would require an expansion of current commissioning, an increase in surgeons providing the service (challenging both in terms of geography and identifying the right personnel) allied with increasing specialist nurse support.
2. Centralise the provision of surgical andrology at the Ulster and Lagan Valley Hospital. Much surgical andrology can now be delivered using a 23-hour facility; services would need to be developed at the Lagan Valley Hospital to support this. It would also require an expansion of current commissioning, an increase in surgeons providing the service allied with increased specialist nurse support.
3. Disinvest in the provision of benign surgical andrology and refer patients to units in Ireland or England.
4. Examine the feasibility of a solution based on a population of 7 million.

Annex A - Full list of hospitals

Trust	Hospital
Northern Trust	Antrim Area Hospital
	Causeway Hospital
	Mid Ulster Hospital
	Magherafelt Hospital
Western Trust	Altnagelvin Hospital
	Omagh Hospital and Primary Care Complex
	South West Acute Hospital
	Roe Valley Hospital
	Limavady Hospital
Southern Trust	Craigavon Area Hospital
	Daisy Hill Hospital
South Eastern Trust	Ulster Hospital
	Lagan Valley Hospital
Belfast Trust	Belfast City Hospital
	Mater Hospital
	Royal Victoria Hospital

Annex B - Southern Health and Social Care Trust Findings and Recommendations

Findings	Recommendations
Workforce	
The medical workforce remains reliant on locum appointments and has difficulty recruiting to substantive posts. This is a recognised problem nationally across the UK due to unfilled consultant posts and a lack of National Training Number's (NTN's) accredited each year.	The Trust should continue to address barriers to recruitment, where these are within their control. A middle grade rota can comprise an extended workforce that can include advanced nurse practitioners and physician's associates in addition to more usual medical roles. Developing areas of sub-specialist practice can also aid recruitment and retention of staff.
The unit receives 3 NTN's per year; there is an unequal distribution of trainee numbers across Northern Ireland.	The Training Programme Director (TPD) for urology should continue to work with individual units to ensure that trainees are allocated to departments in line with the trainees' educational needs and that areas of particular training value are utilised well.
Facilities including HVLC site	
While outpatient facilities for consulting, diagnostic procedures and therapeutic interventions are adequate, much of the Urology Investigation Unit (UIU) is currently occupied by other services if there is an outpatient room available. Urology has primary use of the outpatient rooms in Thorndale, it is only utilised by other services if the rooms are not utilised	Subject to funding, the Trust needs to urgently re-establish the UIU. Facilities to consult, perform outpatient diagnostics and offer therapeutic interventions need to be brought into one place and be future-proofed in terms of the anticipated growth in outpatient work
Theatre capacity has not been restored following the pandemic and the consultants no longer have access to an all-day theatre list.	Trust management should ensure that Trusts are optimising their theatre capacity in order that each urologist has, as a minimum, 2 sessions of theatre activity for 42 weeks of the year, when not Consultant of the Week.
The protected elective capacity at Lagan Valley Hospital is an impressive development, led by the South Eastern Trust but also utilised by Southern and Belfast teams. It has enhanced the daycase opportunities and created a hub for a regional bladder outlet service, enabling significant progress on recovering the waiting list. The unit is highly efficient and appears to be working well.	The Lagan Valley facility is a key component of elective recovery. The Southern Trust needs to ensure that the facility is used to maximum effect by its clinicians, aiming for maximum utilisation of available lists and unnecessary cancellations at short notice due to annual leave and professional leave.
Outpatients and diagnostics	
Cancer pathways need to be further streamlined and designed to avoid inefficiencies in terms of clinician time.	There should be a 'straight to test' approach for suspected prostate cancer patients requiring an MRI scan. It is not good use of clinician time to telephone patients in

	advance of the test and this could be managed by standard template letters. There should be protected ultrasound slots for patients being assessed for suspected cancer in relation to haematuria. With development of the UIU, a gold standard approach would be a sonographer working alongside the haematuria flexible cystoscopy list.
Turnaround times for MRI scans and reporting delays in biopsy results mean that the suspected prostate cancer pathway is significant delayed.	Further efforts must be made to reduce the delays in access to and reporting of imaging and pathology.
Oncology	
Up to 25% of patients currently admitted for a transurethral resection of bladder tumour (TURBT) or bladder biopsy could be managed as an outpatient under local anaesthesia using TULA.	A TULA service should be implemented promptly. It is a low-cost innovation with a short learning curve and could lead to rapid capacity release in theatres, by moving such patients out of theatre and into an outpatient setting.
Approximately 40-50% of TURBT procedures can be done as a day case, facilitated by in-theatre administration of Mitomycin-C.	The day case TURBT pathway for Craigavon Area Hospital should be developed further at Lagan Valley Hospital and Daisy Hill Hospital for stable ASA 3 patients and below and become the default pathway for patients who are suitable for a day case approach.
Current provision of Mitomycin-C is problematic	In theatre Mitomycin-C should be the default option for suitable patients, irrespective of the facility in which the procedure is performed.
Radical nephrectomy is provided by two surgeons at Craigavon Area Hospital. Patients requiring partial nephrectomy are referred to Belfast City Hospital using an in-reach model	The nephrectomy service should be formally provided as part of a networked service across the various Trusts that offer this surgery in Northern Ireland. There should be a single MDT and the ability to cross-cover each other's clinical practice in the situation whereby a single-handed surgeon is on leave or absent from work for other reasons.
Urgent and emergency care	
Further improvements could be made with regard to the management of acute stone patients. This includes improved access to 'hot' ureteroscopy and improved use of acute extra-corporeal shockwave lithotripsy (ESWL).	The department should further develop their use of a 'book and return' pathway for urgent ureteroscopy at Lagan Valley Hospital. Once established, the acute lithotripsy service at Craigavon Area Hospital should be

	used by default for primary treatment in suitable patients. A seamless referral pathway needs to be agreed across Urology departments in NI.
Men awaiting bladder outlet surgery represent one of the longest backlogs in urology and is a particular problem in NI. Men at greatest risk of poor care are those who have indwelling catheters.	The department should have a urinary retention pathway that allows for rapid access back to the service for a TWOC and or assessment for bladder outlet surgery. The pathway should dovetail with the work that has already been done on the BOO surgery at the Lagan Valley facility.
Specialist services	
Stone service.	It has been agreed that Extra-Corporeal Shock Wave Lithotripsy (ESWL) and Percutaneous Nephrolithotomy (PCNL) surgery will be centralised at Craigavon Area Hospital. This will require the provision of 42 all day lists per year (2 procedures per list).There will need to be additional capacity for other types of complex endourological stone procedures.
ESWL.	The facilities for the delivery of ESWL will need to be upgraded to facilitate the delivery of 4-5 patients for ESWL per half-day list.
There is currently under-provision of benign andrology surgery across NI.	Given the regionalisation of this service in WHSCT the trust should consider disinvesting in the provision of benign andrology. There are now good examples nationally of delivering andrology surgery in 'cold' elective sites. Clinicians with expertise in this area should work as part of a regional andrology service for NI, including the continued provision of penile cancer surgery at Altnagelvin Hospital.
Pathways for female and functional urological treatments need to be clearly agreed and described.	Assessment and common treatments (such as botox / intra-vesical therapies) should be provided at the Trust. There is consensus that the service for more complex or refractory patients will be centralised to Altnagelvin Hospital.

Annex C - South Eastern Health and Social Care Trust Findings and Recommendations

Finding	Recommendation
Workforce	
The specialist nursing team is under-staffed when compared to the workload. There are significant opportunities that could be explored for extended roles.	Subject to funding, the Clinical Nurse Specialist (CNS) team should be expanded further as a priority area of development for the Trust. Their roles should continue to be extended to include delivery of LA trans-perineal prostate biopsy, flexible cystoscopy and Botox. TULA could also be considered, once established. Given the expansion of bladder outlet surgery services, a CNS should be employed to manage the lower urinary tract symptoms (LUTS) pathway.
There are two physician's associates (PAs) in post in the unit and there is significant scope for them to support service delivery in both acute and elective care.	The department should refer to the new Urology PA curriculum that has been developed as well as the GIRFT Academy UIU guide to map out the career development plan for the PAs and how they will contribute to the long-term vision for the service.
The unit only receives 1 NTN trainee per year but there is significant scope to offer more training within the unit (*e.g*. training in BOO surgery at Lagan Valley).	The TPD for urology should continue to work with individual units to ensure that trainees are allocated to departments in line with the trainees' educational needs and that areas of particular training value are utilised well.
Facilities including HVLC site	
The current outpatient and diagnostic facilities are not adequate for the service, given that a majority of urological investigations treatment are outpatient-based.	A headline priority for the Trust should be the urgent development and delivery of a UIU subject to funding. Facilities to consult, perform outpatient diagnostics and offer therapeutic interventions need to be brought into one place and be future-proofed in terms of the anticipated growth in outpatient work (including re-patriation of outsourced work). A UIU is the ideal place to provide office accommodation for clinical and administrative staff so that training and clinical interaction can be facilitated.
The protected elective capacity at Lagan Valley is an impressive development, led by the South Eastern Trust but also utilised by Southern and	The Lagan Valley facility warrants continued support and expansion of capacity. It is a key component of elective recovery. Likewise,

Belfast teams. It has enhanced the day case opportunities and created a hub for a regional bladder outlet service, enabling significant progress on recovering the waiting list. The unit is highly efficient and appears to be working well.	investment in any further technologies that are required is likely to be good use of resources with the opportunity for patients across NI benefitting from this excellent service. The South Eastern team should continue to lead on development of the networked BOO surgery service across NI.
Outpatients and diagnostics	
Cancer pathways need to be further streamlined and designed to avoid inefficiencies in terms of clinician time.	There should be a 'straight to test' approach for suspected prostate cancer patients requiring an MRI scan. It is not good use of clinician time to telephone patients in advance of the test and this could be managed by standard template letters. There should be protected ultrasound slots for patients being assessed for suspected cancer in relation to haematuria. With development of the UIU, a gold standard approach would be a sonographer working alongside the haematuria flexible cystoscopy list.
Turnaround times for MRI scans and reporting delays in biopsy results mean that the suspected prostate cancer pathway is significant delayed.	Further efforts must be made to reduce the delays in access to and reporting of imaging and pathology.
Oncology	
Up to 25% of patients currently admitted for a TURBT or bladder biopsy could be managed as an outpatient under local anaesthesia using TULA.	A TULA service should be implemented promptly. It is a low-cost innovation with a short learning curve and could lead to rapid capacity release in theatres, by moving such patients out of theatre and into an outpatient setting. Lagan Valley Hospital would be a good site for this service, based in a procedure room.
Approximately 40-50% of TURBT procedures can be done as a day case, facilitated by in-theatre administration of Mitomycin-C.	The day case TURBT pathway should be developed further at Lagan Valley Hospital and become the default pathway for patients who are suitable for a day case approach.
Radical nephrectomy is provided by a single surgeon at the Ulster Hospital. Patients requiring partial nephrectomy are referred to BCH.	The nephrectomy service should be formally provided as part of a networked service across the various Trusts that offer this surgery in NI. There should be a single MDT and the ability to cross-cover each other's clinical practice in the situation whereby a single-handed surgeon is on leave or absent

	from work for other reasons. This will also mitigate against differences in access times should they occur.
Urgent and emergency care	
Further improvements could be made with regard to the management of acute stone patients. This includes improved access to 'hot' ureteroscopy and improved use of acute extra-corporeal shockwave lithotripsy (ESWL).	The department should further develop their use of a 'book and return' pathway for urgent ureteroscopy at Lagan Valley Hospital. Once established, the acute lithotripsy service at Craigavon Area Hospital should be used by default for primary treatment in suitable patients. A seamless referral pathway needs to be agreed between the two departments.
Men awaiting bladder outlet surgery represent one of the longest backlogs in urology and is a particular problem in NI. Men at greatest risk of poor care are those who have indwelling catheters.	The department should have a urinary retention pathway that allows for rapid access back to the service for a TWOC and or assessment for bladder outlet surgery. The pathway should dovetail with the excellent work that has already been done on the BOO surgery service to date.
Specialist services	
There is currently under-provision of benign andrology surgery across NI.	There are now good examples nationally of delivering andrology surgery in 'cold' elective sites. Clinicians with expertise in this area should work as part of a regional andrology service for NI, including the continued provision of penile cancer surgery at Altnagelvin.
PCNL is done in small numbers currently and this should be addressed.	It has been agreed that PCNL surgery will be centralised at Craigavon Area Hospital and the business case has already been worked through.
Pathways for female and functional urological treatments need to be clearly agreed and described.	Assessment and common treatments (such as botox / intra-vesical therapies) should be provided at the Trust. There is consensus that the service for more complex or refractory patients will be centralised to Altnagelvin Hospital.

Annex D - Belfast Health and Social Care Trust Findings and Recommendations

Finding	Recommendation
Workforce	
For a major cancer centre, the specialist nursing team is grossly under-staffed when compared to the workload. There are significant opportunities that could be explored for extended roles, once staffing levels are improved.	The CNS team should be expanded further as an urgent action for the Trust. A cancer centre serving 1.8 million people would be expected to have a CNS team that is sub-specialised, with each CNS having a specific area of interest (bladder, kidney, prostate and penile / testicular). They should be able to cross-cover colleagues. Nursing roles should continue to be extended to include delivery of LA trans-perineal prostate biopsy, flexible cystoscopy and Botox. TULA could also be considered, once established.
The current consultant complement is currently understaffed to provide the cancer services with respect to robotic prostatectomy, cystectomy and elements of renal cancer surgery	The trust should expand the number of consultants to provide urological surgical oncology for Northern Ireland subject to funding.
Cross-site working is challenging for the Belfast team as they are required to cover both the City Hospital and the Royal Victoria Hospital.	Expansion of middle grade support is needed to support the delivery of emergency care and to alleviate some of the issues associated with split-site working. A modern, middle grade workforce should include extended roles such as physician associates or nurse practitioners.
Outpatients and diagnostics	
The current outpatient and diagnostic facilities are not adequate for the service, given that a majority of urological investigations treatment are outpatient-based.	A headline priority for the Trust should be the urgent development and delivery of a UIU subject to funding. Facilities to consult, perform outpatient diagnostics and offer therapeutic interventions need to be brought into one place and be future-proofed in terms of the anticipated growth in outpatient work (including re-patriation of outsourced work). A UIU is the ideal place to provide office accommodation for clinical and administrative staff so that training and clinical interaction can be facilitated.
Up to 25% of patients currently admitted for a TURBT or bladder biopsy could be managed as	A TULA service should be implemented promptly. It is a low-cost innovation with a

an outpatient under local anaesthesia using TULA.	short learning curve and could lead to rapid capacity release in theatres, by moving such patients out of theatre and into an outpatient setting.
Facilities including HVLC site	
There can be difficulties in offering timely treatment for patients requiring less major forms of surgery (for example, TURBT). This is due to the pressures associated with the major surgery workload.	The day case TURBT pathway should be developed further, with consideration given to using the facilities at either the Mater Hospital or at Lagan Valley Hospital. Daycase TURBT should become the default pathway for patients who are suitable for a day case approach. Decompressing the service at Belfast City Hospital would help to alleviate pressures and ensure more equitable access to surgery for patients.
Approximately 40-50% of TURBT procedures can be done as a day case, facilitated by in-theatre administration of Mitomycin-C.	Every effort must be made to ensure that suitable patients get access to intravesical Mitomycin at the time of their surgery.
Men awaiting bladder outlet surgery represent one of the longest backlogs in urology and is a particular problem in NI. Men at greatest risk of poor care are those who have indwelling catheters.	Addressing the waiting time for men with lower urinary tract symptoms should be a priority for the trust. The pathway should dovetail with the work that has already been done on the networked BOO surgery service to date. The delivery of elective BOO surgery should be focused on the South Eastern team, which will also alleviate some of the pressures in Belfast due to the major cancer workload.
Oncology	
Theatre provision is wholly inadequate for the delivery of major urological cancer surgery in N Ireland. There are long delays to treatment and a high proportion of patients needing specific forms of cancer surgery (radical prostatectomy) are required to travel to Southern Ireland for their care. A DaVinci robot is available, with trained surgeons, but it is significantly under-utilised.	There is the clinical expertise to be able to offer the full range of surgical treatment options to patients from across NI, diagnosed with urological cancer. The prime reason that patients are currently delayed in their care or having to travel elsewhere is due to the lack of theatre facilities at Belfast City Hospital. All specialties are competing for theatre access in a highly constrained environment comprising only 5 functioning operating theatres. This capacity gap needs to be urgently addressed and this report includes estimates of the capacity that is required to make the service self-sufficient and able to treat the

	population without the need to travel out of NI. Trust management to ensure the robot is utilised throughout the week, given the volume of robotic surgery that needs to be performed. Subject to funding, serious consideration needs to be given to a second robotic service in Altnagelvin Hospital, as Belfast Trust is clearly not in a position to accommodate the required expansion of services necessary to meet the population need. Robotically-Assisted Partial Nephrectomy (RAPN) and radical cystectomy should remain on a single site but robotic-assisted laparoscopic prostatectomy (RALP) and other renal surgery could be performed across two sites with robust MDT and governance arrangements. The Trust need to be extremely cautious of expanding robotic programmes into new surgical specialties ahead of addressing their capacity for the treatment of patients with urological cancer, where robotically-assisted surgery is the standard of care for major urological cancer. DN this needs to be moved to WHSCT or as a regional recommendation
There is expertise in the delivery of more complex aspects of major kidney cancer surgery.	The Belfast team should participate in the formation of a virtual MDT with colleagues undertaking single-handed, laparoscopic nephrectomy across NI to ensure equitable access to surgery in the event of consultant annual leave / unexpected absence.
Urgent and emergency care	
The Royal Victoria Hospital lacks an ambulatory area for urology and patients are initially directed to ED from primary care.	For a centre of this size, the Royal Victoria Hospital should have a dedicated ambulatory area for the management of patients with urological conditions requiring urgent and emergency care. Patients should not be directed to ED from primary care or other centres. This is inappropriate and they should be managed through an ambulatory unit.
There is currently a postcode-based system for patients who attend Antrim Area Hospital, with	It is our recommendation that the current postcode-based system is removed and the

an overly complex arrangement that extends to Altnagelvin Hospital. It is not conducive with safe patient care and there needs to be greater ownership of this issue by a single provider.	arrangements between Trusts simplified in the interests of safe patient care. All patients attending Antrim Area Hospital who require onward care should be directed to Belfast Trust and those attending the Causeway Hospital directed to Altnagelvin Hospital (see Western recommendations).
Patients requiring admission are currently admitted to a ward that is predominantly focused on orthopaedics and not overly experienced in urological care.	The current ward setting is not working well for the provision of admitted emergency care for patients with urgent urological conditions. The Trust needs to urgently develop a more suitable ward base in order to meet this need.
There are no offices available to the Urology team on the Royal Victoria Hospital site, where the majority of acute services are delivered.	The clinical team should be provided with access to adequate office facilities to allow them to undertake their administrative work whilst on call.
Further improvements could be made with regard to the management of acute stone patients. This should include improved access to 'hot' ureteroscopy and improved use of acute ESWL.	The department should further develop their use of a 'book and return' pathway for urgent ureteroscopy, offering suitable patients treatment at Royal Victoria Hospital. Once established, the acute lithotripsy service at Craigavon Area Hospital should be used by default for primary treatment in suitable patients. A seamless referral pathway needs to be agreed between the two departments.
Men presenting with acute urinary retention face long delays in getting access to appropriate treatments.	The department should have a urinary retention pathway that allows for rapid access back to the service for a TWOC and or assessment for bladder outlet surgery. The pathway should dovetail with the work that has already been done on the networked BOO surgery service to date. The delivery of BOO surgery should be focused on the South Eastern team, which has the potential to alleviate some of the pressures in Belfast due to the major cancer workload.
Specialist services	
PCNL is done in small numbers currently and this should be addressed.	It has been agreed that PCNL surgery will be centralised at Craigavon Area Hospital and the business case has already been worked through.

Pathways for female and functional urological treatments need to be clearly agreed and described.	Assessment and common treatments (such as botox / intra-vesical therapies) should be provided at the Trust.
Because of the pressure on theatre space at Belfast City Hospital, there are long delays for patients requiring benign reconstructive surgery.	Greater use should be made of HVLC sites (Lagan Valley Hospital (day case) and potentially the Mater Hospital for the delivery of short stay (23 hours) female and functional urology For patients requiring more complex surgery, services should be developed at Altnagelvin Hospital with an in-reach model

Annex E - Western Health and Social Care Trust Findings and Recommendations

Finding	Recommendation
Workforce	
The specialist nursing workforce is a strength at Altnagelvin Hospital, with CNS's delivering flexible cystoscopy, LUTS assessment clinics, ED clinics and cancer follow-up clinics.	Subject to funding, the CNS team should be expanded further as a priority area of development for the Trust. Their roles should be extended to include delivery of LA trans-perineal prostate biopsy, flexible cystoscopy and Botox. TULA could also be considered, once established.
The medical workforce remains reliant on locum appointments and has difficulty recruiting to substantive posts. This is a recognised problem nationally across the UK due to unfilled consultant posts and a lack of NTNs accredited each year.	The department should continue to address barriers to recruitment, where these are within their control. This would include a more robust middle grade rota of cover for on-call as the current consultants are largely the first point of contact for four acute Trusts (Causeway, SWAH, Antrim and Altnagelvin). A middle grade rota can comprise an extended workforce that can include advanced nurse practitioners and physician's associates in addition to more usual medical roles. Developing areas of sub-specialist practice can also aid recruitment and retention of staff. Please see below regarding robotic surgery. The Department of Health should also consider incentivisation of terms and conditions in the Western Trust, in order to attract consultants into the area.
Outpatients and diagnostics	
Waiting access times for outpatients at the Western Trust are the best in NI (see Figure 5). The team are to be congratulated on this, particularly given the lack of dedicated outpatient facilities highlighted below.	Learning from the Western Trust should be shared with other sites to understand how the waiting times can be improved at other Trusts.
Accommodation for medical and nursing staff is inadequate with cramped facilities and poorly linked to other clinical areas.	Please see the recommendation on development of a UIU.
Outpatient facilities for consulting, diagnostic procedures and therapeutic interventions are wholly inadequate and are of the lowest standard of all the urology units in NI. They are also disparate in terms of their location throughout the Trust. It will remain difficult provide efficient and timely outpatient care	The Trust needs to urgently develop and deliver plans for a co-located UIU subject to funding. Facilities to consult, perform outpatient diagnostics and offer therapeutic interventions need to be brought into one place and be future-proofed in terms of the anticipated growth in outpatient work. A UIU is the ideal place to provide office

without urgent investment and re-design of facilities.	accommodation for clinical and administrative staff so that training and clinical interaction can be facilitated.
Cancer pathways need to be further streamlined and designed to avoid inefficiencies in terms of clinician time.	There should be a 'straight to test' approach for suspected prostate cancer patients requiring an MRI scan. It is not good use of clinician time to telephone patients in advance of the test and this could be managed by standard template letters. There should be protected ultrasound slots for patients being assessed for suspected cancer in relation to haematuria. With development of the UIU, a gold standard approach would be a sonographer working alongside the haematuria flexible cystoscopy list.
Up to 25% of patients currently admitted for a TURBT or bladder biopsy could be managed as an outpatient under local anaesthesia using TULA.	A TULA service should be implemented promptly. It is a low-cost innovation with a short learning curve and could lead to rapid capacity release in theatres, by moving such patients out of theatre and into an outpatient setting.
Facilities including HVLC sites	
Theatre facilities at Altnagelvin Hospital are inadequate, with the majority of operating lists being offered in a theatre that has been decommissioned previously, on more than one occasion. The theatre footprint is too small for a modern operating theatre and cannot safely accommodate the patient, the staff and the wide array of urological equipment that is needed to undertake contemporary urological surgery.	There need to be urgent plans for the provision of suitable operating theatres for urological surgery. A majority of such surgery can be performed in daycase facilities, with a smaller component requiring in-patient care (usually due to patient co-morbidity or case complexity). It is not acceptable to continue delivering surgery in the existing facilities in the medium to long term.
Theatre capacity has not been restored following the pandemic and the consultants no longer have access to an all-day theatre list.	As a minimum, each consultant needs access to a main theatre for 2 sessions per week 42 weeks of the year.
Minor and intermediate procedures continue to be undertaken in theatre at the Causeway Hospital but the set-up is highly inefficient. The team have not been given access to daycase beds and problems with patient flow means that start-times of 10.30am or later are common. The lists are poorly utilised in terms of volume of work.	Elective surgical work at the Causeway Hospital should be reviewed with consideration of future provision in-house at Altnagelvin Hospital or Omagh.
Flexible cystoscopies are being performed in theatre at the Causeway Hospital.	This practice needs to stop and should be provided in an outpatient setting by default. It is an inappropriate use of a theatre environment.

Oncology	
Given the significant shortfall in the ability of Belfast Trust to provide the necessary resource for major cancer surgery, serious consideration needs to be given to a second robotic platform at Altnagelvin Hospital.	With appropriate investment and recruitment, there are sufficient volumes of work in NI to justify a second robotic surgery programme at Altnagelvin Hospital. Ideally, it would be implemented as part of a cross-specialty platform, given that colorectal surgery and gynaecological surgery is beginning to transition at pace towards a robotic approach. At present, only 50 of an estimated 250 men undergo RALP in Belfast and our predictions are that the province needs 5-6 RALP surgeons across the two sites if it is to meet this need. Renal surgery is also likely to become robotically-assisted in the near future, in keeping with this change of practice on the mainland. Recruitment of surgeons with the necessary skills will be the major barrier but establishing a high-volume robotic service at the Trust would appeal to certain individuals and make Western Trust a more attractive place to deliver urology. It would also complement the facilities that are provided at the oncology centre for patients requiring radiotherapy or chemotherapy. This development could be critical in ensuring long-term viability of the urology service in the West. Implementation of this recommendation will be subject to funding.
Radical nephrectomy is provided by a single surgeon at Altnagelvin Hospital. Patients requiring partial nephrectomy are referred to Belfast City Hospital.	The nephrectomy service should be formally provided as part of a networked service across the various Trusts that offer this surgery in NI. There should be a single MDT and the ability to cross-cover each other's clinical practice in the situation whereby a single-handed surgeon is on leave or absent from work for other reasons. This will also mitigate against differences in access times should they occur.
Altnagelvin Hospital is the referral site for penile cancer services in NI. It is predominantly a single-handed practice with over 75% of the consultant's theatre capacity being used this work. For this reason There is very little benign work being performed.	Ideally, the service would be expanded with appointment of another andrologist but, in the current climate, it is unlikely that another andrologist could be found and appointed due to a national shortage. To mitigate the risks associated with single-handed practice, the unit needs to have a close-working

	relationship with services on the mainland. This is currently at The Christie NHS Foundation Trust in Manchester.
Urgent and emergency care	
Urgent and emergency care pathways are not functioning consistently across the Trusts that sit within catchment for the Altnagelvin on-call team. This is particularly true in regard to the Trusts in the Northern sector (Causeway and Antrim) but also applies to South West Acute Hospital (SWAH). As a result, there is significant variation in the provision of acute urological care leading to postcode variation for patients.	Urgent action is needed to clarify these pathways and agree the arrangements for the provision of urgent and emergency care. The Urology Teams at Altnagelvin, in association with General Surgery and ED colleagues in the Northern Trust and Belfast Health and Social Care Trust, should develop contemporary clear protocols and care pathways for Urology patients requiring transfer and onward specialist urological treatment. These should include pathways for acute ureteric colic, urinary retention, haematuria and urosepsis management. It is our recommendation that the current postcode-based system is removed and the arrangements between Trusts simplified in the interests of safe patient care. All patients attending Antrim Area Hospital who require onward care should be directed to Belfast Trust and those attending the Causeway Hospital directed to Altnagelvin Hospital.
Interventional radiology provision is predicated on a single radiologist and is predominantly only available 'in-hours'. There are plans for an outreach, networked model later this year supported by Belfast Trust.	Ensure there is a clear protocol in place with associated access arrangements for the provision of interventional radiology, including out-of-hours cover.
Improvements could be made with regard to the management of acute stone patients. This includes improved access to 'hot' ureteroscopy and improved use of acute ESWL.	The department should further develop their use of a 'book and return' pathway for urgent ureteroscopy. Once established, the acute lithotripsy service at Craigavon Area Hospital should be used by default for suitable patients. A seamless referral pathway needs to be agreed between the Western team and Craigavon Area Hospital.
Specialist services	
While andrology surgery is offered at Altnagelvin Hospital, the service is reliant on a single surgeon and with the pressures of the penile cancer service, there is little time or resource available for the service	Ideally, the service would be expanded with appointment of another andrologist but, in the current climate, it is unlikely that another andrologist could be found and appointed due to a national shortage.
Stone service	It has been agreed that ESWL and PCNL surgery will be centralised at Craigavon Area Hospital.

Men awaiting bladder outlet surgery represent one of the longest backlogs in urology and is a particular problem in NI. Men at greatest risk of poor care are those who have indwelling catheters.	The department should have a urinary retention pathway that allows for rapid access back to the service for a TWOC and or assessment for bladder outlet surgery. The pathway should dovetail with the work that has already been done on the BOO surgery pathway at the Lagan Valley facility. There should be a networked approached to this service.
Pathways for female and functional urological treatments need to be clearly agreed and described.	Assessment and common treatments (such as botox / intra-vesical therapies) should be provided at the Trust. There is consensus that the service for more complex or refractory patients will be centralised to Altnagelvin Hospital.
Other observations	
The clinicians cited a disconnect between the previous management team and the clinical team, with a lack of business meetings since the initial COVID surge. It was felt that there was still some work to do to ensure the current relationships functioned well.	There should be a regular (monthly at least) meeting between the clinical team and the service management team, with opportunities to link in with more senior managers and executives. Meetings should have formal agendas, minutes and actions. Actions should be reviewed at each meeting.

Annex F - Northern Trust Findings and Recommendations

Findings	Recommendation
Workforce	
The community continence team nursing team is under-resourced and communication with the Urology teams at Altnagelvin Area Hospital and Belfast City Hospital is patchy.	Strengthening the links between the community team and urological services would enable better access to urological services (e.g. LUTS treatment and Stone management) for patients .
Outpatients and diagnostics	
Patients are traveling long distances to either Belfast or Derry for outpatient consultations	A priority for the Trust should be the further development of the UIU at Whiteabbey. Facilities to consult, perform outpatient diagnostics and offer therapeutic interventions need to be brought into one place enabling patients to be seen and managed without having to travel into Belfast
Facilities including HVLC sites	
Under-utilisation of Urology daycase facilities at both Causeway Hospital and Antrim Area Hospital.	Given the current shortage of urological in the Western Health Trust a review of elective urology at Causeway should be undertaken. Better use of the daycase facility at Antrim Area Hospital aligned with GIRFT principles should be introduced.
Urgent and emergency care (UEC)	
There is no on-site provision of specialist urological care in Antrim Area Hospital or Causeway Hospital. Initial triage and care for common urological conditions (including torsion) is provided by the acute general surgical team. A percentage of patients also end up being cared for by physicians on the medical wards. Depending on a patient's postcode, patients requiring onward urological care are referred to either Altnagelvin Hospital or Belfast Trust. A number of concerns were raised by the local teams (represented by ED, general surgery, medicine and anaesthesia at the site visit). • There were no clear protocols in use for the management of common urological conditions. • Although advice could be sought from the urology on-call team at Altnagelvin or Belfast Trust, specific management plans were not always clear. • 'Admit locally' was said to be a common initial instruction from the on-call team to	It is our recommendation that the current postcode-based system is removed and the arrangements between Trusts simplified in the interests of safe patient care. All patients attending Antrim Area Hospital who require onward care should be directed to Belfast Trust and those attending the Causeway Hospital directed to Altnagelvin. As a matter of urgency, senior clinical leaders from the relevant specialties at each Trust should meet and agree the re-configuration of services. There needs to be clear protocols in place for the common urological emergencies. As a minimum, these should include pathways for urosepsis, haematuria, acute ureteric colic, urinary retention and epididymo-orchitis. The focus should be on ambulatory models of care, where safe to do so. There should be explicit guidance as to how patients could be reviewed at Belfast Trust for longer-term management plans or subsequent attendance at urology ambulatory assessment units.

ED / acute take, leading to further calls between hospitals to clarify the plans for onward care. • When transfers were required, they were often delayed and subject to site meetings between the referring and receiving Trusts. • There was consensus that patients requiring urological input were not receiving the same timely input or urological oversight that patients in the urology units had access to.	Operational site teams should be part of these discussions, to agree how patient transfer can be optimised in order to mitigate against delays in specialist urological input. The urology on-call team at the receiving unit(should ensure that clear plans are given for immediate care of the acute urology patients as well as clear advice on what follow-up is required and how that will be arranged. Following introduction of these pathways, a follow-up meeting between clinical leads should take place after 3 months to check that they are effective in delivering safe urological care in the acute setting.
Oncology and Subspecialist Urology	
When patients who had undergone oncological procedures performed at another trust presented with complications, there were unnecessary delays in transferring patients.	A SLA and clear pathways should be rapidly instituted to enable the swift transfer of patients requiring specialist urological care.
Other	
Clinicians and senior managers present at the site visit could not recall any recent meetings between clinical leads at each Trust to address issues of mutual concern.	Given the issues raised in this review, it would be sensible to schedule an annual meeting between senior clinical leaders across the Trusts to ensure ongoing oversight and governance.

Annex G: Useful links to GIRFT Urology Pathways and Good Practice Guidance

To access the documentation, please click on the links below.

1) NHS England - Model Hospital
2) GIRFT National Urology Report
3) Diagnostics: Recovery and Renewal Report.
4) MedTech Funding Mandate policy 2022/23: guidance for NHS commissioners and providers of NHS-funded care
5) Day case surgery rates
6) GIRFT Good Practice Guide for Urology
7) Clinically-led Specialty Outpatient Guidance
8) Urology Outpatient Transformation
9) Urology: Towards better care for patients with bladder cancer
10) Urology: Towards better care for patients with acute urinary tract stones
11) Urology: towards better care for patients with bladder outlet obstruction
12) Urology: the path to recovery
13) Specialised kidney, bladder and prostate cancer services.
14) Minor peno-scrotal surgery pathway
15) Cystoscopy plus (rigid cystoscopy, endoscopic lower urinary tract procedures)

Annex H: Glossary of Terms and Abbreviations

Abbreviation	Term
A and G	Advice and guidance
BADS	British Association of Day Surgery
BOO	Bladder outflow obstruction
BPH	Benign Prostatic Hyperplasia
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.
CEPOD	Confidential enquiry into Peri-operative deaths; CEPOD lists are a means of prioritising patients for surgery, based on clinical need
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.
ED	Emergency department or erectile dysfunction
ESWL	Extra-corporeal shock wave lithotripsy
GIRFT	Getting it Right First Time
GSI	Genuine stress incontinence
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.
HoLEP	Holmium enucleation of the prostate; surgical treatment for BPH
HVLC	High volume low complexity
LATP	local anaesthetic transperineal (prostate biopsy)
LUTS	lower urinary tract symptoms
IR	Interventional radiology
Laparoscopic surgery	Surgery performed using a laparoscope; a special type of endoscope inserted through a small incision in the abdominal wall.
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).
MDT	Multi-disciplinary teams
NICaN	Northern Ireland Cancer Network
NICE	National Institute for Health Care Excellence
NIEPC	Northern Ireland Electronic Patient Care
NIMDTA	Northern Ireland Medical and Dental Training Authority
NTN	National training number
PCNL	Percutaneous nephrolithotomy; key hole surgery on the kidney to treat renal stones
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.
PA	Physician Associate

PAE	Prostate artery embolisation
RARP	Robotically-assisted radical prostatectomy
PIFU	Patient initiated follow-up
Rezum	Surgical treatment for benign prostate enlargement
RNOH	Royal National Orthopaedic Hospital
PSA	Prostate Specific Antigen
RTT	Referral to treatment time
SLA	Service level agreement
SOP	Standard operating procedure
SNS	Sacral nerve stimulation (treatment for refractory bladder over-activity)
TP	Trans perineal (as in transperineal biopsy)
TPD	Training Programme Director
TRUS	Tran-rectal ultrasound
TULA	Transurethral laser ablation
TUR	Trans-urethral resection
TURBT	Transurethral resection of bladder tumour
TURis	Trans-urethral resection in saline
TURP	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.
TWOC	Trial without catheter
UAN	Urology Area Network
UEC	Unplanned and emergency care
UIU	Urology Investigation Unit
Urolift	Surgical treatment for benign prostate enlargement
VVF	Vesico-vaginal fistula (an abnormal communication between the bladder and vagina)
WTE	Whole time equivalent

Southern Health and Social Care Trust

Southern HSC Trust

Getting it Right First Time

Urology

Southern Trust Recommendations November 2023

RAG rating	No. of actions
	6 (33%)
	10 (56%)
	2 (11%)

An updated version of this Action Plan dated 6 March 2024 can be found at TRU-306468 to TRU-306488. Annotated by the Urology Services Inquiry.

Received from SHSCT 16/02/2024. Annotated by the Urology Services Inquiry.

WORKFORCE					
RECOMMENDATION 1					
The Trust should continue to address barriers to recruitment, where these are within their control. A middle grade rota can comprise an Developing areas of sub-specialist practice can also aid recruitment and retention of staff.					
Original Findings	**Responsible Person**	**Action(s) Required to Deliver Recommendation(s)**	**Timescale**	**Status RAG**	**Evidence of Completion**
The medical workforce remains reliant on locum appointments and has difficulty recruiting to substantive posts. This is a recognised problem nationally across the UK due to unfilled consultant posts and a lack of National Training Number's (NTN's) accredited each year.	Cathrine Reid / Mark Haynes	Since the GIRFT Visit in March 2023 the Urology Team have advertised for the following medical staff: • Specialty Doctor – Commenced Aug 2024 Temp initially until recurrent funding is secured • International recruitment – successfully appointed 3 Urology Consultants. Commencing 1 x Dec 23 and 2 x Feb 24 • Physician Associate – advertised, offered and declined. Back out to advertise. Temp initially until recurrent funding is secured We will continue with one Locum Consultant until all Substantive Consultant posts are filled.	Complete		

RECOMMENDATION 2					
The Training Programme Director (TPD) for urology should continue to work with individual units to ensure that trainees are allocated to departments in line with the trainees' educational needs and that areas of particular training value are utilised well.					
Original Findings	**Responsible Person**	**Action(s) Required to Deliver Recommendation(s)**	**Timescale**	**Status RAG**	**Evidence of Completion**
The unit receives 3 NTN's per year; there is an unequal distribution of trainee numbers across Northern Ireland.	Mr Tony Glackin	Southern Trust trainees get appropriate learning experiences in SHSCT as evidenced at ARCP and national training survey. The Urology consultants insist on the trainees following a defined job plan. Additional national trainee numbers were created. At this time a process was undertaken by NIMDT where by proposed additional SPR placement proposals from each Trust were objectively accessed and ranked in order to determine the placement of the additional numbers.	complete		

Facilities including HLVC Site
RECOMMENDATION 3
Subject to funding, the Trust needs to urgently re-establish the UIU. Facilities to consult, perform outpatient diagnostics and offer therapeutic interventions need to be brought into one place and be future-proofed in terms of the anticipated growth in outpatient work

Getting it Right First Time, Urology, Southern Trust

Original Findings	Responsible Director	Action(s) Required to Deliver Recommendation(s)	Timescale	Status RAG	Evidence of Completion
While outpatient facilities for consulting, diagnostic procedures and therapeutic interventions are adequate, much of the Urology Investigation Unit (UIU) is currently occupied by other services if there is an outpatient room available. Urology has primary use of the outpatient rooms in Thorndale, it is only utilised by other services if the rooms are not utilised	Cathrine Reid / Lynn Lappin / Wendy Clayton	The Thorndale Urology Unit is specifically for the Urology Services. It comprises of 9 consultation rooms and 2 treatment rooms. All consultation rooms are flexible to allow procedures such as bladder scanning/difficult catheter changes/ Haem clinics etc Treatment rooms are available for TP Biopsies and Urodynamic Clinics. Post covid there were 2 specialities outside of urology using the outpatient rooms as these were not occupied due to medical vacancies. However, since recruitment the Thorndale Unit is occupied solely by Urology Services In addition we have created 2 additional outpatient rooms just outside Thorndale Unit for overflow of outpatient clinics if required	Complete		

Getting it Right First Time, Urology, Southern Trust

RECOMMENDATION 4					
Trust management should ensure that Trusts are optimising their theatre capacity in order that each urologist has, as a minimum, 2					
Original Findings	**Responsible Director**	**Action(s) Required to Deliver Recommendation(s)**	**Timescale**	**Status RAG**	**Evidence of Completion**
Theatre capacity has not been restored following the pandemic and the consultants no longer have access to an all-day theatre list.	Cathrine Reid / Declan	The Urology surgeons from August 2023 have their job planned theatre sessions per week, the service is back to full funded sessions We are delivering the full Urology funded theatre sessions by Urology Consultants from other Trusts backfilling if theatre is available	Aug 2023		

Getting it Right First Time, Urology, Southern Trust

RECOMMENDATION 5					
The Lagan Valley facility is a key component of elective recovery. The Southern Trust needs to ensure that the facility is used to maximum effect by its clinicians, aiming for maximum utilisation of available lists and unnecessary cancellations at short notice due to annual leave					
Original Findings	**Responsible Director**	**Action(s) Required to Deliver Recommendation(s)**	**Timescale**	**Status RAG**	**Evidence of Completion**
The protected elective capacity at Lagan Valley Hospital is an impressive development, led by the South Eastern Trust but also utilised by Southern and Belfast teams. It has enhanced the daycase opportunities and created a hub for a regional bladder outlet service, enabling significant progress on recovering the waiting list. The unit is highly efficient and appears to be working well.	Mark Haynes / Wendy Clayton	The Southern Trust does send an operator to Lagan Valley Hospital each Wednesday approx 48 weeks of the year	Complete		

Outpatients and diagnostics					
RECOMMENDATION 6					
There should be a 'straight to test' approach for suspected prostate cancer patients requiring an MRI scan. It is not good use of clinician time to telephone patients in advance of the test and this could be managed by standard template letters. There should be protected ultrasound slots for patients being assessed for suspected cancer in relation to haematuria. With development of the UIU, a gold standard approach would be a sonographer working alongside the haematuria flexible cystoscopy list.					
	Responsible Director	**Action(s) Required to Deliver Recommendation(s)**	**Timescale**	**Status RAG**	**Evidence of Completion**
Cancer pathways need to be further streamlined and designed to avoid inefficiencies in terms of clinician time.	Cathrine Reid / Barry Conway / Lynn Lappin / Mark Haynes/ Wendy Clayton	Suspected Prostate cancer pathway is currently being reviewed regionally as part of NICAN and also being considered along with the Regional Diagnostic Centre (RDC) project There is a meeting arranged Wed 10 Jan 24 between Cancer, Radiology and Urology team to discuss and consider a Prostate RDC pathway Commissioning assistance will be required to achieve this recommendation However, Southern trust would welcome discussion regarding haematuria and whether imaging prior to flex cyst is more efficient from a provision perspective than imaging at the time of attendance	Est. Dec 2024		

RECOMMENDATION 7					
Further efforts must be made to reduce the delays in access to and reporting of imaging and pathology.					
Original Findings	**Responsible Director**	**Action(s) Required to Deliver Recommendation(s)**	**Timescale**	**Status RAG**	**Evidence of Completion**
Turnaround times for MRI scans and reporting delays in biopsy results mean that the suspected prostate cancer pathway is significant delayed.	Barry Conway/ Denise Newell / Geoff Kennedy	12/12/23 Prostate pathway snapshot Date for MRI scan – decision to biopsy = 14 days MRI imaging is included in the pathway streamlining process in Recommendation 6 Currently there are 57 MRI prostates on the waiting list – 24 of these are prioritised as red flag – all of these are appointed with the exception of 1 and only one is currently waiting over the 2 weeks. From a reporting perspective on average 40.5% of red flag and urgent examinations are reported within 2 days. There are additional radiologists	Completed		

		that have been trained up to report in this area however, with ongoing demands across the system it is difficult to increase this at the moment.			

Oncology					
RECOMMENDATION 8					
Original Findings	**Responsible Director**	**Action(s) Required to Deliver Recommendation(s)**	**Timescale**	**Status RAG**	**Evidence of Completion**
Up to 25% of patients currently admitted for a transurethral resection of bladder tumour (TURBT) or bladder biopsy could be managed as an outpatient under local anaesthesia using TULA.	Mark Haynes / Wendy Clayton	Funding has been received from SPPG and 1 xTULA equipment ordered Outpatient Sister has advised that the TULA has arrived and waiting on estates asset ID label. They have been emailed again last week about it. Currently waiting on the delivery of accessories to go with the TULA 2 x CNS's are going to a training session in January 2024 in London	April 2024		

Getting it Right First Time, Urology, Southern Trust

RECOMMENDATION 9					
The day case TURBT pathway for Craigavon Area Hospital should be developed further at Lagan Valley Hospital and Daisy Hill Hospital for stable ASA 3 patients and below and become the default pathway for patients who are suitable for a day case approach.					
Original Findings	**Responsible Director**	**Action(s) Required to Deliver Recommendation(s)**	**Timescale**	**Status RAG**	**Evidence of Completion**
Approximately 40-50% of TURBT procedures can be done as a day case, facilitated by in-theatre administration of Mitomycin-C.	Mark Haynes / Helena Murray	Urology moved to DHH theatres during COVID Previously, Urology services were in CAH main theatres only and would not have operated in DHH. Therefore, theatres nursing team will require training and protocols drawn up Initial start-up will be DHH day surgery theatres. Meeting to be arranged with MDH and Theatre management (estimated 19/1/24)	Est March 2024		

RECOMMENDATION 10					
In theatre Mitomycin-C should be the default option for suitable patients, irrespective of the facility in which the procedure is performed.					
Original Findings	**Responsible Director**	**Action(s) Required to Deliver Recommendation(s)**	**Timescale**	**Status RAG**	**Evidence of Completion**
Current provision of Mitomycin-C is problematic	Declan McClements / Helena Murray	See recommendation 9 Initial start-up will be DHH day surgery theatres. Meeting to be arranged with MDH and Theatre management (estimated 19/1/24)	April 2024		

Getting it Right First Time, Urology, Southern Trust

RECOMMENDATION 11					
The nephrectomy service should be formally provided as part of a networked service across the various Trusts that offer this surgery in Northern Ireland. There should be a single MDT and the ability to cross-cover each other's clinical practice in the situation whereby a					
Original Findings	**Responsible Director**	**Action(s) Required to Deliver Recommendation(s)**	**Timescale**	**Status RAG**	**Evidence of Completion**
Radical nephrectomy is provided by two surgeons at Craigavon Area Hospital. Patients requiring partial nephrectomy are referred to Belfast City Hospital using an in-reach model	Mark Haynes	This is a regional recommendation. From a Southern Trust perspective 2 substantive Urology Consultants provide radical nephrectomy and from Sept 2023 patients have been transferred from Belfast to Southern Trust waiting list due to long waiting times in Belfast Trust for robotic procedures. A renal cancer project had been initiated in early 2023 with the support from NICAN A regional meeting took place in October 2023 where region wide agreement for a single region waiting time was agreed This subsequently has been discussed through the PIG group with the view to implementation over the next 3 months	Est Feb 2024		

Urgent and Emergency Care					
RECOMMENDATION 12					
The department should further develop their use of a 'book and return' pathway for urgent ureteroscopy at Lagan Valley Hospital. Once established, the acute lithotripsy service at Craigavon Area Hospital should be used by default for primary treatment in suitable patients. A seamless referral pathway needs to be agreed across Urology departments in NI.					
Original Findings	**Responsible Person**	**Action(s) Required to Deliver Recommendation(s)**	**Timescale**	**Status RAG**	**Evidence of Completion**
Further improvements could be made with regard to the management of acute stone patients. This includes improved access to 'hot' ureteroscopy and improved use of acute extra-corporeal shockwave lithotripsy (ESWL).	Cathrine Reid / Lynn Lappin / Wendy Clayton / Mark Haynes	We presume there will be discussion regarding Book and return for urgent ureteroscopy at the regional PIG meeting as the department is to develop Once established Southern Trust would be happy to utilise and partake in delivery	Est April 2024		

Getting it Right First Time, Urology, Southern Trust

RECOMMENDATION 13					
The department should have a urinary retention pathway that allows for rapid access back to the service for a TWOC and or assessment for bladder outlet surgery. The pathway should dovetail with the work that has already been done on the BOO surgery at the Lagan Valley					
Original Findings	**Responsible Person**	**Action(s) Required to Deliver Recommendation(s)**	**Timescale**	**Status RAG**	**Evidence of Completion**
Men awaiting bladder outlet surgery represent one of the longest backlogs in urology and is a particular problem in NI. Men at greatest risk of poor care are those who have indwelling catheters.	Mark Haynes / Wendy Clayton	There is currently an agreed route for patients from ED into the outpatient urology service for trial removal of catheter and subsequent through the Lower urinary tract symptoms (LUTS) / Bladder outlet obstruction (BOO) nurse specialist service which already dovetails with the available daycase bladder outlet surgical options in NI. The pathway could be improved and discussions have commenced with ED with a view to improving the pathway, however, the biggest challenge to delivering a timely service is capacity	June 2024		

Specialist services					
RECOMMENDATION 14					
It has been agreed that Extra-Corporeal Shock Wave Lithotripsy (ESWL) and Percutaneous Nephrolithotomy (PCNL) surgery will be centralised at Craigavon Area Hospital. This will require the provision of 42 all day lists per year (2 procedures per list).There will need to be additional capacity for other types of					
Original Findings	**Responsible Person**	**Action(s) Required to Deliver Recommendation(s)**	**Timescale**	**Status RAG**	**Evidence of Completion**
Stone service.	Cathrine Reid / Lynn Lappin / Declan McClements Mark Haynes / Wendy Clayton	The Southern Trust has submitted an IPT for the ESWL and is finalising an IPT for PCNL service **ESWL** – regional service has commenced, including both elective and emergency ESWL procedures region wide. **PCNL** – the regional PCNL surgery sessions have commenced in the Craigavon Hospital but using Southern Trust core sessions. 2 consultants from Belfast Trust come to CAH to undertake long waiting PCNL surgery	April 2024		

Getting it Right First Time, Urology, Southern Trust

RECOMMENDATION 15					
The facilities for the delivery of ESWL will need to be upgraded to facilitate the delivery of 4-5 patients for ESWL per half-day list.					
Original Findings	**Responsible Person**	**Action(s) Required to Deliver Recommendation(s)**	**Timescale**	**Status RAG**	**Evidence of Completion**
ESWL.	Cathrine Reid / Lynn Lappin / Barry Conway	The ESWL currently has 4 patients AM and 3 patients PM per session When radiographers are recruited this will increase to 4-5 patients per session Interviewing Dec 2024 with estimated start date of March 2024	March 24		

Getting it Right First Time, Urology, Southern Trust

RECOMMENDATION 16					
Given the regionalisation of this service in WHSCT the trust should consider disinvesting in the provision of benign andrology. There are now good examples nationally of delivering andrology surgery in 'cold' elective sites. Clinicians with expertise in this area should work as					
Original Findings	**Responsible Person**	**Action(s) Required to Deliver Recommendation(s)**	**Timescale**	**Status RAG**	**Evidence of Completion**
There is currently under-provision of benign andrology surgery across NI.	Mark Haynes	The Southern Trust agree that benign andrology should be a specialist service undertaken by a small team as a regional service, ideally co-located with the penile cancer service, and utilising regional day case facilities where appropriate. Penile straightening surgery for example, has not been undertaken by any of the Southern Trust team for a number of years and none of the team are in a position to be able to offer this surgery. There are currently a number of patients on the waiting list for this surgery and we have no means of providing this surgery at present. This includes many of the trusts longest waiters.	Regional		

RECOMMENDATION 17					
Assessment and common treatments (such as botox / intra-vesical therapies) should be provided at the Trust. There is consensus that the service for more complex or refractory patients will be centralised to Altnagelvin Hospital.					
Original Findings	**Responsible Person**	**Action(s) Required to Deliver Recommendation(s)**	**Timescale**	**Status RAG**	**Evidence of Completion**
Pathways for female and functional urological treatments need to be clearly agreed and described.	SPPG	Action to be discussed at the Regional Urology PIG meetings			

Getting it Right First Time, Urology, Southern Trust

Outpatient Care					
RECOMMENDATION 18					
Original Findings	**Responsible Person**	**Action(s) Required to Deliver Recommendation(s)**	**Timescale**	**Status RAG**	**Evidence of Completion**
The DoH should ensure that Trusts review their outpatient practice with a view to reducing the number of unnecessary review appointments, aspiring to a new to follow-up ratio of 1:2.		The Southern Trust are participating in the Regional Outpatient Modernisation Project. Mr Haynes has volunteered for the Enhanced Clinical Triage and Patient Initiated Follow up (PIFU) Task & Finish Groups. Meeting scheduled for Mon 15/1/24 (Led by SPPG) As per Southern Trust sharepoint Urology New : Review ratio at the end of Nov 23 is 1:5 average. This is not a true reflection as there are more review clinics than new clinics due to priority of MDM reviews.			