

# A framework for re-establishing and developing urology services in the COVID-19 era

Audience: NHS providers of urology services

Purpose: This document describes the scope of work needed to build high quality and robust urology services in the COVID-19 era. It provides a self-assessment tool for providers to assess their progress and signposts to existing examples of innovation, guidance and other resources.

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# Introduction

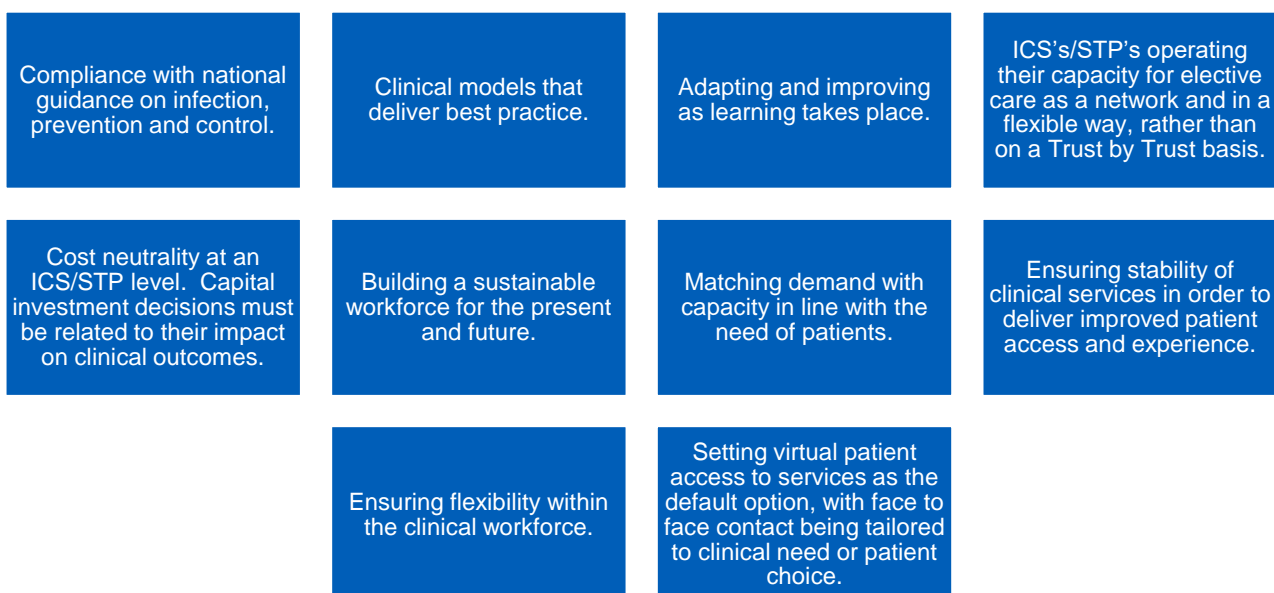
Over the past 4 years, a considerable amount of work had gone on looking at the quality of care provision and its cost effectiveness across surgical specialties, including Urology. The Getting it Right First Time (GIRFT) programme was at the forefront of the process, by providing an insight into the variance in the delivery of urological care nationally and redefining standards of care.

The emergence of COVID-19 pandemic has had a devastating impact on the NHS's ability to deliver its full range of services and nationally has seen a reduction of over 50% in elective surgical care with growing waiting lists and a marked increase in 18 and 52 week waiters. It has become clear that, for the foreseeable future, the way that care is provided will need to be different from traditional ways of working if the situation is to be redressed. Every health crisis affords an opportunity to think about how care is delivered and how it might be improved. There is now a major opportunity to re-set the way in which care is developed in some areas of the NHS, using the current pandemic as a catalyst for change and improvement, to innovate and use the opportunity to re-interpret and implement recommendations from the GIRFT national report on urology (ref 1). We sense a growing enthusiasm in the NHS to 'share and learn' in order to rapidly disseminate best practice.

## Progress to date: The London Programme

In London, 5 Integrated Care Systems/Strategic Transformations Partnerships (ICSs/STPs), comprising geographically co-located trusts have been working with GIRFT to build a programme for service improvement and delivery in the peri and post -COVID era. This programme has been formally titled 'The Transforming NHS, High Volumes and Low Complexity Programme' and is also known as 'The London Programme'.

This work is guided by ten overarching principles or components:



The initiative in London was spearheaded by orthopaedics and ophthalmology, with urology being one of five specialties which are in a second wave of specialties whose programmes are getting under way.

**Moving forward: developing urology services across England**

The aim of this document is to describe the scope of the work that will be need to be undertaken in order to build sustainable high quality and robust urological services in the new era. To help clinical networks come to terms with the agenda that will need to be addressed, there is an opportunity for providers to assess progress across the programme using a self-assessment tool, which will be provided as part of the “Gateway” documentation, outlined in appendix 1. This documentation can be used to monitor progress against the “sentinel” metrics (detailed later in the document) and the broader agenda which is mapped out as well.

The document also provides some signposts to existing examples of innovative working practices and to guidance which might help project teams avoid the need to continuously ‘reinvent the wheel’. It is hoped that these resources will be updated in future editions of this guide, building on the collective experience of teams adopting a share and learn approach to their work. Workstreams have been established to produce guidance that will fill some of the gaps which have already been identified. The workstream projects are collaborative and involve clinicians, managers, a range of NHS bodies, including GIRFT, and the key professional organisations, the British Association of Urological Surgeons (BAUS), the British Association of Urological Nurses (BAUN) and the British Association of Day Case surgery (BADS).



## Key documents referred to throughout this framework

### GIRFT programme national specialty report on urology

Published July 2018

[www.gettingitrightfirsttime.co.uk/urology-report/](http://www.gettingitrightfirsttime.co.uk/urology-report/)

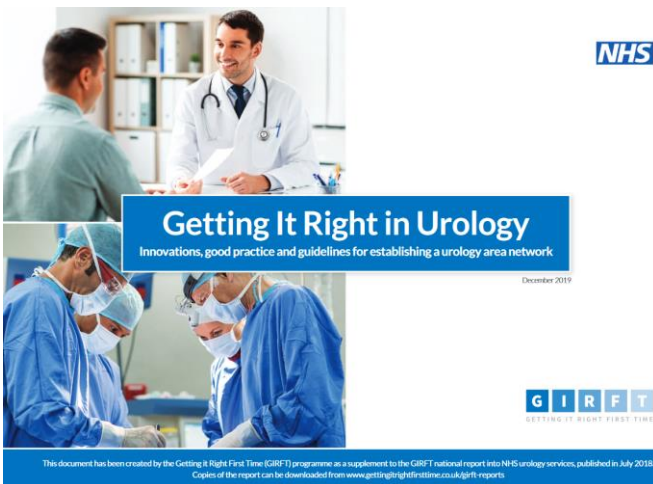


### Urology

GIRFT Programme National Specialty Report

by Simon Harrison  
GIRFT Clinical Lead for Urology

July 2018



### GIRFT Good Practice handbook for urology

Published December 2019

[www.gettingitrightfirsttime.co.uk/good-practice-handbooks/](http://www.gettingitrightfirsttime.co.uk/good-practice-handbooks/)

# Part 1 - Foundations for Recovery

## Collaborative working in urology

The [GIRFT national report on urology](#) (ref 1) set out why urology would need to develop increasing collaboration between individual urology departments, and proposed the development of Urology Area Networks (UANs) as a practical way of delivering joint working. GIRFT set out guidelines for establishing UANs in the '[Getting It Right in Urology good practice guide](#)', published in December 2019 (ref 2). This detailed guidance has significant resonance to those who are developing collaborative working models in response to the COVID-19 challenge. The specialty is already moving away from care being provided by isolated hospital urology departments, thanks to work that has already taken place to develop UANs.

In the London Programme, ICSs/STPs have taken a lead role in defining how further collaborative working will be developed. Across England such working could be organised at an ICS/STP level. Trusts within an ICS/STP could form, in effect, a single UAN, or two or more UANs could be established within an ICS/STP footprint. Such arrangements should be determined locally.

Once there is clarity as to how urology networks are to be organised, there is the opportunity to use the whole of a UAN footprint to increase efficiency, ensure equity of access and establish resilience in case of further service closures as a result of flare ups of the pandemic. Networked arrangements also have the potential to address other challenges such as recruitment, the provision of 24/7 emergency care, and the development of sub specialty practices.

## Clinical Leadership and Project Management

If urology is to develop an integrated model of working, there will be a compelling need to identify clinical leaders at trust, UAN and ICS/STP levels. Those who are providing clinical leadership will need to be supported through the involvement of the wider clinical team, notably specialist nurses and unit managers. In particular there needs to be effective project management input.

A key component is good communication, ensuring that the wider team is engaged with the emerging process and its rationale.

For the London pilot, one of the GIRFT Joint Clinical Leads for urology (SH, JMcG, KJO) linked with each of the ICSs/STPs in order to provide support and to ensure that focus is maintained on some of the key objectives of the programme. This model may be replicated nationally. BAUS Regional Representatives will be fully appraised of the work that is going on nationally so that shared learning can occur and where appropriate, provide additional professional support. BAUN has agreed to provide similar input.

## Monitoring and Measuring

The GIRFT programme has demonstrated the value of using national data resources to develop metrics which are valuable markers of clinical quality and service efficiency. Access to Model hospital <https://model.nhs.uk/> is straightforward and any clinician can register. The site contains a plethora of metrics, covering outpatient and inpatient care and allows users to benchmark their own services against peer organisations.

Key to the development of a recovery plan for urological surgery is the development of specialty specific metrics (outlined below). These reflect some of the recommendations from the 2018 GIRFT Urology report and practical pressures on clinical services with respect to the provision of timely ureteroscopy, bladder outflow surgery and bladder cancer diagnostics. The metrics shown below were found to have broad support from urologists in London during the pilot phase of the London programme.

Metric/Recommendation
Day case rate for patients receiving male bladder outflow surgery
Emergency readmissions within 30 days for patients following male bladder outflow surgery (%)
The average number of days between diagnosis of urinary retention and surgery for male patients (male bladder outflow surgery only)
Day case rate for patients receiving TURBT
Emergency readmissions within 30 days for patients following TURBT (%)
Average wait for patients from referral to TURBT, but only for patients who go on to have cystectomy within 9 months.
Day case rate for patients receiving ureteroscopy
Percentage of emergency admissions with urinary tract stone that go on to have a ureteric stent inserted as a primary procedure during the emergency admission
Referral to treatment targets (18 and 52 weeks)
% greater than 52 weeks - see above
Proportion of outpatient visits that are non-face to face



As part of the London Programme Pilot, local urologists in conjunction with GIRFT, supported the development of specific specialty dashboards that relate to the re-setting of clinical services following the COVID-19 epidemic. These Model Hospital dashboards, and accompanying “Gateway” documentation, (see appendix 1) will be used to monitor progress. There will be a particular focus on the “sentinel” metrics, but the Gateway documentation also provides details of additional metrics that it will be useful to monitor. The Gateway documents also include a self-assessment tool which covers the wider issues which can be used by UAN teams as a guide to the key issues that need to be looked at, and then use the Gateway system to monitor their progress.

The Urology GIRFT report (2018) noted significant variation in length of stay and other metrics across England. Such variation was not infrequently due to ‘custom and practice’, rather than clinical need. One of the fundamental aspirations of the recovery plan piloted initially in the London programme is that new service models which are developed to meet the challenge of the COVID-19 epidemic should aspire to deliver care which equates to the upper decile performance that was seen prior to the COVID-19 shutdown. The baseline that will be used is the performance achieved by Trusts in the top decile during the first three months of 2020. For example, it is expected that the day case rates which were achieved for different procedures by the top ten percent of Trusts in January to March 2020 will be aspired to by all Trusts and UANs as services reopen.

## Communication and shared learning across urology

It is predictable that a huge amount of work is needed in order to reset and reshape the NHS following the COVID-19 pandemic. Recognising that it is unrealistic to expect each provider network to work from scratch on all the different protocols and guidelines that will be needed, it is therefore fundamental that a philosophy of shared learning is in place. Learning and experience must also be shared between specialties. Inter-specialty interaction has and will continue to be coordinated and supported by GIRFT. This will enable best practice to be established through the sharing of experience across the NHS. This effort will be supported by the GIRFT Academy (see below). A wide variation of documents (both generic and specific to urology) relating to pathways, protocols etc will be continually updated by the GIRFT Best Practice Academy. This can be accessed at

<https://gettingitrightfirsttime.co.uk/best-practice-library/>

BAUS has an enviable reputation in the provision of procedure specific information that is widely used across the country. GIRFT recognises that the links with BAUS and BAUN have been crucial to providing wider professional expertise to the London Programme and enabling the wider national urological community to learn from, and start to adopt, some of the practices that have pioneered in London. The expectation is that this major collaborative and learning initiative will be carried out using a range of different media. These initiatives will be jointly hosted by the GIRFT Academy, BAUS and BAUN and will include:



- regular webinars
- social media
- the BAUS TV channel on YouTube
- further development of a portfolio of case studies, building on the existing [GIRFT Good Practice Handbook](#).

These resources will be located or sign-posted in a single repository as part of the GIRFT Academy Best Practice web portal.

Where there are gaps in knowledge and guidance, such as managing outpatient referrals, remote consultation etc, small working groups are being established in order to produce guides and educational material to meet the needs of the specialty. The groups will work under the auspices of GIRFT, BAUS and BAUN, as well as other relevant organisations. They will meet virtually and work to tight, prescribed timescales; discussions are already taking place with the British Association for Day Surgery and the NHS England and NHS Improvement National Outpatient Transformation Programme.

## Governance and Litigation Avoidance

It is vital that new ways of working are developed and implemented in a way that is underpinned by strong governance arrangements. Decisions about services must be justified and documented, and new ways of working will need to be underpinned by appropriate protocols. The GIRFT Report into Urology (2018) showed significant differences between providers; the best performer were estimated to cost an average of £0 per urological admission, while at the other end of the scale, one provider generated an average of £251 of litigation costs per admission. Consequently, robust governance arrangements need to be in place and decisions about altering pathways of care need to be justified. Failure to do so risks leaving the NHS open to a wave of litigation, in which current circumstances are ignored and cases are judged in the context of historical practice.

The GIRFT programme has incorporated guidance on averting the rise in litigation into all of its national specialty reports and publishes comparative data on the costs of claims for all hospital clinical departments.

# Part 2 - A framework for recovery

## Workforce and resources

The core of urological care is centred around outpatient care, rapid diagnostics and high-volume but relatively low-complexity surgery. The pooling of both human and physical resources across an ICS/STP or a UAN is the basis of developing more flexible, efficient, responsive and robust clinical services than can be provided by individual hospital departments. Deploying those resources in a way which maximises the efficiency and quality of the work of a combined urology service will be vital to meeting the post COVID-19 challenge.

The recovery and reset of services will require thorough planning and careful implementation. Success will only be achieved if sufficient time is set aside for managers and clinicians to be able to engage fully with their recovery programme. That time will need to be identified and protected so that changes that need to be made are prioritised and driven through.

### Agenda to be addressed

- Perform a review of the available workforce (clinical, managerial and administrative) across the network.
- Establish cross-site flexibility through 'passporting' of staff to allow working in different Trusts.
- Perform a review and continue monitoring to ensure that all staff are carrying out work that is appropriate to their grade and makes best use of their skills. In particular, avoid administrative work being inappropriately carried out by clinical staff.
- Perform a stock-check of the facilities that are available within the network in order to plan patient pathways. Facilities will include those relating to outpatient work, elective day case and in-patient operating and emergency care. Key equipment will also need to be considered in order to ensure that its use is optimised. Patient pathways should ensure that care is being carried out in the optimal environment and that repeated attendances are minimised where possible.
- Establish effective ways of sharing medical records, laboratory results and imaging across the network.

## Education, training and research

While the primary function of a clinical department is to see, investigate and treat patients, it will be important to ensure that other key departmental responsibilities are not subsumed by the need to reset clinical services.

### Agenda to be addressed

- Review the urology network's responsibilities in relation to the education of medical, nursing and other trainees.
- Prepare training plans across the network to ensure that high quality training is provided in an efficient and effective way. Delivering high volume, low complexity work in a dedicated setting has the potential to provide significant training opportunities in core urology.
- Review the research responsibilities of the urology network.
- Ensure that there is continuing recruitment into existing clinical trials and that resources are maintained to allow a continuing commitment to research.

### Examples of good or innovative practice

A number of departments have benefitted greatly by standing down all scheduled clinical work on one half-day a week. This session can be used for training and departmental administration. Concentrating these activities into a set time guarantees that the majority of the department can contribute fully and efficiently in these areas. For example, the session might include one hour of formal training, a one-hour departmental business meeting, time for work on clinical governance and time for research administration.

## Primary care and referral management

Traditional practice has all too often provided an inflexible interface between primary and secondary care colleagues. This can lead to patients being seen in outpatient clinics when a referral could have been avoided, and an inappropriate number of consultant to consultant referrals due to patients not being directed to the appropriate sub-specialist. As the pandemic has evolved, so too has clinicians' ability to deliver outpatient care remotely. Virtual consultations are likely to become the default option for most outpatient activity in the post COVID-19 era.

### Agenda to be addressed

- Review how primary care colleagues are able to access urology services and discuss with GPs how this interface might be improved.
- Ensure that GPs have access to robust and easily accessible guidance regarding referrals to urology services and offer telephone and/or e-mail advice in order to avoid unnecessary formal referrals. Many urology units have already developed material to support this initiative.
- Develop intelligent triage systems for referrals to urology services. It is essential that patients are accurately directed to the most appropriate pathway. This might be a video or telephone outpatient consultation, a one-stop outpatient clinic, or a standard face-to-face outpatient consultation.

### Examples of good or innovative practice

Triage of referrals can be undertaken by a well-trained administrative officer, with access to advice from clinical staff, rather than by clinical staff themselves. This system readily allows for all referrals to be triaged within twenty-four hours of receipt and avoids unnecessary use of clinical time.

## Outpatient services

There has been an explosion in the use of non-face-to-face or ‘virtual’ consultations and virtual clinics (where results are reviewed without the patient’s participation and a management plan is communicated to the patient afterwards) during the current pandemic. Clinicians and patients have rapidly adapted to this new way of practicing medicine, and discovered its potential benefits and pitfalls. It is now inconceivable that such technology won’t become embedded into clinical practice in the long-term.

### Agenda to be addressed

- Review the mix and availability of different formats for outpatient care. These include standard face-to-face outpatient consultations, visits to one-stop clinics where investigations and consultations are conducted in a single session, video or telephone consultations and virtual clinics. Over time, the capacity of the different types of outpatient contacts will change, so that the system will need to be sensitive and flexible enough to adjust capacity between different types of outpatient contact and is likely to require investment in dedicated private facilities and equipment, including dual screens and voice recognition.
- Ensure that protocols are in place to embed best practice in post-COVID-19 face-to-face work and non-face-to-face activity.
- Ensure that one-stop clinic capacity is sufficient to manage all patients who are referred with conditions suitable for the one-stop approach. This will necessitate building adequate imaging and investigation availability into the one-stop clinic system.
- Review the availability and the suitability of facilities for different types of outpatient contact. In particular, use the redesign of outpatient footprints in Trusts to establish Urological Investigations Units (UIUs) where these are currently not available. The flexibility of being able to carry out outpatient urological investigations and procedures in a unit which is run by the Urology Team will be increasingly important and will maximise efficiency. It will also reduce repeated or prolonged hospital attendances by patients.
- Ensure that any prior investigations that are carried out are available to the clinician when they conduct their consultation with the patient.

### Resources

‘How to undertake teleconsultations with patients’ video by Archie Fernando. [BAUS TV Channel](#) (Ref 3)

### Examples of good or innovative practice

- Establishing a Urological Investigations Unit (UIU) in Mid Yorkshire Hospitals NHS Trust, see page 14 in the GIRFT Good Practice Handbook.
- Virtual review clinics at Pennine Acute Hospitals NHS Trust, see page 19 in the GIRFT Good Practice Handbook.

- Patient telephone service following a transurethral resection of the prostate (TURP) at George Eliot Hospital NHS Trust, see page 22 in the GIRFT Good Practice handbook.
- Remote follow-up for patients with prostate cancer at Leeds Teaching Hospitals NHS Trust, see page 27 in the GIRFT Good Practice handbook.
- Community follow-up for patients with stable prostate cancer at Harrogate and District NHS Foundation Trust, see page 28 in the GIRFT Good Practice handbook.

## Waiting List Management

Waiting lists for outpatient consultations, investigations and operative procedures have built up alarmingly during the period of NHS lockdown. In London during the first six months of the COVID-19 pandemic, the number of patients waiting more than 52 weeks for surgery deteriorated from 500 to over 15,000 for all surgical specialties. It is therefore vital that there are strong governance processes in place in order to manage the risks of this situation, and minimise its detrimental effect on patient experience and outcomes.

### Agenda to be addressed

- Ensure that outpatient and procedure waiting lists are actively managed with clear lines of responsibility.
- Ensure that all waiting lists are validated with appropriate clinical input being provided to that process. Validation procedures will need to be continuous, rather than carried out as one-off exercises, and must incorporate means of supporting patients to make informed decisions with regard to requesting or declining on-going care. There is an expectation that Trusts will have clinically reviewed within eReview, and actioned their inpatient waiting lists (those on an admitted patient pathway for a procedure) by 23rd October, 2020. The expectation is that Trusts, CCGs and ICSs will notify [ereview.programme@nhs.net](mailto:ereview.programme@nhs.net) of the name and contact details of the Elective Care Recovery Lead to act as a point of contact for the Regional and National e-Review programme teams.
- Ensure that there is a robust risk assessment process attached to waiting list validation.
- Prioritise patients who are waiting to receive care using a structured process.

### Resources

- Exeter protocol for validation (ref 4).
- BAUS guidance on waiting list prioritisation (ref 5).



## Elective procedures

Protocols and policies have been developed and implemented as cancer and urgent elective work are managed during the epidemic. Extending new ways of working more widely will require further planning, for example identifying sites which have high levels of COVID-19 security. This approach is often referred to as using “green” pathways and “green” sites. There is a specific initiative to establish elective surgery units that will deal with high-volume/low-complexity surgery as a response to the COVID-19 pandemic. This aspect of elective procedure provision is described in the next subsection of this document (see below).

### Agenda to be addressed

- Ensure that elective work is carried out with appropriate COVID-19 security in place. Where possible, “green” pathways and sites should be established.
- Maximise the use of non-operative procedures where appropriate. For example, considering the use of lithotripsy in patients with urinary tract stones who are suitable for either lithotripsy or an endoscopic procedure. See NICE guidance <https://www.nice.org.uk/guidance/ng118>
- Maximise the use of day-case surgery, ensuring that pathways support the maximal use of day-case surgery in line with British Association of Day Surgery guidance.
- Ensure that enhanced recovery pathways are in place in order to minimise in-patient stays.
- Ensure that multidisciplinary planning and risk-management is in place for patients undergoing complex procedures.

### Resources

- Royal College of Surgeons of England COVID secure practice guidelines (Ref 6)
- GIRFT BADS APOM National Day Surgery Delivery Pack (Ref 7)
- BADS guidance (Ref 8)
- Enhanced recovery guidance on BAUS website (Ref 9, 10, 11)

### Examples of good or innovative practice

- Laser ablation of bladder tumours in an outpatient setting at Ashford and St Peter’s Hospitals NHS Foundation Trust, see page 21 in the GIRFT Good Practice handbook.
- Hospital to home services at The Dudley Group NHS Foundation Trust and The Royal Wolverhampton NHS Trust, see pages 22 - 23 in the GIRFT Good Practice handbook.
- Enhanced recovery programme for nephrectomy at University Hospitals of North Midlands NHS Trust, see page 24 in the GIRFT Good Practice handbook.
- Nurse-led urology rapid access unit at South Tyneside and Sunderland NHS Foundation Trust, see page 26 in the GIRFT Good Practice handbook.

- The Guy's and St Thomas' NHS Foundation Trust team have established pathways that allow prompt access to their fixed site lithotripter for patients from all of the hospitals in the South East London area.
- At UCLH, complex pelvic cancer surgery, which had been previously centralised to that Trust from the North London area, has been protected through the use of a “green site”, separate from the main acute hospital.

## Setting up high-volume / low-complexity urology hubs

A key component of the London Programme has been to address the rapidly growing waiting list for high-volume but relatively low-complexity surgery. Five clinical pathways were developed for work which can be carried in elective surgery hubs. These include minor peno-scrotal surgery, cystoscopy plus, bladder outflow obstruction surgery, ureteroscopy and stent management, and transurethral resection of bladder tumours (TURBT). (see appendix 2).

As TURBT is an integral part of the bladder cancer diagnostic and treatment pathway, the option of carrying out TURBT operations in hubs will hopefully not need to be taken up, as local cancer services should cope with this workload.

Understandably, the development of designated hubs in London has progressed at different rates, but is being urgently pursued in all five ICS/STP areas. Clinicians have been robust in feeding back their concerns about the need for early information about the facilities that will be available, how the hubs will be staffed and what financial support is available. These key issues are outside of the control of clinicians, but it is clear that this initiative has high-level support from the Department of Health and Social Care and will be progressed with a continuing sense of urgency.

It is therefore important that clinicians focus their attention on the issues that need their input, and are under their control. One way to think about this is to address the following question:

***"If hub theatre and ward facilities are ready to admit their first patients in four weeks' time, what needs to be put in place to ensure the agreed clinical pathways run smoothly?"***

This will involve agreeing protocols, procedures and documentation for the hub sites, hopefully with plenty of cross-trust collaboration in order to share the burden. A key priority for each of the hub sites is to get a team in place that can complete the detailed work required. Ideally this will require a hub lead urologist, lead anaesthetist, a hub lead nurse and a hub lead manager for each site. That leadership team will need to coordinate efforts to sort out the operational details that will underpin hub working. Much of the operational work will be generic and there will also need to be regular communication between surgical specialties in order to share and learn, thereby spreading workloads and limiting duplication.

The issues that will need to be primarily dealt with by the **ICS and host trust team** include:

- Funding.
- Identification and provision of facilities – theatres, wards etc.
- Staffing with ward and theatre nurses, anaesthetists, administrators and managers.
- Provision of general trust services – microbiology, histopathology, human resources support etc.

- Provision of general trust policies, such as thrombo-embolic prophylaxis regimes.
- Provision of patient transport to and from hubs.
- Establishment of inter-linked IT systems that enable seamless electronic communication across the whole system.

The issues that need to be taken on by ICS leaders and the managers of the host trust of the hub will need to be agreed by all and clearly understood. Progress with these tasks will need to be regularly communicated with the hub clinical leadership team, but should not require direct clinical input.

Tasks that will need to be taken on by the **Hub Clinical Leadership** teams include:

- Identification of consultants who will provide the service for each pathway.
- Identification of specialist nurses who will support hub staff by providing training and advice.
- Building a model for teaching and training medical, nursing and other staff within the hub.
- Creating an audit programme for hub work, based around patient experience and the achievement of “top decile” performance.
- Creating a comprehensive set of protocols, procedures and documentation for each of the clinical pathways.

Clinical leadership, with close management engagement, will be required in order to get hubs up and running. The agreed clinical pathways (Appendix 2) form the basis for the delivering care in elective surgery hubs. However, there are a number of tasks that need to be completed in order to operationalise those pathways; these are listed in the table below. As guidance documents emerge, exemplars will be added to the GIRFT Best Practice Academy so that other units/UANs can adapt them to suit their own requirements. The Best Practice Library is available at:

<https://gettingitrightfirsttime.co.uk/best-practice-library/>

It seems likely that hub working will be rolled out to many parts of the country. Being able to access high-quality guidance and documentation available from the work carried out in London and other areas will help facilitate future roll-out nationally.

**Table:** Tasks that will need to be addressed for each of the five clinical pathways so that each pathway can be fully operationalised. The list is not exhaustive!

<ul style="list-style-type: none"> <li>• Agreeing processes for transferring patients to the hub system, including transfer of records and imaging.</li> </ul>
<ul style="list-style-type: none"> <li>• Reviewing regional IT connectivity between hubs and base hospitals</li> </ul>
<ul style="list-style-type: none"> <li>• Establishing how planning meetings will work and outputs be documented.</li> </ul>
<ul style="list-style-type: none"> <li>• Agreeing how operating lists will be put together, including case numbers</li> </ul>
<ul style="list-style-type: none"> <li>• Development of patient information packages.</li> </ul>
<ul style="list-style-type: none"> <li>• Establishing how virtual pre-admission consultations will be arranged and documented.</li> </ul>
<ul style="list-style-type: none"> <li>• Agreeing how consent will be confirmed and documented.</li> </ul>
<ul style="list-style-type: none"> <li>• Agreeing protocols for COVID-19 security</li> </ul>
<ul style="list-style-type: none"> <li>• Setting up arrangements for pre-operative urine testing, and other investigation</li> </ul>
<ul style="list-style-type: none"> <li>• Review procedures for electronic prescribing to local pharmacies pre-op for antibiotics / anticoagulation bridging and post op to discharge with analgesia, antibiotics and anticoagulation (if required).</li> </ul>
<ul style="list-style-type: none"> <li>• Working to build the urological knowledge of the pre-assessment nursing team.</li> </ul>
<ul style="list-style-type: none"> <li>• Agreeing a list of essential equipment that will be available for each of the clinical pathways, and ensuring that ad hoc additions to that list are avoided as far as possible.</li> </ul>
<ul style="list-style-type: none"> <li>• Agreeing the format of admission documentation.</li> </ul>
<ul style="list-style-type: none"> <li>• Agree arrangements re provision of patient transport / access to the hub</li> </ul>
<ul style="list-style-type: none"> <li>• Preparing guidance documentation to support nurse-led discharge.</li> </ul>
<ul style="list-style-type: none"> <li>• Preparing patient discharge information documents</li> </ul>
<ul style="list-style-type: none"> <li>• Agreeing how discharge information will be provided to GPs and referring clinicians.</li> </ul>
<ul style="list-style-type: none"> <li>• Establishing how emergency post-discharge support to patients will be provided.</li> </ul>
<ul style="list-style-type: none"> <li>• Establishing how catheter/stent/drain removal arrangements will work.</li> </ul>
<ul style="list-style-type: none"> <li>• Agreeing arrangements for the review of results, notably histopathology reports.</li> </ul>
<ul style="list-style-type: none"> <li>• Agreeing criteria and processes for discharging patients from follow up, or transferring care back to the referring trust.</li> </ul>

## Emergency services

Providing emergency care to urology patients presents particular challenges, as there are difficulties in ensuring that patients and staff are managed in a way that minimises the risk of viral transmission, should an infected patient present with an acute urological condition.

### Agenda to be addressed

- Ensure that primary care colleagues have access to alternatives to admission and that all urology staff can similarly divert patients away from admission, where clinically appropriate. Alternative services may include urinary retention pathways to avoid admission, rapid diagnostics in suspected ureteric colic, acute clinics and the provision of advice on a non-face-to-face basis.
- Review the number of hospital sites into which emergency urology cases are admitted. Given that acute admissions will not have undergone a comprehensive COVID-19 screening process, it is important that co-location of acute and elective urology services is avoided. One obvious approach is to develop red and green sites, effectively as an acute/elective split.
- Ensure that emergency urology in-patients are managed with robust COVID-19 secure policies in place.
- Maximise the opportunities for delivering same day emergency care through rapid access to key investigations, notably ultrasound and CT scanning.

### Resources

Need COVID-19 security document for acute admissions.

### Examples of good or innovative practice

- Nurse-led urology rapid access unit at South Tyneside and Sunderland NHS Foundation Trust, see [page 26 in the GIRFT Good Practice handbook](#).
- Urological assessment unit at Sheffield Teaching Hospitals NHS Foundation Trust, see [page 29 in the GIRFT Good Practice handbook](#).
- Consultant Connect Network at South Warwickshire NHS Foundation Trust, see [page 30 in the GIRFT Good Practice handbook](#).
- University College London Hospitals NHS Foundation Trust has experience of running separate blue and green sites during the pandemic. This has enabled the urology department to minimise the risk of emergency patients, who might have COVID-19, being admitted into the COVID-19-secure elective unit.

## Procurement

The GIRFT programme has demonstrated that significant cost savings are available through improvements in procurement processes. In urology, this particularly applies to the purchase of disposable equipment that is used in large quantities, such as catheters, stents and guidewires. The development of working across UANs and ICSs/STPs provides a further opportunity to rationalise the use of disposable equipment. This process will require input from clinicians in order to safeguard quality while maximising cost-effectiveness.

### **Agenda to be addressed**

- Ensure that there is high-level clinical input into decisions about procurement of clinical equipment.
- Examine opportunities to rationalise the procurement of clinical equipment across the widest suitable footprint – London-wide, ICS/STP-wide or Trust-wide.



## Part 3 - References and Resources

1. GIRFT National Speciality Report for Urology: <https://gettingitrightfirsttime.co.uk/wp-content/uploads/2018/07/Urology-June18-M.pdf>
2. Getting It Right in Urology: Innovations, good practice and guidelines for establishing a urology area network: <https://gettingitrightfirsttime.co.uk/wp-content/uploads/2019/12/GIRFT-Urology-Innovations-A4-Dec19-p.pdf>
3. How to undertake teleconsultations with patients. BAUS TV Channel (<https://www.youtube.com/watch?v=P3c3ZvVI-OY>)
4. Exeter protocol for validation – to get from John McGrath
5. BAUS Guidance on waiting list prioritisation available to BAUS members at <https://www.baus.org.uk/default.aspx>
6. <https://www.rcseng.ac.uk/coronavirus/recovery-of-surgical-services/>
7. GIRFT BADS APOM National Day Surgery Delivery Pack
8. BADS reference
9. [https://www.baus.org.uk/professionals/baus\\_business/news/91/enhanced\\_recovery\\_programme/](https://www.baus.org.uk/professionals/baus_business/news/91/enhanced_recovery_programme/)
10. <https://www.nhs.uk/conditions/enhanced-recovery/>
11. [https://www.baus.org.uk/professionals/baus\\_business/news/91/enhanced\\_recovery\\_programme/](https://www.baus.org.uk/professionals/baus_business/news/91/enhanced_recovery_programme/)

# Part 4 - Appendices

## Appendix 1. The Gateway Framework

Metric/Recommendation	
Sentinel metrics	Day case rate for patients receiving male bladder outflow surgery
	Emergency readmissions within 30 days for patients following male bladder outflow surgery (%)
	The average number of days between diagnosis of urinary retention (EM) and surgery (EL) for male patients, for those receiving surgery only
	Day case rate for patients receiving TURBT
	Emergency readmissions within 30 days for patients following TURBT (%)
	Average wait for patients before TURBT, but only for patients who go on to have cystectomy within 9 months.
	Day case rate for patients receiving ureteroscopy
	Emergency admission with urinary tract stone, stent/ureteroscopy/ESWL rates during the admission
	% ureteroscopy - see above
	% ESWL - see above
	% No procedure - see above
	Referral to treatment targets (18 and 52 weeks)
	% greater than 52 weeks - see above
	Proportion of outpatient visits that are non-face to face
1. GIRFT Model Hospital Metrics	Average length of stay for elective cystectomy procedure
	Emergency readmission following cystectomy within 30 days
	Return admission for another urology procedure within one year following cystectomy
	Average length of stay for nephrectomy procedures
	Emergency readmission following nephrectomy within 30 days
	Daycase rate for cystoscopy
	Daycase rate for ESWL

	Daycase rate for Urethroplasty
	Average length of stay for percutaneous nephrolithotomy (PCNL)
	Emergency readmission following percutaneous nephrolithotomy (PCNL)
	Return admission for another urology procedure following percutaneous nephrolithotomy (PCNL) within one year
	Average length of stay for prostatectomy procedures
	Emergency readmission following radical prostatectomy within 30 days
	Return admission for another urology procedure within one year following prostatectomy
	Average length of stay for surgery for ureteric stone
<b>Urology Handbook</b>	Perform a stock-check of the available workforce (clinical, managerial and administrative) across the network.
	Establish cross site flexibility through passporting of staff to allow working in different Trusts.
	Perform an audit -check and continue monitoring to ensure that all staff are carrying out work which is appropriate to their grade and makes best use of their skills. In particular, avoid administrative work being inappropriately carried out by clinical staff.
	Establish effective ways of sharing medical records, laboratory results and imaging across the network.
	Perform a stock-check of the facilities that are available within the network in order to plan patient pathways. Facilities will include those relating to out-patient work, elective day case and in-patient operating and emergency care. Key equipment will also need to be considered in order to ensure that its use is optimised. Patient pathways should ensure that care is being carried out in the optimal environment and minimise repeated attendances where possible.
	Review the availability and the suitability of facilities for different types of out-patient contact. In particular, use the redesign of out-patient footprints in Trusts to establish Urological Investigations Units where these are currently not available. The flexibility of being able to carry out out-patient urological investigations and procedures in a unit which is run by the Urology Team will be increasingly important and will maximise efficiency. It will also reduce repeated or prolonged hospital attendances by patients.
	Ensure that elective work is carried out with appropriate COVID-19 security in place. Where possible, “green” pathways and sites should be established.
Review the urology network’s responsibilities in relation to the education of medical, nursing and other trainees.	

<p>Prepare training plans across the network to ensure that high quality training is provided in an efficient and effective way. This may involve providing trainees with access to training opportunities in a wider range of settings, including the independent sector.</p>
<p>Review the research responsibilities of the urology network.</p>
<p>Ensure that there is continuing recruitment into existing clinical trials and that resources are maintained to allow a continuing commitment to research.</p>
<p>Review how primary care colleagues are able to access urology services and discuss with GPs how this interface might be improved.</p>
<p>Ensure that GPs have access to robust and easily accessible guidance regarding referrals to urology services and offer telephone and/or e-mail advice in order to avoid unnecessary formal referrals.</p>
<p>Ensure that primary care colleagues have access to alternatives to admission and that all urology staff can similarly divert patients away from admission, where appropriate. Alternative services include acute clinics and the provision of advice on a non-face-to-face basis.</p>
<p>Develop intelligent triage systems for referrals to urology services. It is essential that patients are accurately directed to the most appropriate pathway. This might be a non-face-to-face out-patient consultation, a one-stop out-patient clinic, or a standard face-to-face out-patient consultation.</p>
<p>Review the mix and availability of different formats for out-patient care. These include standard face-to-face out-patient consultations, visits to one-stop clinics where investigations and consultations are conducted in a single session, non-face-to-face consultations and virtual clinics. Over time, the capacity of the different types of out-patient contacts will change, so that the system will need to be sensitive and flexible enough to adjust capacity between different types of out-patient contact.</p>
<p>Ensure that protocols are in place to embed best practice in post-Covid-19 face-to-face work and non-face-to-face activity.</p>
<p>Maximise the use of non-operative procedures where appropriate. For example, considering the use of lithotripsy in patients with urinary tract stones who are suitable for either lithotripsy or an endoscopic procedure.</p>
<p>Maximise the use of day case surgery, ensuring that pathways support the maximal use of day case surgery in line with British Association of Day Surgery guidance.</p>
<p>Ensure that enhanced recovery pathways are in place in order to minimise in-patient stays.</p>
<p>Ensure that out-patient and operation waiting lists are actively managed with clear lines of responsibility to named individuals.</p>

	Ensure that all waiting lists are validated with appropriate clinical input being provided to that process. Validation procedures will need to be continuous, rather than carried out as one-off exercises.
	Ensure that there is a robust risk assessment process attached to waiting list validation.
	Prioritise patients who are waiting to receive care using a structured process.
	Review the number of hospital sites into which emergency urology cases are admitted. Given that acute admissions will not have undergone a comprehensive COVID-19 screening process, it is important that colocation of acute and elective urology services is avoided. One obvious approach is to develop red and green sites, effectively as an acute/elective split.
	Ensure that emergency urology in-patients are managed with robust COVID-19 secure policies in place.
	Maximise the opportunities for delivering same day emergency care through rapid access to key investigations, notably ultrasound and CT scanning.
	Ensure that there is high-level clinical input into decisions about procurement of clinical equipment.
	Examine opportunities to rationalise the procurement of clinical equipment across the widest suitable footprint – London-wide, ICS/STP-wide or Trust-wide.
<b>Best Practice document</b>	Daycase TURBT: 0 LOS TURBY/technologies
	Daycase BOO: 0 LOS BOO surgery / technologies
	Daycase URS : elective 0 LOS URS
	ESWL networks
	Emergency stone pathway: access to URS/stent/SWL - same admission
	Retention BOO surgery: reducing time to definitive treatment in urinary retention
	TURBT to radical treatment: reducing time to definitive treatment in urinary retention
	OP provision: accessing referral guidelines
	OP provision: advice and guidance
	OP provision: intelligent triage
	OP provision: virtual consulting
OP provision: face to face consulting	

	OP provision: one-stop clinics
	Urology Investigation Unit
	Ensure that there is agreement between ICS/STPs and Trusts as to which Trust urology departments are going to work together as a Urological Area Network (UAN).
<b>Developing Effective Urology Networking</b>	Ensure that there is agreement between ICS/STPs and Trusts as to which Trust urology departments are going to work together as a Urological Area Network (UAN).
	Establish clinical leadership arrangements, management structure, governance arrangements, financial arrangements and communication strategy for the UAN
	Build the UAN service specification for emergency care.
	Build the UAN service specification for general urology.
	Build the UAN service specification for urological oncology.
	Build the UAN service specification for urinary tract stones and endourology.
	Build the UAN service specification for female, neurological and urodynamic urology.
	Build the UAN service specification for andrology and male genitourinary reconstruction.
Build the UAN service specification for paediatric urology.	

## Appendix 2. Pathways for high-volume relatively low-complexity urological surgery

### Introduction

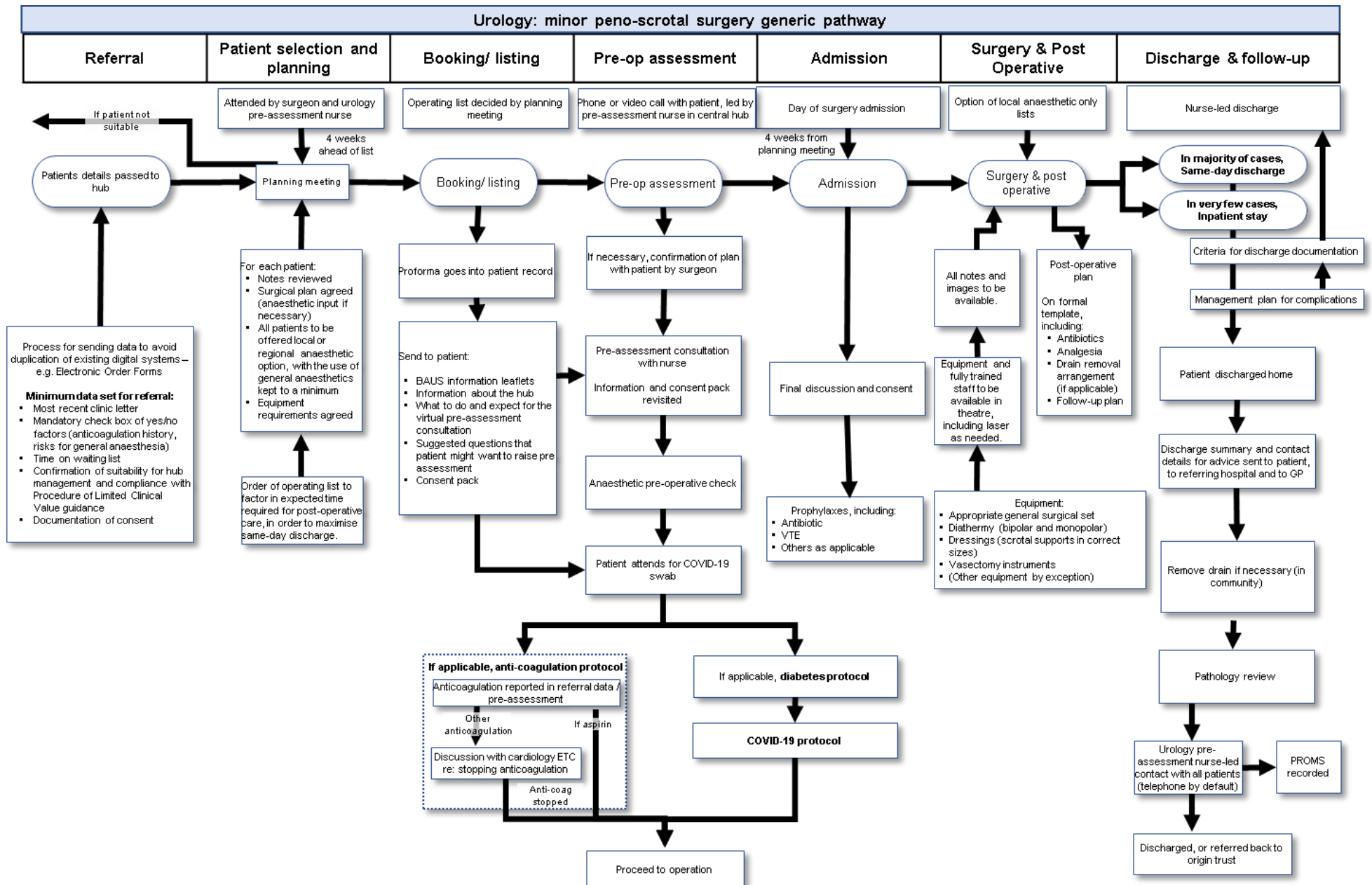
It has been recognised that restoring adequate capacity to deal with the waiting list backlog, and on-going demand, for high volume, relatively low complexity urological surgery will require additional resources and new ways of working. The London Programme has developed a major workstream to establish elective surgical hubs that will carry out this type of surgery at volume, and in ways which deliver care at historical top-decile performance for quality and efficiency.

A major part of the initiative has been to build agreed pathways for common procedures that can be used across London in all the planned surgical hubs. The pathways are:

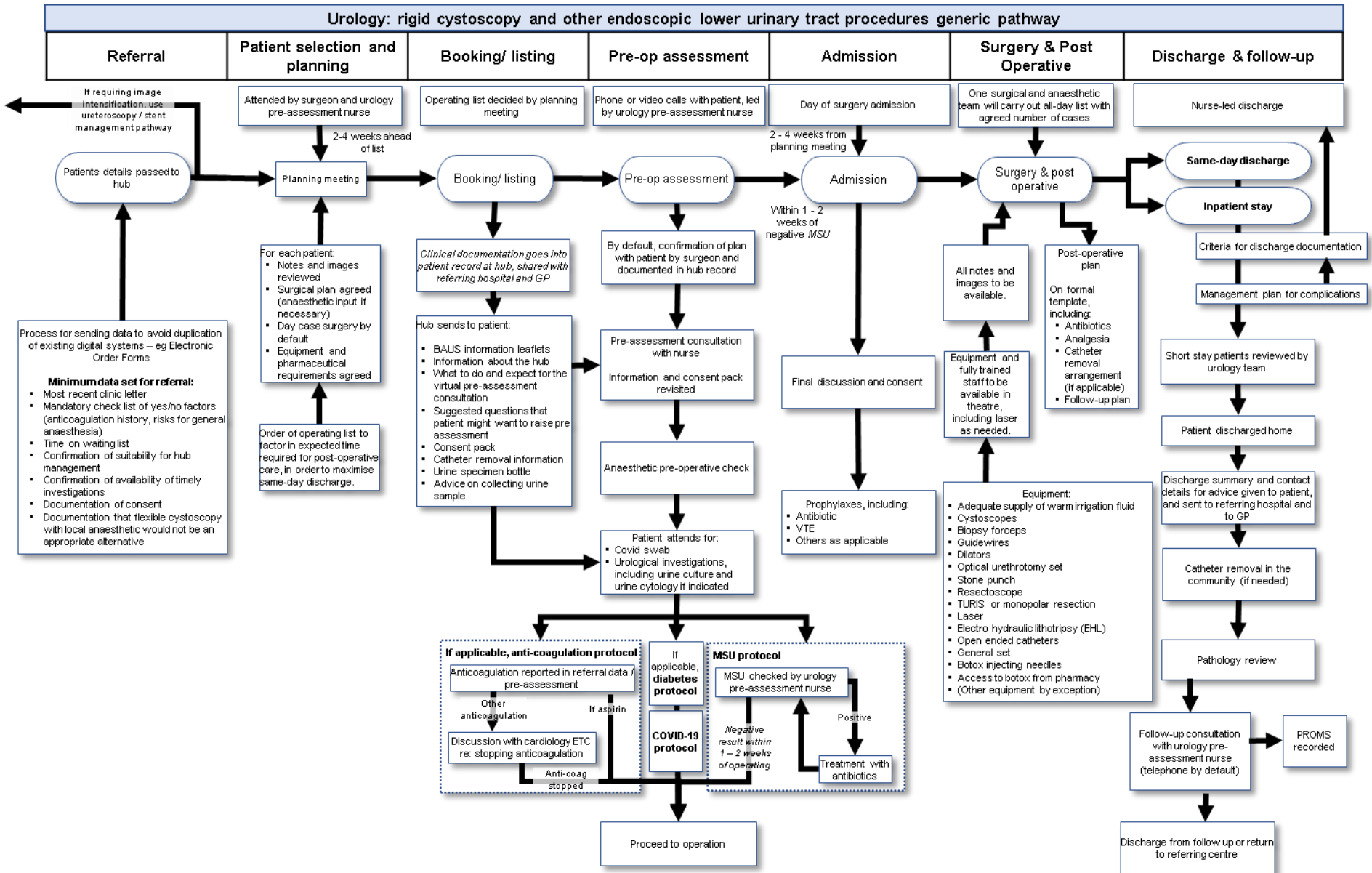
- Minor peno-scrotal surgery. This will deal, in particular, with circumcision, hydrocoele correction and excision of epididymal cysts; vasectomy might also be included.
- Cystoscopy 'plus'. This covers lower urinary tract endoscopic surgery that does not require the use of image intensification. Included will be procedures such as GA cystoscopy, bladder biopsy, cysto-litholapaxy, GA cystoscopy and botox (when required) and urethrotomy.
- Male bladder outflow obstruction surgery. This covers all of the main modalities for treating prostatic enlargement and bladder neck obstruction. Included are transurethral resection of the prostate in saline, laser photo-vapourisation of the prostate, laser enucleation of the prostate and newer minimally invasive procedures, Urolift and Rezum.
- Ureteroscopy and stent management. This covers elective ureteroscopic surgery, particularly dealing with upper urinary tract stones, and the insertion, exchange and removal of ureteric stents.
- Trans urethral resection of bladder tumours. This pathway is included although it is hoped that it will not have to be activated as it is anticipated that the management of bladder tumours will continue to be provided through existing elective urology facilities. The pathway would only come into use if a flare up of the epidemic resulted in the closure of elective urological surgery outside of the new elective surgical hubs.



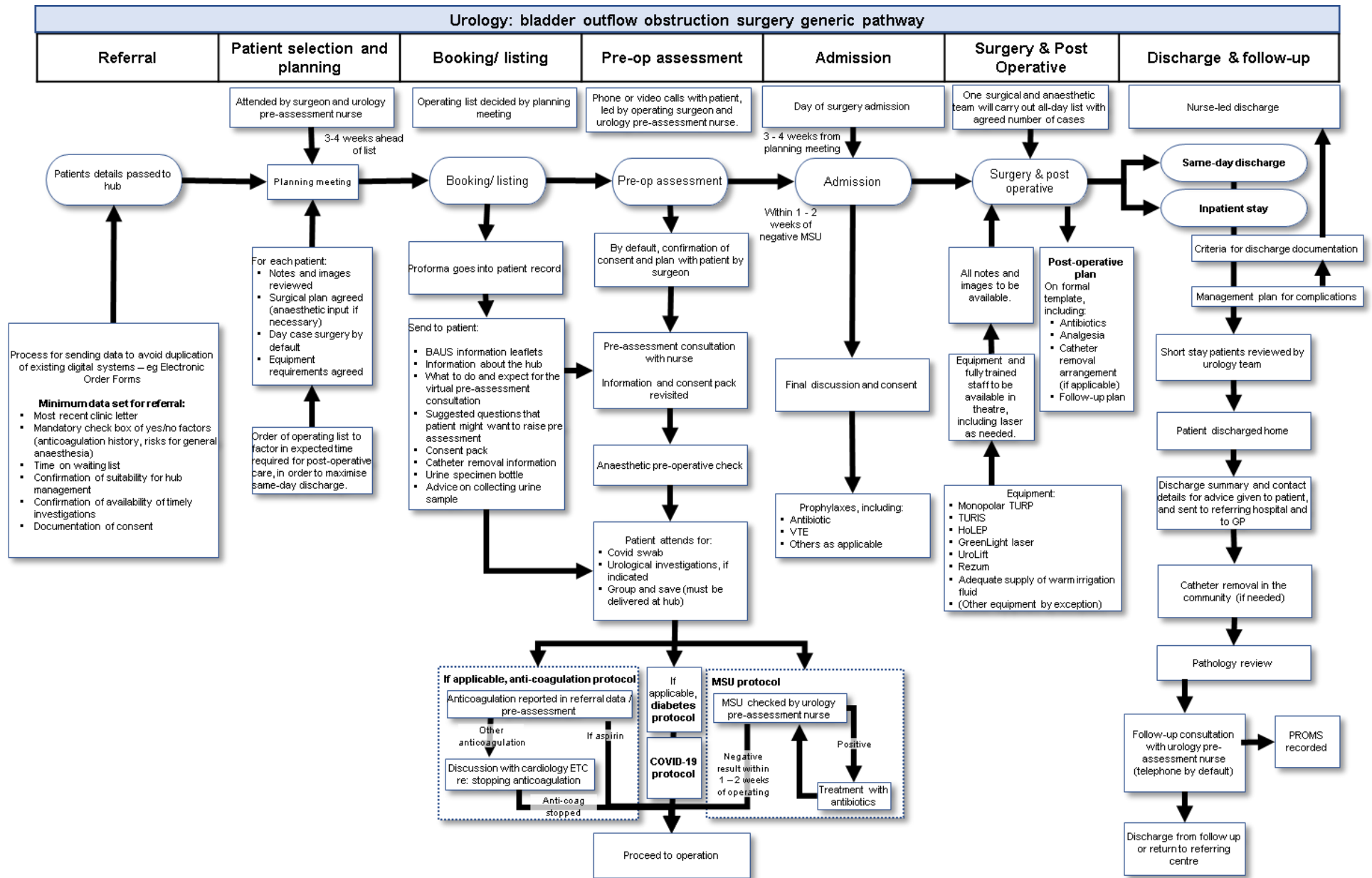
## Appendix 2.1 Pathway for minor inguinoscrotal surgery



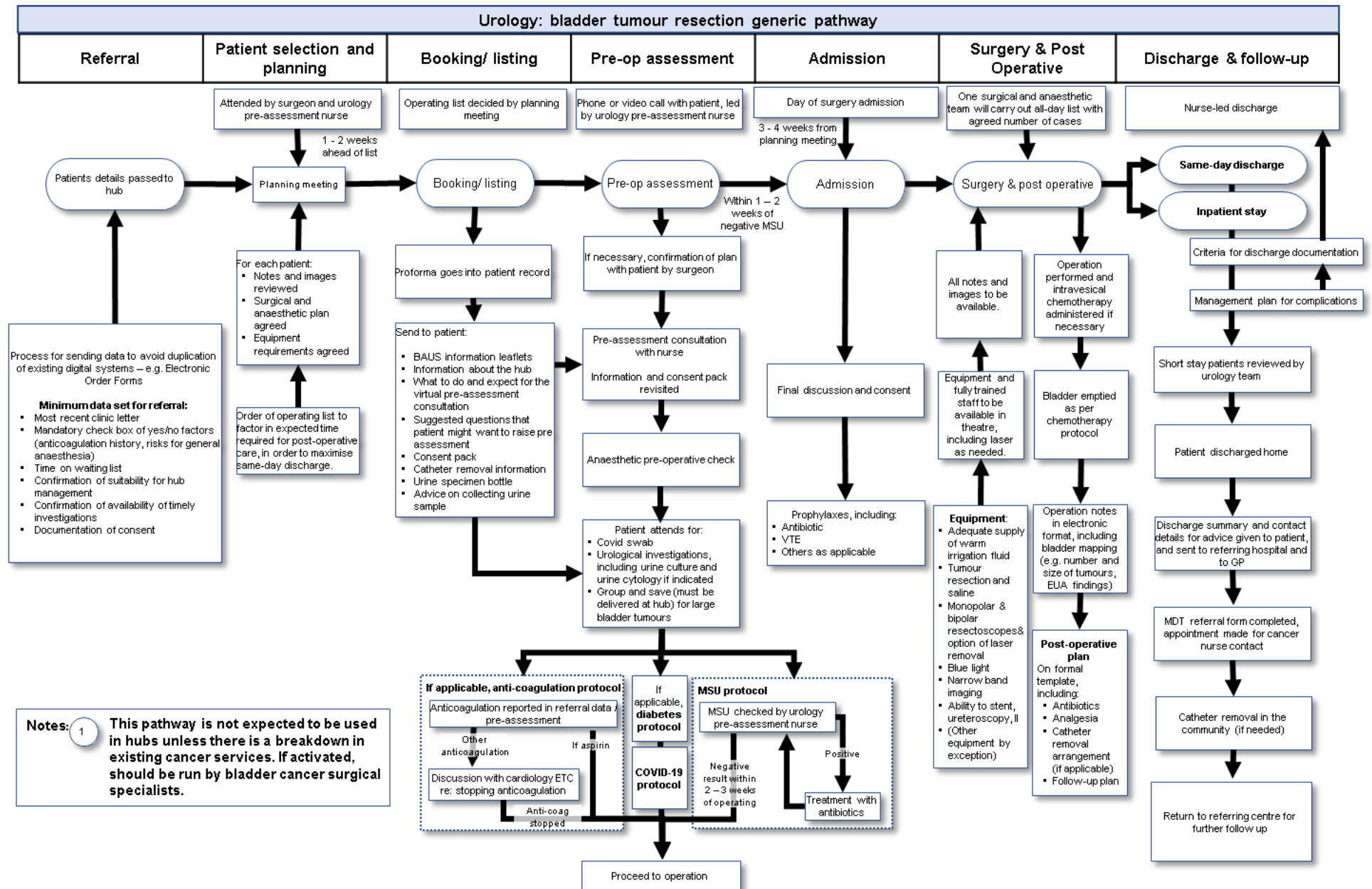
## Appendix 2.2 Pathway for cystoscopy plus (rigid cystoscopy and other endoscopic lower urinary tract procedures)



## Appendix 2.3 Pathway for bladder outflow obstruction



## Appendix 2.4 Pathway for bladder tumour resection



## Appendix 2.5 Pathway for ureteroscopy and stent management

