



# Getting It Right in Urology

Innovations, good practice and guidelines for establishing a urology area network

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## About GIRFT

The Getting It Right First Time (GIRFT) programme covers 40+ surgical and medical specialties, working directly with frontline clinicians to identify and reduce unwarranted variations in service delivery and clinical practice. Each GIRFT specialty review results in a report that includes a range of evidence-based recommendations that our clinical leads, all experts in their field, feel would truly make a difference to patient care and efficiency in that specialty. In tackling the variation in the way services are provided and delivered, we are able to identify recommendations that can help improve the quality of care and outcomes for patients, as well as helping the NHS deliver much-needed efficiency savings.

For details of any of these case studies, email [info@gettingitrightfirsttime.co.uk](mailto:info@gettingitrightfirsttime.co.uk)

## About this guide

This guide has been written to support hospital trusts in developing their urology services and to consider how best to establish a urology area network (UAN). It has been produced as a supplement to the GIRFT programme's national specialty report into NHS urology services, authored by GIRFT clinical lead Simon Harrison and published in July 2018. The report was the result of Mr Harrison's national review of NHS urology services in England undertaken between August 2016 and April 2019.

During this review Mr Harrison made 134 visits, covering 140 trusts and was able to capture various evidences of good practice across the country. Following publication of his national specialty report in July 2018, Mr Harrison has collated these examples of good practice aimed at developing a resource to increase collaboration across trusts to improve service development and networking.

The national GIRFT urology report highlights 18 recommendations. These focus on how resources across this large specialty could be better used to improve the patient experience by reducing waiting times, enabling more care to be provided via outpatient settings and providing more effective pathways to definitive treatments.

To do that, the report recommends changes to service configuration within trusts, changes to staffing arrangements – extending the role of specialist nurses and asking consultants to focus more on emergency care – and a greater emphasis on networking between urology departments.

A key recommendation is No 14: ***Establish urology area networks (UANs), comprising several urology departments that provide comprehensive coverage of urological services, beyond existing network arrangements, to optimise quality and efficiency.***

This recommendation encourages trusts to establish networks, with different parts of the urology workload centred at different providers within a urology area network. There are strong foundations within urology for such a move, in the form of networks for cancer care and reconstructive urology. This document offers guidance and good practice examples to help trusts adopt this network approach for a greater range of conditions.

### Part 1: Setting Up UANs

In this section GIRFT urology clinical lead Simon Harrison highlights what to consider when forming networks between trusts. The guide is based on the insight and detail captured on his 134 visits, which took place between August 2016 and April 2018.

Throughout the document there are suggestions and things to consider whilst establishing a urology area network. It seeks to help trusts examine how their urology services are currently functioning and whether in-house improvements can be made prior to the formation of a UAN.

### Part 2: Good practice case studies

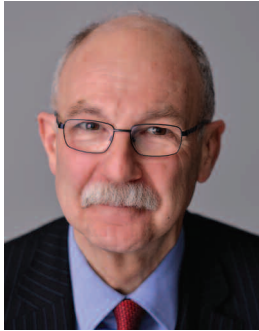
This section offers examples of good practice across urology departments which can be used to support the improvement and development of urology services. Each case study supports one or more GIRFT recommendation and provides information on how it was established and implemented.

## Recommendations from the GIRFT national report on urology

**The GIRFT National Specialty Report for Urology was published in July 2018 and made 18 recommendations. They are:**

1. Develop a structured training curriculum for specialist urological nurses and establish accredited training departments.
2. Provide job planning for clinical nurse specialists and ensure appropriate skill mix.
3. Increase the provision of Urological Investigations Units (UIUs), providing a dedicated resource for urological outpatient care.
4. Review follow-up rates against a median of 1:2 first outpatient to follow-up.
5. Take further action to improve RTT performance for common conditions and pathways.
6. Address the potential adverse effects of existing cancer diagnostic and treatment standards.
7. Review guidance for urology cancer MDT working.
8. Reduce average length of stay across the specialty through enhanced recovery and increased use of day case pathways, while monitoring causes and rates of emergency readmissions.
9. Improve the secondary care pathway for patients with urinary tract stones.
10. Provide consultant-delivered emergency urology care in every trust by reducing elective commitments for consultants on call.
11. Review workloads of on-call consultants to ensure the sustainability of on-call arrangements.
12. Ensure high-quality emergency urological care is available in all areas seven days a week by focusing available resources at weekends on a smaller number of departments, while allowing some departments to operate on a five-day basis.
13. Review the approach to providing care for patients who require urgent surgery for urinary tract trauma and related conditions.
14. Establish urology area networks (UANs), comprising several urology departments that provide comprehensive coverage of urological services, beyond existing network arrangements, to optimise quality and efficiency.
15. Reduce the numbers of complex surgical procedures that are carried out in small volume centres, using networks as they develop.
16. Align data collection efforts across urology and ensure that data collected are relevant and have a value that is in proportion to the resources needed for its collection.
17. Enable improved procurement of devices and consumables through cost and pricing transparency, aggregation and consolidation, and the spreading of best practice.
18. Reduce litigation costs by application of the GIRFT programme's five-point plan.

# Part 1: Establishing a urology area network



**Simon Harrison**

*Simon was a consultant urologist at Pinderfields Hospital, Wakefield, from 1992 to December 2016. Pursuing a special interest in neurological urology, Simon developed a tertiary referral practice for patients with complex lower urinary tract dysfunction. Simon has served on the Council of the British Association of Urological Surgeons (BAUS), been chairman of the BAUS Section of Female, Neurological and Urodynamic Urology, and was chairman of the NICE Guideline Development Panel for the guideline on Urinary Incontinence in Neurological Disease.*

## Introduction

A urology area network (UAN) is a collaborative arrangement between several urology departments that establishes a coordinated and comprehensive urology service. Typically, between one and four trusts can be involved; most networks will cover a population of between 750,000 and 1.5 million people.

Urology services are currently commissioned on a trust by trust basis but this model is under severe pressure as many smaller departments are now at the limit of sustainability. Getting It Right First Time (GIRFT) discussions with trusts have identified the development of UANs as a means of enabling services to develop resilience while helping to increase the efficient use of resources and address unwarranted clinical variation.

Of particular concern to smaller urology units are:

- Problems with recruitment and retention of urology staff, which is threatening the long-term viability of some district general hospital departments.
- Poor integration of services with larger urology centres. In many parts of the country, the degree of integration of services between smaller units and the larger urology centres is limited, leading to variable access to sub-specialist care and inefficient use of high-cost equipment, such as extracorporeal shockwave lithotripters.
- Problems meeting the requirements for increased levels of consultant involvement in the provision of on-call services and timely consultant review of emergency urology admissions.

Particular issues that should be addressed by the development of a UAN are:

- The establishment of more robust, consultant-delivered, comprehensive and efficient emergency services.
- Improved access to better developed sub-specialist services.
- Mitigation for recruitment problems into small urology units.
- More effective use of resources and procurement of equipment.
- An ability to balance workloads across a network's facilities, therefore improving compliance with NHS targets.

## Developing a country-wide plan for UANs

It is essential that every UAN is developed with the assurance that its formation is compatible with an overall national plan for developing UANs. The danger of ad-hoc development of UANs is that 'orphan' urology departments may be left out of UANs and the pattern of UANs that emerges might not be optimised with regard to patient access, the population served and facilities.

A national consultation on a draft arrangement for UANs has been carried out. This has enabled the GIRFT team to map the extent to which UANs are established and under construction. It is clear that there is considerable interest in progressing UAN development, with the majority of trusts being able to identify the UAN in which their urology department will participate.

Once it is established that a UAN is compatible with the national model, it will be necessary to liaise with stakeholders, such as commissioners, neighbouring providers and STP/ICSs, in order to ensure that the proposal is compatible with wider regional planning. Patient perspectives will also be important.

A key feature of development is that, while a UAN should be part of an overarching national model for UANs, the way in which it develops and is run is locally determined, not externally imposed. In other words, having agreed the geographical boundaries of a UAN, the challenge to local UAN clinicians and managers is to design a co-ordinated urology service which is optimised with respect to both quality and cost effectiveness.

## Dealing with core issues

There is already considerable experience within the NHS in establishing networks. In urology, the establishment of a urology cancer network means that there is experience of network development within the specialty. Key issues that need to be considered, as the first phase of establishing a UAN, include the following:

### **(a) Clinical leadership**

A clinical leadership team needs to be established in order to ensure that there is clinical expertise at the forefront of the development of the UAN service. Leadership should not be confined purely to urology consultants, although it is inevitable that consultants will play key roles.

### **(b) Management structure**

There needs to be a clear management structure for a UAN which is able to make decisions about service development across all of the trusts that are participating in the UAN. There should be clarity as to which decisions would need escalation to higher tiers of management within the participating organisations.

### **(c) Governance arrangements**

It is important that there is clarity as to the way in which governance issues will be dealt with across the participating trusts.

### **(d) Financial arrangements**

Networking will inevitably mean that there are patient flows between different trusts. Mechanisms need to be put in place that ensure that the way in which financial arrangements underpin patient flows is understood and agreed. It is essential that finance mechanisms are seamless and do not unduly complicate patient pathways.

### **(e) Liaison with stakeholders and communication**

There is a need to establish the stakeholders that have an interest in a UAN. Clarity is required regarding communication arrangements within the UAN, and with external bodies and the public.

### **(f) Project management methodology**

As with any significant change project, it is important that there is a structured project management approach embedded in UAN development.



## Network principles

UANs should work under an agreed set of principles which can be used to underpin decision-making. The following are principles that might be adopted:

- Create a network of urology departments, each of which is sustainable in the long term, with the staffing and facilities to offer high-quality care.
- Provide equitable access to services and skills for all patients in the UAN catchment area. There should be mechanisms in place to monitor and audit access to services and patient experience.
- Develop an organisation of services which ensures that patients are treated as close to their homes as is compatible with the provision of high-quality care.
- Inappropriate follow up of patients in departments that are remote from their homes should be avoided, either by specialists out-reaching or by follow up being transferred on the basis of a protocol of ongoing care.
- Avoid over-centralisation of services, so that centralisation should only occur when there are strong grounds for believing that better quality care can be provided through a centralising model.
- Consider the siting of a specialist service within a network in a way which does not inevitably mean that every specialist service is provided in the network's main urology centre. It is essential to provide a coherent overall plan which, in many cases, would involve developing some areas of specialisation away from the major centre.
- Allocate resources in a way which addresses the needs of all of the departments within a network, with mechanisms to avoid disproportionate allocation of staffing, facilities and equipment across the network.
- Provide clearly defined pathways of care which are underpinned by formal multidisciplinary team processes, where appropriate.
- Make clear the responsibilities of those departments providing particular aspects of networked care, with mechanisms in place to ensure that departments provided with a particular resource facilitate equal access to that resource from all areas of the network.
- Ensure that the UAN has an inbuilt capacity to develop and sustain the necessary urological workforce, with a particular focus on developing the skills of the urology specialist nursing workforce and supporting the on-call generic surgical teams that will be providing out of hours urological care in the smaller urology units.

## Network design

A starting point for the process of designing the UAN service is to undertake a 'stock take' of the existing services, and demand on those services. This will include:

- Workforce.
- Out-patient, day case and in-patient facilities.
- Out-patient, day case and in-patient capacity, e.g. numbers of clinics and lists.
- Equipment.

It will also be appropriate to assess the potential for service re-organisation. For example, is it realistic to build in a major re-timetabling exercise that will affect a host of other specialties, or should the re-organisation be carried out within existing urology facilities?

It will also be necessary to look at possibilities for capital investment into the service. A limited amount of capital might be needed in order to develop a Urological Investigations Unit (UIU); investment might also be needed for equipment.

## Describing the UAN service using a service specification

The advantage of developing a service specification is that it should provide clarity about the formulation of a service to clinicians, provider organisations, commissioners and the public. While the design of the network will be locally determined, there will be an expectation that the model produced will move the service in a direction which accords with national directives and the GIRFT Programme National Specialty Report for Urology.

A service specification for a UAN might include a description of each service component showing evidence that common clinical pathways and documentation has been adopted. Each service component should be described in terms of the entry points into the service (e.g. from primary care, secondary care or emergency admissions) and the clinical pathway to be followed within the urology area network. This might include transfer for particular aspects of care within the network of trusts, or continuity of care in one of the network's departments. It is also important to describe how patients exit from UAN care, and the criteria for discharge back to primary care or complete discharge from all services.

The UAN specification should also map out how multidisciplinary team working is organised for cancer and complex benign conditions.

### (a) Emergency care

It is anticipated that urological emergency care will be led by consultants with a personal, 'hands on' approach. Consideration should be given to the way in which consultant continuity of care is provided, for example, by looking at a consultant of the week model. There will need to be a description as to how patients with emergency and urgent urology conditions access the acute urology service from all of the networked hospital sites. For example, explicit targets should be set for the speed of response to in-patient referrals.

It is recognised that urology on-call consultants who are not supported by a middle grade tier of specialty doctors will be under considerable pressure, as there is a risk of them being called in out of hours to deal with a range of, often relatively minor, conditions. The network description should include details of mitigating actions which are taken to support consultants in this situation.

Emergency arrangements should include details of access to interventional radiology, fully-equipped emergency urology theatres and extracorporeal shock wave lithotripsy.

The efficient use of resources may mean that one or more urology departments within the overall UAN work on a five-day basis and close at weekends, thereby converting to a centralised model of urological weekend care.

A service specification for a UAN acute urology service should consider the following:

- Which departments are open for seven days, whether there are any five-day urology departments and whether there are any hospitals which do not have an acute urology service.
- On-call medical and nursing cover, demonstrating how continuity of care is maintained, and the elective workload of the team is either cancelled or adjusted to allow for adequate senior involvement in the hands-on delivery of acute urological care.
- Out of hours arrangements, particularly looking at the way the service avoids excessively onerous patterns of work for members of the team. This particularly applies to consultants working in smaller departments where there is no middle grade tier of urology medical cover.
- Arrangements for consultant ward rounds, ensuring that there is clarity about the provision of continuity of care.
- Arrangements for review of in-patient emergency referrals. The expectation would be that ward referrals are seen by an appropriately experienced member of the team within 24 hours of receipt.
- How alternatives to hospital admission are provided. This might include nurse-led urology acute assessment, the provision of rapid access clinics and the delivery of same day discharge for appropriate patients.
- Arrangements for 24/7 interventional radiology support.
- The organisation of emergency operating for urological patients. These arrangements should allow all suitable patients with urinary tract stones to undergo definitive surgery, rather than a temporising insertion of a ureteric stent, with a requirement to return for a further procedure in circumstances where the stone could have been dealt with at the first procedure.
- Arrangements for accessing extracorporeal shock wave lithotripsy for patients admitted as an emergency with a urinary tract stone.
- A specific description of arrangements for managing patients with testicular torsion. Such provision should cover all age groups and ensure that surgical exploration of the scrotum can be performed with no inappropriate delays.
- Arrangements for managing patients who require emergency open or complex urological surgery. It might be helpful to consider two scenarios: firstly, the patient admitted with serious renal trauma and, secondly, the patient undergoing surgery under the care of another specialty (such as obstetrics, gynaecology or colorectal surgery) who sustains iatrogenic urinary tract trauma, including ureteric and bladder injuries. If the local on-call urologist is not able to manage the particular problem, what alternative arrangements are in place?



## **(b) General urology**

It is anticipated that general urological care will be provided in all of the UAN departments. However, there is a shift towards traditional general urological procedures becoming more sub-specialist in nature. For example, it is anticipated that a UAN would plot a pathway towards the majority of patients undergoing male bladder outflow obstruction surgery being treated through day case pathways. This may mean that laser prostatectomy is developed in one of the network departments, rather than standard monopolar transurethral prostatectomy being offered on all sites.

A service specification for general urology should include a description as to how the UAN has developed efficient general urology services. These might include:

- A description of out-patient services, including the possible use of a one-stop approach to out-patient management.
- A description of the way in which the use of in-patient beds is minimised through the use of technology to utilise day case pathways (e.g. laser prostatectomy). In addition, the use of enhanced recovery as a means of providing early discharge should be included. This may include provision for removal of catheters in the community, or on an out-patient basis.

## **(c) Urological oncology**

Arrangements for the management of patients with urological cancer are already established through cancer network arrangements. The expectation is that such arrangements will remain in place, with UANs not impacting on this organisation to any great extent. It should be noted that not all UANs will undertake major pelvic cancer surgery and complex renal cancer surgery. Inevitably, only a minority of UANs will offer management of penile cancer and advanced testicular cancer. This emphasises that a UAN does not work in complete isolation from other urology services, and that there is, inevitably and correctly, going to be some flow of patients between UANs.

The issues that should be set out in a service specification for the subspecialty of urological oncology should include the following:

- Protocols and pathways of care.
- MDT working protocols.
- Arrangements for balancing the workload across the UAN. For example, this might include the option of centralising complex renal cancer surgery, such as partial nephrectomy, open nephrectomy for large tumours, and nephroureterectomy. While, in order to avoid excessive waiting lists in the central hospital, it might be appropriate to undertake 'routine' laparoscopic nephrectomies in another of the UAN centres.
- The service should describe how patients are managed after initial assessment and treatment. Such arrangements might include shared care protocols, the development of 'survivorship' services, and interaction with palliative care.

## **(d) Urinary tract stones and endourology**

There is an increasing expectation that patients with urinary tract stones will have the majority of their management under the care of a consultant with a special interest in endourology. The UAN should therefore look to provide good access to specialised stone clinics and clarify the pathway for patients who require expert care for metabolic stone problems. Equitable access should be ensured for the full range of stone treatments, from extracorporeal shock wave lithotripsy to percutaneous nephrolithotomy.

The numbers of patients having some of the more complex stone procedures is relatively small. There needs to be agreement, established through MDT working, on the UAN's approach to the management of complex stone problems. Complex stone surgery, such as PCNL, should almost certainly only be provided in one trust in order to build up expertise in that trust's team. Such an arrangement does not preclude consultants from other trusts within the network being included in the surgical team carrying out such surgery.

Aspects of endourology that should be specified include:

- The organisation of specialist stone clinics, including the use of virtual stone clinics.
- A description of how lithotripsy is accessed.
- The provision of specific lists for acute and urgent stone cases, and for complex stone surgery, such as percutaneous nephrolithotomy.
- A description of the protocols and pathways that allow access to specialist metabolic assessment.
- The endourology service should specify how surgery is provided for other underlying conditions of the upper urinary tract, including pelviureteric junction obstruction and adrenal surgery. There is a requirement to avoid this type of complex surgery being carried out in very small numbers, which means that there is a need to deliver a degree of centralisation.

## **(e) Female, neurological and urodynamic urology**

Currently, many trusts have a poorly developed female and neurological urology services. Within the UAN, there should be at least one, but preferably more than one, consultant with a sub-specialist interest in this field. They should have a hands-on leadership role with urodynamic investigations and undertake multidisciplinary team working with colleagues in urogynaecology. There is also the potential for them to network more widely and work within a regional MDT.

A service specification for this subspecialty should include:

- Evidence of clinical leadership of the service, including the provision of some consultant-provided urodynamic lists.

- Pathways for investigating and managing subspecialist cases, including the surgical management of incontinence, the management of the patient with neurogenic lower urinary tract dysfunction and the management of patients requiring lower urinary tract reconstructive surgery.
- The description of the arrangements for MDT working, locally with uro-gynaecology colleagues, and in the wider region.
- The specification should describe what governance arrangements are in place to cover the work of non-consultant clinicians who may be managing many patients, for example in continence services.

### **(f) Andrology and male genitourinary reconstruction**

Each UAN should have at least one consultant specialising in this field, although it is ideal to have at least two people involved. They should take a leadership role in relation to the management of the conditions that fall under the umbrella of andrology and, in particular, ensure that Nurse-led care is well supported and monitored. Pathways should be in place for referring patients into the specialist andrology service. In many UANs, there will need to be pathways that then lead on to referral to regional centres for patients with the most complex conditions.

A service specification should include:

- A description of the clinical leadership of the subspecialty.
- A description of pathways for specialist andrology care, including the management of Peyronie's disease, erectile dysfunction, infertility and urethral stricture disease.
- Access to centralised subspecialist care should be provided, either within the UAN or to another service, for patients requiring complex interventions, such as urethroplasty.
- The specification should describe what governance arrangements are in place to cover the work of non-consultant clinicians who may be managing many andrology patients, for example in erectile dysfunction clinics.

### **(g) Paediatric urology**

The UAN description document should set out how paediatric services are provided. This should cover the management of the child who presents as an emergency with suspected testicular torsion, as well as children undergoing 'general urology' paediatric care, for example, management of the undescended testis or foreskin problems, and those requiring specialist paediatric urology input.

Arrangements for MDT working with the regional specialist paediatric urology team will need to be described.

A service specification should include:

- A description as to how a general paediatric urology service links to the regional specialist paediatric urology service.
- There should be a description of arrangements for provision of specialist paediatric anaesthetic and nursing expertise.

## Part 2: Good practice case studies in Urology

### Adolescent Urology Services

Newcastle upon Tyne Hospitals NHS Foundation Trust

#### Motivations and aims

There was a need to develop a robust transfer of care process for patients from paediatric to adult urology care. Previously the transfer of care from paediatric surgery to adult urology was by way of referral letter only and this was felt to be unsatisfactory for a number of reasons. The nature of these cases meant they were often very complex (the majority of patients had neuropathic lower urinary tract dysfunction) and it was recognised that a 15-minute new patient appointment in adult urology was not long enough for a full case appraisal. The adult and paediatric team in this organisation were separate services operating out of different hospital sites. The initial aim by the team was to set up the provision of a transition clinic in a familiar setting was felt to be most appropriate. The establishment of a joint clinic allowed a multidisciplinary (MDT) approach to cases with full participation from the paediatric surgery and adult urology teams including the clinical leads within this sub-specialist area.

#### What was done

The transition clinic was established five years ago and has since provided an efficient method for the transfer of patient care from paediatric surgery to adult urology care. It was conceived after recognition that these complex patients needed an MDT approach to their care during the transition phase, and has been extremely well received by patients and carers. A face-to-face extended consultation with key members of the adult urology team is held in the paediatric surgery clinic area to achieve smooth transition of care. At this extended (30 minute) appointment the patients and carers have the chance to meet the adult urology team who will be managing their care going forward. In the appointment a full appraisal of the patient's case is undertaken and an outline of future investigations or treatment is provided along with point of contact details for the adult urology team. The practice is now well established and has received excellent feedback from service users.

#### Key points of good practice:

- Transition service for the transfer of care of adolescent urology patients
- Joint clinic approach with paediatric and adult urology teams
- Full review of previous urological history
- Planning ongoing care in adult urology
- Lead by consultants and nurse specialists from both adult urology and paediatric surgery
- Evaluation of transition clinic by patients is embedded

#### Successes and lessons learned

One of the key features of the clinic is the embedded feedback from patients and carers. This is primarily designed to ensure high levels of understanding and to check that all questions have been answered. The main challenge in setting up a clinic such as this is to achieve engagement from clinicians and management within the respective departments (urology and paediatric surgery). This was well supported at Newcastle upon Tyne Hospitals NHS Foundation Trust and has been a key factor in its success. The paediatric and adult nephrologists in the trust are looking to pilot a similar scheme.

#### This case study links to GIRFT urology report recommendation 14:

Establish urology area networks (UANs), comprising several urology departments that provide comprehensive coverage of urological services, beyond existing network arrangements, to optimise quality and efficiency.

# Cancer and Benign Separation

## Medway NHS Foundation Trust and Dartford and Gravesham NHS Trust

### Motivations and aims

In 2004 the West Kent review into urology oncology services identified Medway as the specialist MDT centre to support the requirement to be IOG Compliant. To enable this trusts needed to consider the delivery of other urological services and managing the workforce to enable urologists to continue building and maintaining skills and knowledge in complex urological procedures. This included:

- Patient pathways to deliver the best care at the right place for the management of their urological condition;
- Availability of equipment – fixed rather than mobile lithotripter service in a dedicated unit and development of a comprehensive stone centre with all resources.

### What was done

In 2004, Medway NHS Foundation Trust (MFT) supported by Darent Valley Hospital (DVH) was awarded the status of West Kent Urology Cancer Centre (WKUCC), which now hosts specialist MDT and major cancer surgery with local MDTs at DVH and Maidstone & Tunbridge Wells Hospitals.

MFT in exchange supported DVH to develop a complex stone service, transferring all stone extraction and lithotripsy service from MFT to DVH. This has allowed sharing of expertise including joint consultant appointments. It also facilitated the starting of stone MDM in Darent Valley Hospital, the first in the region.

### Key points of good practice

- Establishment of MDM based regional West Kent Urology Cancer Centre (WKUCC) and regional stone centre with participation from all key experts including urologists, radiologists, oncologists, pathologists, nurse practitioners, stone metabolic consultant and nephrologists.
- Defined clinical pathways for the management of patients with urological cancer and complex stones.
- Joint appointments – stone surgeon across both sites with opportunity for more to be developed.
- Right expertise – surgeons and nurses appropriately trained.

- Innovative facilities with Da Vinci Robot at WKUCC and fixed lithotripter at Darent Valley Hospital. This also led to the establishment of a one-stop cancer diagnostic centre, the Poplar Unit at Darent Valley Hospital.
- Regular audit against national and international standards - the centres' figures are equal to or better than national median with regards to hospital stay and complication rates etc.
- Good quality specialist doctors, research and clinical fellows who are providing excellent middle grade support. Some of them have also pursued the MCh course. The centres have attracted young doctors and they are obtaining national training numbers regularly. The centres have overcome the problem of national shortage of middle grade doctors in urology.
- Comprehensive training to the specialist registrars.
- Presentations and publications in peer-reviewed journals.
- Excellent Patient Reported Outcome Measures (PROMS).
- Good engagement with local universities with academic appointments, teaching and translational research.

### Successes

- Centralisation of urological cancer at WKUCC
- Stone work via MDM
- Increase in capacity with joint appointments
- Closer working together of the entire team
- Better patient care for both cancer and stone patients with excellent patient satisfaction.

### Lessons learned

Capacity to manage across both sites is required – this is largely an issue of staff capacity because of the need to travel between sites.

Initially, emergency stone work to ensure availability of a lithotripter slot to allow patients to transfer across.

### This case study links to GIRFT urology report recommendations:

5. Take further action to improve RTT performance for common conditions and pathways.
14. Establish urology area networks (UANs), comprising several urology departments that provide comprehensive coverage of urological services, beyond existing network arrangements, to optimise quality and efficiency.

# Establishing a Urological Investigations Unit

## Mid Yorkshire Hospitals NHS Trust

### Motivations and aims

The establishment of a Urological Investigation Unit (UIU) has enabled a better patient experience through the ability to perform multiple investigations at the same time, in the same place, thereby streamlining the patient journey.

It has improved staff experience, and especially the ability to manage patients at their first presentation to outpatients without having to wait for basic investigations. It also provides a setting for specialist nurse development to improve the ability to attract and retain staff.

Crucially, many of the roles traditionally performed by doctors are now able to be undertaken by nurse specialists, thereby freeing up junior doctors for training and freeing up consultant time.

### What was done

Discussions were held with estates team to confirm the space required and led to development of an existing area in Dewsbury District Hospital and incorporating the units into new builds at Pontefract General Infirmary and Pinderfields General Hospitals.

A business case demonstrated to the trust executive that the UIUs were a worthwhile development. Decisions were made on which investigations and treatments were to be provided and staffing while building in flexibility for the future. The workforce incorporated existing staff and job re-planning where necessary.

### Key points of good practice

- Centralisation of urology investigations, procedures and treatments.
- Allow key investigations, eg: flow rates, IPSS, to be completed prior to first OPD review.
- Improved patient experience.
- Development of nurse specialist roles.
- Improved referral to treatment target performance.
- Allows flexibility of sessions to manage changes in demand and capacity.

### Successes

The stone service team has won 'team of the year'. There is now an UIU at each of the three hospital sites. Each unit is run by a nurse specialist and delivers a wide variety of investigations and procedures including:

- Flow rates
- Flexible cystoscopies – (including Botox injections and ureteric stent removals)
- ESWL
- TRUS guided prostate biopsies
- Standard and video urodynamic studies
- Bladder installations (BCG, MMC, GAG replacement therapy)
- Catheter changes
- Pad testing
- Intermittent self-catheterisation teaching
- Trial without catheter

### Lessons learned

To be imaginative when considering what services can be provided in a UIU setting, and to provide sufficient toilet facilities.

### This case study links to GIRFT urology report recommendation 3:

Increase the provision of Urological Investigations Units (UIUs), providing a dedicated resource for urological outpatient care.

# Nurse-led Botox Injection Service

## East Lancashire Hospitals NHS Trust

### Motivations and aims

To improve the patient experience and help avoid unnecessary follow-ups.

### What was done

This is now a well-established service, developed in 2014 for patients with urodynamically proven idiopathic detrusor over-activity or neurogenic detrusor over-activity.

The nurse cystoscopist took on the role following formal Botox training, with mentoring and supervision by the lead consultant urologist, until she was assessed as being competent.

The business manager supported production of the business plan, development of pathways and protocols, COSSH, admissions, coding, microbiology and pharmacy involvement.

Patients can call the specialist nurse to be re-listed improving access to the service.

The benefits of the Botulinum Toxin Injection Service are that patients may avoid a general anaesthesia where appropriate. It improves the efficiency and quality of service, allowing more theatre time and surgeon time for other procedures.

### Successes

- The service is well established, providing one session per week. It requires the nurse cystoscopist to organise pre/peri/post Botox care.
- A telephone review/relist service has reduced patient follow-up attendance to the clinic.
- The service achieved first prize for best poster from *BAUN in 2017 for Patient pain perception with local anaesthetic Botox injections to the bladder*

### Lessons learned

A nurse prescribing qualification would be beneficial to reduce the reliance on a doctor for prescribing.

### Resources

- [BAUS Botox patient information leaflet](#)
- [EAU guideline neuro lower urinary tract dysfunction 2009](#)
- [COSHH](#)
- [NICE clinical guideline NG 123](#)
- [APPG report continence services England 2013](#)
- [NICE 2012 urinary incontinence in neurological diseases](#)

### This case study links to GIRFT urology report recommendations:

2. Provide job planning for clinical nurse specialists and ensure appropriate skill mix.
3. Increase the provision of Urological Investigations Units (UIUs), providing a dedicated resource for urological outpatient care.
5. Take further action to improve RTT performance for common conditions and pathways.
8. Reduce average length of stay across the specialty through enhanced recovery and increased use of day case pathways, while monitoring causes and rates of emergency readmissions.



# Nurse-led Intravesical Botox Injections

## Hull University Teaching Hospitals NHS Trust

### Motivations and aims

The urology department at Hull University Teaching Hospitals NHS Trust has been building its team of nurse cystoscopists for several years. It is recognised that with adequate competency assessed training in flexible cystoscopy nurse specialists are able to provide a comprehensive service. This service historically has included bladder cancer surveillance, removal of ureteric stents and some cystoscopic techniques to aid insertion of vesical lines for cystometrogram (CMG).

The demand for flexible cystoscopy has come under increasing pressure over recent years with a high demand for capacity to provide diagnostic cystoscopy. National awareness campaigns have prompted extra demand meaning capacity is at a premium. Intravesical Botox is also administered on these cystoscopy lists.

About 80% of patients receiving this treatment do so in an outpatient setting. Traditionally this has been provided on existing diagnostic flexible cystoscopy lists by consultant urologists or registrars. However, increasing demand has meant that patients listed for Botulinum Toxin A injections can be waiting several months, which has a significant impact on quality of life as their severe symptoms return.

### What was done

In a drive to improve patient outcomes and satisfaction, an expansion of nursing practice to undertake nurse-led intravesical Botox injections by nurse cystoscopists has been implemented. This also frees up consultant time. An experienced nurse cystoscopist attended initial training with Allergan, and completed supervised practice with a consultant urologist.

A further specialist nurse is currently being trained in cystoscopy and following a business case it is anticipated that additional surveillance cystoscopy capacity can be provided when competence is achieved.

### Successes

Nurse specialists are motivated and keen to take on the new role.

Capacity has been increased by one appointment per week at least, with improved waiting times for patients, improved quality of life and better patient satisfaction. There is now extra capacity on consultant lists to perform diagnostic cystoscopy.

### Lessons learned

High demand for capacity within the cystoscopy suite for diagnostic/ haematuria lists has posed a challenge for creating more nurse-led Botox slots.

A business case is being built to create an independent nurse-led Botox list each week but there are challenges with capacity and room availability.

### This case study links to GIRFT urology report recommendations:

2. Provide job planning for clinical nurse specialists and ensure appropriate skill mix.
3. Increase the provision of Urological Investigations Units (UIUs), providing a dedicated resource for urological outpatient care.
5. Take further action to improve RTT performance for common conditions and pathways.
8. Reduce average length of stay across the specialty through enhanced recovery and increased use of day case pathways, while monitoring causes and rates of emergency readmissions.

# Establishing a nurse-led Botox service

Salford Royal NHS Foundation Trust

## Motivations and aims

The department of urology at Salford Royal NHS Foundation Trust, Salford Care Organisation, part of the Northern Care Alliance NHS Group, has led the development of nurse-led services since 1997. Building on the skills of systematic leadership, the core elements of advanced practice include research and quality improvement, educational development, and advanced knowledge and skills were utilised for the development of a nurse led, patient centred service for patients undertaking BOTOX® administration.

The development of a nurse-led Botox clinic and subsequent use of quality improvement tools to evaluate the service was utilised in the development of an initial nurse-led national Botox masterclass (in collaboration with Allergan) and actively developed the key elements of competence that would be embedded into the BAUN/BAUS 2nd edition of the flexible cystoscopy guidelines as national standards for training to support the on-going development of urological nurses.

## What was done

The introduction of a nurse-led Botox service was undertaken in 2013 to transfer the patient caseload from a consultant-led GA service to an ambulatory out-patient service

Throughout the implementation of the transfer of services a prospective patient satisfaction survey indicated a high level of patient satisfaction. The nurse-led clinic noted the increase in demand resulting in insufficient capacity to treat patients in the current nurse-led out-patient template.

In view of the increasing waiting times a quality improvement project was developed in the early part of 2016 utilising lean methodology. The impact was to enable the team to successfully implement improved and standardised ways of improving the productivity and efficiency of the clinics (including the consultant-led clinic), managing the increasing demand without additional resource. A prospective study of patient satisfaction identified there was no negative impact on patient satisfaction by increasing throughput in these clinics when compared to previous studies.

This development has freed up consultant time, reduced theatre demand and increased capacity of the clinics without utilising increase resource.

## Successes

Nurse specialists are motivated and keen to take on new roles. However, there needs to be a framework for urological nurses to develop their practice. To support knowledge and skill development regular Botox masterclasses enable the sharing of experience and national guiding standards to ensure services develop and embed evidence-based practice, reflect the national standards and deliver these via clinically-credible practitioners and clinicians.

The ongoing development of national standards (BAUN/BAUS) needs to be consistent across the urological medical and non-medical workforce.

Sharing quality improvement practice demonstrates the ability to improve waiting times, quality of life and sustained high levels of patient satisfaction. The workforce benefits from increased capacity on consultant theatre lists for use for other GA procedures and the satisfaction of utilising the experienced nursing workforce available.

## Lessons learned

Standardised work is a complete Plan, Do, Study, Act (PDSA) system which:

- Contains an agreed-upon set of work procedures (standards)
- Establishes the current best and most reliable methods and sequences for each process
- Establishes each worker to deliver the expected results
- Enables a stable baseline to a process in order to systematically improve operations.

Utilising a quality improvement approach can support the continuous improvement of urological services, safely reduce costs and deliver a high level of patient satisfaction.

Sharing the developments of nurse-led services and delivering a national programme of Botox masterclasses can harness the development and build on the skills of urology nurses while freeing up the consultant urologist for alternative complex urological work.

### This case study links to GIRFT urology report recommendations:

1. Develop a structured training curriculum for specialist urological nurses and establish accredited training departments.
2. Provide job planning for clinical nurse specialists and ensure appropriate skill mix.

# Open Access Review Service

## Surrey and Sussex Healthcare NHS Trust

### Motivations and aims

Patients were attending the emergency department with minor problems such as blocked catheters or infected wounds. Providing an open access service via the urology ward deals effectively with these patients, freeing up resources in the emergency department and reducing the time patients have to wait to have their problem addressed.

### What was done

The open access review clinic is an established nurse-led acute ward attender service which allows patients to ring the urology ward for advice and / or to arrange a review appointment in the urology suite, as appropriate. The nurse-led service deals with several minor problems, such as: blocked catheters; bladder washout; urine infection; retention of urine; catheterisation; trial without catheter; removal of stent on string; IV antibiotics; wound review post minor surgery.

While the service is nurse-led, the urology medical team is also available and consulted with, as necessary. Junior staff and urology specialist nursing staff work together to learn new knowledge and skills.

The telephone calls and any advice given are recorded in a communication diary. Attendances are recorded in the patient administration system (Cerner) and documented in the patient's health record.

The service is discussed at the monthly urology clinical governance meeting and attendance volumes are recorded in the urology ward.

Patients experience a timely and streamlined service from staff with specialist urology skills and expertise and are assured that they can seek advice and /or help, 24 hours a day, any day of the week. Staff give details of the service to patients on discharge.

### Successes

- Reduced ED attendances
- Timely and personalised care
- Improved access – available 24/7
- Re-admission prevention
- Patient satisfaction

### Lessons learned

- It is important to maintain good governance and recording and this is overcome by completion of communication diary where staff can see what advice was given by a previous colleague, and the recording of attendances in health records and the patient administration system.
- Issues with clinic space were overcome by arranging appointments, where possible, when clinic space is available and avoiding busy planned clinic times.
- Effective triage prior to attendance is always carried out by the nurse in charge of the ward or one of the urology clinical nurse specialists

### This case study links to GIRFT urology report recommendations:

2. Provide job planning for clinical nurse specialists and ensure appropriate skill mix.
3. Increase the provision of Urological Investigations Units (UIUs), providing a dedicated resource for urological outpatient care.
8. Reduce average length of stay across the specialty through enhanced recovery and increased use of day case pathways, while monitoring causes and rates of emergency readmissions.
11. Review workloads of on-call consultants to ensure the sustainability of on-call arrangements.

# Virtual Review Clinics

## Pennine Acute Hospitals NHS Trust

### Motivations and aims

In 2018/19 the urology directorate piloted a limited number of virtual follow-up clinics due to follow-up out-patient capacity constraints. The outcome of the pilot showed that virtual clinics are effective in urology if patients are triaged appropriately, selected on condition type. The initial findings showed that up to 40% of patients entered into the virtual clinic were discharged back to primary care with advice and/or guidance to the GP and patient, while allowing for a 100% increase in clinic capacity. A further 10-20% had diagnostic investigations ordered, which would be reviewed and further communication sent to avoid unnecessary hospital visits.

A virtual clinic is defined as a planned contact by the healthcare professional responsible for care with a patient for the purposes of clinical consultation, advice and treatment planning.

A limited literature review was undertaken to understand the volume, methods and efficacy of virtual clinics across the UK to act as a benchmark for Pennine Acute's practise. A study published by St Vincent's Hospital, Dublin, on 'Prospective evaluation of a virtual urology outpatient clinic' concluded that virtual clinics were both cost effective and acted as a failsafe mechanism for reviewing investigation results. In the study 389 patients were entered into a virtual clinic trial which avoided 217 outpatients' visits and discharged 39 patients (10%).

Imperial College Healthcare NHS Trust and University Hospital of London jointly published 'A prospective clinical, cost and environmental analysis of a clinician-led virtual urology clinic' in 2019 where 409 patients were entered into a virtual clinic process. The study outcomes found that 68.5% patients were discharged from further follow-up, with the majority being of working age.

### Success and lessons learned

During a period from 1st April 2019 to 9th August 2019 the urology directorate undertook 30 consultant-led virtual clinics, reviewing 900 patients in total.

A preliminary audit of 100 patients across three consultants was undertaken in August 2019 to benchmark the clinical outcomes against published peers.

The audit found that, of those sampled, 41% of patients reviewed via a virtual clinic were discharged from the service following a consultant review. The proportion of patients discharged remains consistent with previous findings in 2018/19 and is not an outlier compared to other NHS centres.

The introduction of virtual clinics has allowed the service to target unwarranted variations which have arisen for multifactorial reasons, such as;

- Non-consultant led outpatient clinics
- Extensive usage of locum doctors and junior SAS grade doctors
- Unnecessary reviews/overtreatment of simple problems
- Poor management and treatment of more complex cases

### Further information

The directorate continues to review its process of maximising virtual follow up clinic through key actions:

- Introducing a virtual follow-up opt-in service following face-to-face appointments
- Robust selection (waiting list management by condition type)
- Pre-virtual clinic testing (PSA)
- Introducing a urology nurse specialist advice line
- Developing/standardising patient information leaflets when issuing lifestyle and symptom management advice.

### This case study links to GIRFT urology report recommendations:

4. Review follow-up rates against a median of 1:2 first outpatient to follow-up.
5. Take further action to improve RTT performance for common conditions and pathways.

# National Catheter Education Project

## Ashford and St Peter's Hospitals NHS Foundation Trust

### Motivations and aims

The National Catheter Educational Programme is sponsored by Health Education England with a focus on teaching good catheter practice across all healthcare settings in the UK and is based at the Ashford & St Peter's NHS Foundation Trust.

Its aim is to:

- Improve clinical care, patient safety and patient experience by developing multi-professional urinary catheter training and awareness.
- Improve staff education and confidence in dealing with common catheter related problems.
- Reduce avoidable admission to hospital.
- Reduce catheter complications.
- Improve the lives of patients.

### What was done

The training programme was initially started internally as a project within the urology department to fill a gap in catheter training in medical and nursing training. It subsequently grew to cover the Kent, Sussex and one Surrey region. Following its success, it received funding from Health Education England and has been rolled out nationally.

The programme focuses on educating nurses and other professionals from all healthcare settings in the management of urinary catheters. To date, more than 500 hospital and community staff have been trained with respect to catheter care.

The one-day course incorporates ten modules. The training is aimed at any staff group involved in the care of people with catheters. Attendees have included carers, nurses, health care assistants, paramedics, physiotherapists, doctors and surgeons. The session covers the anatomy, different types of catheters, the microbiology of catheters, when they are necessary to use, and how to solve some common catheter-related and continence problems. In addition, the urology department also provides bespoke training sessions upon request.

### Successes

A particularly interesting and important development has been the provision of a palliative care crisis team, who have the capacity to manage catheter and nephrostomy-related problems in the community, thereby avoiding admissions for these vulnerable patients.

### Lessons learned

- Focus on engagement and demonstrating benefits of training programme.
- Ensure a funding stream is established that will allow the training programme to be implemented, sustained, and hopefully expanded.
- Provide workforce time to deliver training sessions – this can be an issue when training is delivered by clinicians and specialist nurses.

### Resources

<https://www.nationalcathetereducationprogramme.org/>

### This case study links to GIRFT urology report recommendation 2:

Provide job planning for clinical nurse specialists and ensure appropriate skill mix.

## Laser Ablation of Bladder Tumours in an Out-patient Setting

Ashford and St Peter's Hospitals NHS Foundation Trust

### Motivations and aims

Ashford and St Peter's Hospitals NHS Foundation Trust is one of the small number of hospitals within the UK offering innovative bladder cancer treatment in an outpatient setting. The service allows patients with bladder cancer to be treated more cost efficiently and it improves the patient experience by avoiding the need for a general anaesthetic and overnight stay.

### What was done

Laser treatment of non-muscle-invasive bladder cancers are undertaken in the outpatient setting (Flexible Cystoscopy Suite) and performed by two trained urology consultants. This allows patients to be treated without needing to be admitted to hospital either as an inpatient or day case and avoids the use of general anaesthetic.

A patient video has been developed to help prepare patients for the procedure.

### Successes

There are significant cost savings in outpatient laser treatment versus inpatient or day case bladder tumour surgery through released theatre space and time, increased productivity and shorter waiting times.

Ashford and St Peters NHS FT and Imperial College Healthcare Trust were finalists in the Best HealthTech Solution for Patient Safety at the HSJ Patient Safety Awards 2019 (2 July 2019) for *outpatient local anaesthetic transurethral laser ablation of non-muscle invasive bladder tumours (TULA)*.

#### This case study links to GIRFT urology report recommendations:

5. Take further action to improve RTT performance for common conditions and pathways.
8. Reduce average length of stay across the specialty through enhanced recovery and increased use of day case pathways, while monitoring causes and rates of emergency readmissions.

## Patient Days & Co-design Projects

Ashford and St Peter's Hospitals NHS Foundation Trust

### Motivations and aims

Ashford and St Peter's Hospitals NHS Foundation Trust's urology department takes a proactive approach to patient feedback. The urology team has implemented 'Patient Days' where patients are invited to discuss the service and provide feedback to help improve the service and patient experience.

A key aim of the patient sessions is to gain a better understanding of patients and their families' experience of the urology service including what works well and what improvements could be made.

### What was done

The 'Patient Days' provide the opportunity to help develop videos for further patient information and education. The videos are subsequently made available online for patients to view before attending for procedures to help prepare them for surgery and manage patient expectations.

The half-day sessions are held a few times during the year with a focused topic looking at a particular pathway e.g. kidney, prostate, catheters and stones. Patients and carers/families are invited to discuss their experience and to help the team consider what improvements could be made. Following the success of these sessions other specialties within the trust have set up something similar to improve patient care and experience.

### Successes

The project has driven a sense of commitment and dedication to making the service better across the entire urology team - admin staff, nurses and consultants.

### Resources

Clinician & Patient videos: [www.youtube.com/watch?v=n6D5H76HUIM&feature=youtu.be](http://www.youtube.com/watch?v=n6D5H76HUIM&feature=youtu.be)  
[www.youtube.com/watch?v=qoKyORn6d9k&feature=youtu.be](http://www.youtube.com/watch?v=qoKyORn6d9k&feature=youtu.be)

#### This case study links to GIRFT urology report recommendation 5:

Take further action to improve RTT performance for common conditions and pathways.



## Patient Telephone Service Following TURP

George Eliot Hospital NHS Trust

### Motivations and aims

A well-established practice at the George Eliot Hospital in Nuneaton offers urology patients a specialist nurse telephone service for post-operative support. The service helps avoid unnecessary re-admissions and A&E attendances by providing patients with access to advice and guidance should they have any problems or concerns following a transurethral resection of the prostate (TURP).

### What was done

Patients undergoing TURP are provided with the contact details of the urology unit in the patient information leaflets at the point of discharge. Any post-operative concerns raised by the patients are assessed by the Urology Clinical Nurse Specialist and patients may be given advice over the phone or asked to attend the urology unit for review.

### Successes

Reviewing patients in the urology unit where possible has helped to reduce attendances at A&E, with fewer patients needing to contact their GP with concerns about their operation or recovery.

### Lessons learned

There is a need to ensure that patients can leave a message and contact details if a clinical nurse specialist is not available to speak to them immediately when they are busy with other commitments.

#### This case study links to GIRFT urology report recommendations:

2. Provide job planning for clinical nurse specialists and ensure appropriate skill mix.
3. Increase the provision of Urological Investigations Units (UIUs), providing a dedicated resource for urological outpatient care.

## Hospital to Home Service

The Dudley Group NHS Foundation Trust

### Motivations and aims

The Dudley Group NHS Foundation Trust has introduced a Hospital to Home (H2H) service for the urology team to help support patients at home and reduce the number of re-admissions and frequent admissions for a defined cohort of patients.

### What was done

The specialty has two senior urology nurses who support and manage patients in the community who require trial without catheters. The nurses manage difficult catheter changes to prevent these patients being admitted to hospital and also teach patients to perform intermittent catheterisation. The Hospital to Home team is based in an office on the urology ward enabling easy access to advice from the urology doctors and consultants.

### Successes

- Providing an office on the urology ward ensures good access to support from the wider clinical team.
- Helps patients to remain at home, improving patient experience and satisfaction.

### Lessons learned

Resourcing the team is a key issue with increasing demand for the service.

#### This case study links to GIRFT urology report recommendation 8:

Reduce average length of stay across the specialty through enhanced recovery and increased use of day case pathways, while monitoring causes and rates of emergency readmissions.

# Hospital to Home Service

## The Royal Wolverhampton NHS Trust

### Motivations and aims

The Hospital to Home team was initially set up to reduce length of stay for post-operative patients undergoing transurethral resection of the prostate (TURP) procedures. Running since 2002 the service has now become well-established, incorporating many other urology services either in the patient's home or in a clinic setting.

### What was done

The initial aim of the service was to reduce the length of stay for TURP patients and increase overall patient throughput. This incorporated a trial without catheter (TWOC) service, delivered in the patient's own home.

The service also set out to reduce outpatient appointments by carrying out telephone follow-up for patients undergoing TURP, therefore freeing up consultant time. Admission avoidance was supported by establishing pathways with the A&E department for patients in retention.

Historically the first change of suprapubic catheter (SPC) was undertaken in outpatient procedure clinics but the introduction of the Hospital to Home service enabled the first change of SPC to be carried out in the patient's home, releasing outpatient capacity for alternative use. This also led to a reduction in the need for hospital transport, as many of the patients involved had motor sensory issues which required hospital transport.

The service started out as a three days per week service and has now been expanded to a seven-day service. Hospital to Home is an integral part of the urology department and embedded into many of its patient pathways.

- Home from Home has now been expanded to cover any urological procedure after which a patient is discharged home with a catheter.
- Nurse-led telephone and/or outpatient clinic follow-ups have been expanded to cover patients who have undergone UroLift and HoLEP procedures, further reducing the need for follow-up consultant appointments.
- Preoperative counselling group sessions for patients having Robotic Radical Prostatectomy surgery have been introduced, helping to reduce patient anxiety, reduce telephone calls to the department and keep patients well-prepared. This has had a positive impact on patient-reported postoperative outcomes.
- Clean intermittent catheterisation (CISC) is taught in the patient's home, enabling more privacy and dignity. A telephone follow-up review clinic has also been set up, increasing patient compliance.

### Successes

The service is now well-established with the workload for the team increasing from 115 episodes of care in 2003 to 832 in 2017. The team has also expanded from 1.74 wte to 3 wte and now offer a seven-day service. Patient satisfaction with the service is high, with 93% of patients being very satisfied with the overall service in 2017.

### Lessons learned

Initially the team was based on the urology ward, with a strict criterion for patient suitability. This resulted in a low volume of patients. Over time this has increased, with confidence in the service also increasing.

There was early scepticism about the service from both patients and some staff. Through engagement with other departments, district nurses, GPs and feedback from patient users, this has now improved.

As a result of ward reconfiguration the Hospital to Home team base moved to the outpatient department. This has improved communication with both medical and administrative staff, who are also based in the same area. As the service grew and capacity became an issue, the service increased to seven days a week (8am-8pm) and covered a 20-mile radius. The addition of clinics in the outpatient department enables out of area patients and pre-operative counselling patients to be seen.

With an increased focus on safeguarding, the team were faced with new challenges. Staff underwent specific training and discussions with the safeguarding team. The team are now able to carry out capacity assessments and best interest meetings in the patient's home, with family members, carers, social workers or other parties.

Lone working can be a challenge. However, in line with local policy, all staff are required to document all planned visits and a local process exists where any staff who have not arrived at the hospital site when expected are contacted. A diary is kept in the outpatient department of all visits that day. If a team member is not back on hospital grounds by 1pm, they are then contacted to ensure they are safe.

### This case study links to GIRFT urology report recommendations:

4. Review follow-up rates against a median of 1:2 first outpatient to follow-up.
5. Take further action to improve RTT performance for common conditions and pathways.
8. Reduce average length of stay across the specialty through enhanced recovery and increased use of day case pathways, while monitoring causes and rates of emergency readmissions.

# Enhanced Recovery Programme for Nephrectomy

## University Hospitals of North Midlands NHS Trust

### Motivations and aims

To offer patients the chance to recover outside the hospital environment, for the hospitals to achieve a shorter length of stay, and to improve the quality and outcomes of upper tract surgery.

### What was done

To enable the enhancement of the recovery programme for nephrectomy, the trust has developed expertise in minimally invasive surgery – the open surgery rate is <5%.

It has also reduced the number of interventions deemed unnecessary, eg; routine drains and catheters.

Patients and the nursing team have been educated on the concept of normalcy immediately after surgery, and this has been implemented.

Systems are in place to ensure the safe review of patients in hospital if required, with protocols developed and shared with district nursing team.

Patients are given direct access to the Surgical Assessment Unit and written information is provided to patients, explaining any red flag symptoms to be aware of.

### Successes

- Reducing length of stay for laparoscopic upper tract surgery;
- Avoiding unnecessary interventions like drains and catheters;

As a part of working group with the British Association of Urological Surgeons, UHNM have co-authored the protocol for enhanced recovery for upper tract surgery.

This is now available on the BAUS website:

[www.baus.org.uk/professionals/baus\\_business/publications/91/enhanced\\_recovery\\_programme](http://www.baus.org.uk/professionals/baus_business/publications/91/enhanced_recovery_programme)

### Lessons learned

From the outset, there was a challenge to change the mindset of the nursing team to break from the established way of doing things.

The trust also needed to educate patients and manage expectations.

With early discharge for nephrectomy and pyeloplasty it was important to have systems in place to ensure the safe review of patients in hospital if required.

### This case study links to GIRFT urology report recommendation 8:

Reduce average length of stay across the specialty through enhanced recovery and increased use of day case pathways, while monitoring causes and rates of emergency readmissions.

# Nurse-led Ambulatory Clinic

## University Hospitals of North Midlands NHS Trust

### Motivations and aims

The nurse-led clinic offers patients the chance to recover at home rather than in hospital. It reduces the length of time patients stay in hospital, reducing the risk of hospital-acquired infection, and improving the patient experience.

### What was done

The urological ambulatory service is led by an expert urological nurse and delivered within a newly-designed model of care which remains connected to the acute urological settings.

This is a four-day service, operating from Tuesday to Friday, run by 1 whole time equivalent registered nurse Band 6, 1 whole time equivalent registered nurse Band 5 and 1 whole time equivalent clinical support worker Band 2.

A urological nurse undertakes the routine medical daily ward rounds with the aim of ensuring patients are put on an appropriate care pathway in a timely manner. Once identified, patients can be transferred into the ambulatory clinic and continue their treatment away from the inpatient setting and undergo a seamless patient discharge.

A programme of education for patients and the nursing team reinforces the message that the earlier normality is restored to patients, the quicker their recovery will be. This includes preventing unnecessary post-operative blood tests and the insertion of unnecessary catheters, drains and IV fluids for any longer than required.

The service has been developed across dual acute hospital sites (Royal Stoke University Hospital in Stoke-on-Trent, and County Hospital in Stafford), and has helped to co-ordinate primary and secondary patient care and optimise multi-disciplinary nursing roles.

Establishing the clinic required renovation of a dedicated clinical area connected to the acute urological ward setting, setting up five side rooms with trolleys and a communal space with four reclining chairs for patients.

### Successes

- Reduced length of stay for laparoscopic upper tract surgery, minimising complications;
- Offering the choice of day surgery to suitable patients;
- Avoiding unnecessary interventions like drains and catheters;
- 100 per cent positive patient satisfaction.

### This case study links to GIRFT urology report recommendations:

2. Provide job planning for clinical nurse specialists and ensure appropriate skill mix.
8. Reduce average length of stay across the specialty through enhanced recovery and increased use of day case pathways, while monitoring causes and rates of emergency readmissions.

# Nurse-led Urology Rapid Access Unit

## South Tyneside and Sunderland NHS Foundation Trust

### Motivations and aims

South Tyneside and Sunderland NHS Foundation Trust identified a need for a nurse-led rapid urology service to:

- Improve access to patients with common urological conditions;
- Reduce admissions for urgent urological conditions which can be managed in an ambulatory setting;
- Reduce the input from junior doctors on initial assessment. Several pathways are now nurse-led;
- Develop nurse practitioner skills, such as examination, prescribing, and appropriate imaging requests;
- Support ED by transferring urology patients with non-life threatening symptoms to URAU;
- Enhance fast specialist care to urology patients.

### What was done

A clinical area was made available from 8am to 8pm seven days a week, staffed by three Band 7 experienced nurse practitioners rostered to cover the practicing service hours.

Information was sent to the Accident and Emergency department and GPs, indicating which conditions could be seen in the URAU department.

The following equipment was made available: Full selection of catheters and guidewires; catheter bag packs to send home with patients; wound dressings; bladder scanner BP/oxygen saturation/temperature capture machine; equipment trolleys; phlebotomy equipment; private examination room with examination couch; IT and notes facilities; Referral and consent forms; TTO medicines antibiotics, analgesia/tamsulosin.

For an initial phase the department was located in urology, before the area was moved to a joint ambulatory care area. This means there is now a receptionist and health care assistants who can take observations and do initial blood tests. There is also rapid ultrasound access five days per week.

### Successes

Referral process to urology nurse practitioners - who take patient history and triage referrals from GPs, spoke site ED and community nurses - has removed the pressures from junior medical trainees.

The average length of stay in the Urology Rapid Access Unit is around two to three hours.

Patients are able to quickly access specialist care and diagnostics which means an admission is avoided in 80% of all attendances.

Unit staff won the British Association of Urology Nurses (BAUN) Team of the Year award in 2015; and the unit was highly commended in the Bright Ideas in Health awards 2016.

### Lessons learned

Clinical skills training is needed, along with prescribing training and IRMER (Ionising Radiation Medical Exposure Regulations) X-ray requesting training.

#### This case study links to GIRFT urology report recommendations:

2. Provide job planning for clinical nurse specialists and ensure appropriate skill mix.
8. Reduce average length of stay across the specialty through enhanced recovery and increased use of day case pathways, while monitoring causes and rates of emergency readmissions.
11. Review workloads of on-call consultants to ensure the sustainability of on-call arrangements

# Remote Follow-up of Patients with Prostate Cancer

Leeds Teaching Hospitals NHS Trust

## Motivations and aims

With more than 8,000 men requiring follow-up after a diagnosis of prostate cancer, the clinical service was overwhelmed. The choice was either to repatriate men with stable disease or requiring follow-up after radical curative treatment to primary care, or to devise a non-medical remote follow-up system.

## What was done

Charitable funding was received to create a database, which would allow the service to introduce a remote follow up system for patients requiring long term surveillance for stable prostate cancer. A consensus group of clinicians agreed the follow-up pathways (timing of consultations face to face, clinical nurse specialist telephone call, remote PSA checking and plans for escalation to clinician).

Initially a review was undertaken by a specialist nurse to determine which protocolised pathway each patient would be on. The remote follow up service is now managed on a day-to-day basis by an administrator with developed pathways of escalation to clinicians.

The system has been devised in collaboration with, and with the full support of, primary care services.

## Successes

The process works well in day-to-day practice, with patients on the remote system receiving standardised follow-up. Numbers of long-term prostate cancer patients who attend for clinical review are now relatively small and clinical staff can concentrate on the increasing numbers of patients with new diagnoses and those with relapsed disease.

## Lessons learned

Challenges came from obtaining blood results from patients who live out of area and from the trust electronic blood request forms. Communication with patients is still by letter and the trust would like to offer an interactive electronic system.

### This case study links to GIRFT urology report recommendations:

4. Review follow-up rates against a median of 1:2 first outpatient to follow-up.
7. Review guidance for urology cancer MDT working.



# Community Follow-up for Patients with Stable Prostate Cancer

Harrogate and District NHS Foundation Trust

## Motivations and aims

Historically, patients with stable prostate cancer were never discharged from secondary care follow-up. The aim has been to:

- Reduce the number of follow-up appointments in hospital;
- Channel secondary care resources to patients with more complex needs;
- Empower patients through education of their condition and PSA diary monitoring;
- Ensure that follow-up remains individualised, while the agreed protocol is adhered to.

## What was done

A protocol was agreed between primary and secondary care regarding community monitoring for patients with stable prostate cancer and those with an elevated PSA. The protocol outlined the role and responsibilities of each team along with an agreed criteria for which patients are suitable for primary care follow-up. Discharge summary templates were drawn up to be sent to the GP including advice on frequency of monitoring, symptoms to look for, and the PSA threshold to trigger re-referral. In order to ensure follow-up pathways remain individualised, patients are consulted with before being discharged to community based follow-up. If agreed the patient will receive education material, a PSA monitoring diary and their GP will be notified.

Guidelines were drawn up alongside the Yorkshire Cancer Network Prostate Cancer Pathway, taking into account the practice of the different specialist teams. GP education events were held to ensure optimum engagement and understanding of the process. It was agreed that all patients on active surveillance would stay in secondary care for their follow-up.

## Successes

The discharge of patients began March 2014, and an audit showed 146 men were discharged from the nurse-led clinic in the first nine months.

Supported discharge with education has been well-received by patients, GPs and the hospital team.

The new protocol adheres to NICE guidelines - NICE prostate cancer guidance 2008 agreed follow-up should take place outside of the hospital for men with stable disease.

## Lessons learned

The engagement with GPs was crucial in developing robust, mutually-agreed pathways for community follow-up.

IT systems needed to be put into place to give power of recall if patients failed to attend for PSA and review.

Engagement of hospital clinicians is important as it takes more time to arrange community discharge than to arrange further review in the clinic.

### This case study links to GIRFT urology report recommendations:

4. Review follow-up rates against a median of 1:2 first outpatient to follow-up.
7. Review guidance for urology cancer MDT working.

# Urological Assessment Unit

## Sheffield Teaching Hospitals NHS Foundation Trust

### Motivations and aims

The UAU service was developed to provide a single point of contact (SPOC) for GPs, emergency departments (ED) and community nurses to provide timely and appropriate access to patients presenting with urological problems. The aim, through collaborative working, was to streamline the assessment process, enable early review with same day diagnostic interventions for this group of patients, and avoid unnecessary inpatient admission, therefore improving the patient experience, reducing variation.

### What was done

The Urology Assessment Unit (UAU) had been co-located within an in-patient area for a number of years. It was recognised that it was predominantly an ambulatory service which could be streamlined to improve the patient pathway if relocated into an out-patient setting. Staff felt that the existing location limited the interventions/investigations that could be offered in a single visit, which often resulted in patients staying overnight.

After a test period, the service relocated in September 2017 and now treats patients rapidly and investigates promptly in the correct environment, with access to equipment for small procedures such as flexible cystoscopies.

Patient pathway protocols were developed and agreed to ensure a consistent approach for the teams to follow, using the Directory of Ambulatory Emergency Care for Adults as a guideline. Patients were categorised into eight key pathways for: acute painful bladder outflow obstruction/catheter-related problems/acute/chronic retention; urinary tract infections; gross haematuria; acute scrotal pain/testicular pain/penile pathology; post procedure concerns; pyelonephritis; renal/ureteric stones; complex care (referral to consultant).

The UAU is a 24-hour service. From 8am and 8.30pm Monday to Friday, the service is based in the urology ambulatory facility and treats an average of 15 patients a day. In addition, it receives around 25 to 30 calls a day and provides advice to other health care professionals.

Out of hours, the UAU reverts back into the in-patient area and there is now a dedicated area to assess and review patients. There has been a culture change towards the provision of ambulatory care and admission avoidance in this setting. Post-operative patients are routinely provided with contact details for the UAU, with patients who have had certain procedures given a 'red card' to expedite care.

A dedicated multi-disciplinary team ensures appropriate senior nurses co-ordinate the clinics. This was achieved by increasing the number of AFC Band 6 nurses and reviewing their roles and responsibilities. Their working times were also adjusted to provide a service until 8.30pm. Consultant availability was initially increased until 8pm, but the service is now predominantly nurse-led due to the consistent and experienced senior nursing support. This has allowed consultant attendance to be reduced to on call, with middle grade medical cover.

Negotiations have taken place with the radiology department, which now provides on the day CT scans within two to four hours for these patients.

Communication and contact with the community nursing service also took place, particularly in relation to catheter management, to help support care in the community and appropriate attendance into secondary care.

### Successes

- Redesign of patient pathway to improve experience and outcomes
- Admission avoidance - reduced bed occupancy and length of stay by three patients per day
- Rapid access to service
- Same day treatment/investigation
- Expert care in the right place at the right time - service more accessible to patients due to its location
- Consistent approach
- Improved communication with ED, GPs and community nursing
- Improved staff satisfaction in both in-patient and out-patient areas
- Monthly Friends & Family test remains very positive

### Lessons learned

There may be some potential challenges around escalating numbers of patients; increasing the availability of staff skilled in flexible cystoscopy (nursing and medical); and the location of the service reverting back to an inpatient environment out of hours.

#### **This case study links to GIRFT urology report recommendations:**

- 2.** Provide job planning for clinical nurse specialists and ensure appropriate skill mix.
- 11.** Review workloads of on-call consultants to ensure the sustainability of on-call arrangements.

## Consultant Connect Network

### South Warwickshire NHS Foundation Trust

#### Motivations and aims

The trust was facing increasing non-elective attendances and admissions for patients who could be managed conservatively out of an acute setting. In a small unit, with only three consultants and no dedicated urology junior staff, this was significantly burdening the system and impacting elective activity.

#### What was done

A rapid advice and guidance service was established by Consultant Connect who aim to improve communication between primary and secondary care. Consultant Connect has the ability to allow general practitioners to gain specialist advice from a national network of consultants across an array of specialties.

The discussion can establish whether a patient needs to be admitted. In some cases, admission can be averted and the patient seen in clinic with investigations already complete, resulting in more efficient management for the patient and the hospital team.

#### Successes

- This has resulted in reduced hospital admissions, better patient care and cost savings. Patients and GPs are happy with the system as they receive more immediate reassurance and a clear plan going forward.
- The establishment of a rapid advice and guidance service allows for better control over admissions and facilitates the streamlining of patients to the appropriate follow-up in a timely fashion.
- Consultant Connect encourages better relations between primary and secondary care.
- The service is very easy to use with few challenges.

#### This case study links to GIRFT urology report recommendations:

4. Review follow-up rates against a median of 1:2 first outpatient to follow-up.
5. Take further action to improve RTT performance for common conditions and pathways.
11. Review workloads of on-call consultants to ensure the sustainability of on-call arrangements.

## Developing the role of Surgical Care Practitioners

### York Teaching Hospitals NHS Foundation Trust

#### Motivations and aims

The urology service at Scarborough Hospital is a consultant-led service with limited junior doctor support in the form of a shared surgical on call rota. The intensity of the shared rota often means there is rarely consistent junior grade support for inpatient care.

Surgical and urological services on the Scarborough Hospital site are evolving and significant changes are planned with a vision of acute urology being centralised on the York Hospital.

Admitted elective care, such as day cases and overnight surgery, will remain on the Scarborough Hospital site.

#### What was done

In order to provide a consistent support to the urology team the role of the Surgical Care Practitioner (SCP) was developed. Currently, the urology elements of the SCP's role is managing in-patients, supervised and supported by the consultant. It is envisaged that their role will expand into 'hot' clinics and surveillance flexible cystoscopy.

The SCPs play a significant role in these development plans, offering a stable on site opinion as a 'urological first responder'.

Within the department of surgery/urology there are two trained SCPs and one in training (year 1). All three are on the Scarborough Hospital Site. They work 7am – 5pm, four days a week. One day a week they are in theatre assisting, and the other three days are on the wards. Their role is complementary to the SAS grade and junior doctors.

The SCP training is a two year Masters course - the first year generic and the second a bespoke year of chosen modules. Additional speciality modules can be added post qualification.

#### Lessons learned

Acquiring and funding a motivated experienced nurse to the role was key to the stability and longevity of the SCP service.

#### Resources

The Royal College of Surgeons provides information to support extended surgical care teams including resources such as business case templates and curriculum frameworks

Royal College of Surgeons Surgical Care Team Standards (2018)

<https://www.rcseng.ac.uk/standards-and-research/standards-and-guidance/service-standards/surgical-care-team-guidance/>

Royal College of Surgeons The Curriculum framework for the surgical care practitioner (2014)

<https://accreditation.rcseng.ac.uk/pdf/SCP%20Curriculum%20Framework%202014.pdf>

Health Education England have set out guidance on establishing common standards for continuing professional development, assessment and appraisal guidelines for medical associate professionals. [Click here to see pdf](#)

#### This case study links to GIRFT urology report recommendations:

5. Take further action to improve RTT performance for common conditions and pathways.
11. Review workloads of on-call consultants to ensure the sustainability of on-call arrangements

# Utilising Surgical Care Practitioners

## University Hospitals of North Midlands NHS Trust

### Motivations and aims

The trust invested in robotic technology in 2015, at the same time as experiencing a decrease in the surgical expertise of specialty trainees allocated to the department. More days off due to rota commitments further limited theatre attendance. Specialist trainees also had to fulfil indicative numbers for their core training. The trust was also very keen to train senior and experienced specialty trainee doctors in robotics.

This led to theatre lists where the bed side quality of assistance was declining and, on some lists, not available. On occasion, it led to consultant colleagues cancelling other activity to assist.

The solution was to recruit, train and upskill a member of the urology theatre team to take the SCP qualification. Surgical Care Practitioners (SCPs) are well-established in many robotic urology centres around the UK. Many are theatre-only SCPs, whereas others have responsibility for a wide range of interventions such as flexible cystoscopy and prostate biopsy.

### What was done:

Royal Stoke University Hospital supported a urology theatre nurse (ODP) to gain surgical assistant level 1 and 2 training. To build on this, an application was then made to join the MSc SCP course at Edge Hill University in Manchester.

By adopting a flexible approach, the SCP has been able to continue to deliver important service commitments, assisting with robotic-assisted laparoscopic prostatectomy (RALP), robotic-assisted radical cystectomy (RARC) and partial nephrectomy, as well as gaining clinical experience on the wards and OPD activities.

### Successes

Surgical Care Practitioners are key to consistent patient care, performance and surgical training.

The trust now has a robotic operating schedule that has robust, highly-skilled bedside assistance. This has led to decreased operating time and therefore better throughput of patients in theatre. Consultant clinics are no longer cancelled to assist in robotic surgery.

There has been significant success in training final year trainees and fellows in robotics, with a growing number going on to gain robotic consultant posts in the UK and abroad.

Surgeons are now pushing the boundaries of robotics locally, with ureteric reconstruction commonplace, more complex partial nephrectomy operations performed and, for prostatectomy, greater use of nerve sparing and the confidence to tackle higher-risk disease.

### Lessons learned

- A standard approach allows everybody to understand their role and be interchangeable
- SCP allows surgical console training of final year NTN and fellows.
- Training an SCP is a significant undertaking requiring a two-year degree level course. To obtain the SCP qualification the candidate must have the support of their department and trust to invest time initially to reap the benefits in the long term.

### Resources

Edge Hill University MSc in SCP: [www.edgehill.ac.uk/courses/surgical-care-practice](http://www.edgehill.ac.uk/courses/surgical-care-practice)

### This case study links to GIRFT urology report recommendations:

5. Take further action to improve RTT performance for common conditions and pathways.
11. Review workloads of on-call consultants to ensure the sustainability of on-call arrangements



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