

Urology: the path to recovery

**A manual for recovering and developing urology services
after the COVID-19 pandemic**

April 2022

Executive Summary

What is urology?

Urology is a specialty that treats problems of the female urinary system and the male genitourinary tract. It is involved in the diagnosis and treatment of disorders of the kidney, ureter, bladder, prostate and male reproductive organs. Much work relates to the diagnosis and treatment of cancers involving those organs, but there are also many patients who suffer from common benign conditions including urinary stone disease, voiding problems and urinary incontinence.

The specialty performs a high volume of diagnostic procedures and outpatient consultations including flexible cystoscopy, prostate biopsy, ultrasound and bladder function tests. A majority of planned surgery is performed endoscopically ('keyhole') with an increasing proportion performed as day cases or outpatient procedures. The emergency urology workload is large and includes treating kidney stones, urinary retention and haematuria (voiding blood).

The range of services is delivered by a large multi-disciplinary team with an increasing number of outpatient services being nurse-led or practitioner-led. Following the pandemic, the urology service in England is facing the fourth largest backlog in elective care by comparison with the ten main surgical specialties in the NHS.

Who should read this manual?

This document has been developed by the GIRFT urology team to support all those with a role in delivering the recovery of urology services following the pandemic, including:

- Urology clinical leads and multi-disciplinary teams involved in the development of urological services
- Operational managers, transformation leads and service improvement teams
- Commissioners involved with urology and service transformation

What is the manual's aim?

The aim is to draw together, in a single document, a description of a strategic approach that will offer a means of delivering both a post-pandemic recovery of urology services and, importantly, the development of services in a way which will deliver clinical quality, equitable access, excellent patient experience and efficiency in the use of resources for the future. Its structure follows the patient pathway.

Key topics in the manual:

1. Strengthening the interface with primary care
2. A contemporary approach to outpatient consulting
3. Outpatient investigation and treatment – including the use of Urology Investigation Units (UIUs)
4. Supporting patients who are waiting for care
5. Delivering planned urological surgery
6. Delivering high quality and efficient emergency urological care
7. Supporting a system-based approach to recovery, and the role of Urology Area Networks
8. Supporting the urological workforce, including training considerations
9. Developing the urological workforce
10. Supporting urological research

Additional resources

11. 'Good practice' case studies
12. Supporting information and linked resources

Foreword

With over 750,000 episodes of care a year, urology is a specialty faced with high demand – but often for patient consultations, investigations and medical care, rather than surgical procedures. Many of the conditions the specialty deals with aren't immediately life-threatening but have a major impact on quality of everyday life. However, urologists also address conditions which can lead to kidney failure and manage several common types of cancer, including prostate, kidney, bladder and testicular cancer.

Urology, as a specialty, was facing significant challenges prior to the pandemic. Capacity for care wasn't reliably matched to demand and workforce projections indicated that this picture would worsen significantly as there is an under-supply of trained urologists and specialist nurses. The COVID-19 pandemic has dramatically impacted further on waiting times, leaving a legacy of unmet need and long waiting lists.

However, the pandemic has demonstrated that there is a greater than expected capacity for changing models of care as seen, for example, in the rapid adoption of remote consulting practices. Furthermore, there is widespread agreement about the changes that should take place within urology services in order to deliver increased efficiency and greater patient throughput, while retaining or enhancing clinical quality and patient experience. For example, through the development of more Urology Investigation Units (UIUs) and high-volume/low-complexity (HVLC) elective surgical hubs. There has also been a move towards 'system-based' working to support services across a region rather than on a provider by provider basis.

The GIRFT methodology of using a wide range of data to inform urology departments about their service, and how they compare with the rest of the country, coupled with individual departmental clinical visits was used to inform the production of the GIRFT National Specialty Report for Urology in 2018. The recommendations of that report (Appendix 1) remain pertinent and retain wide support. A second round of departmental deep-dives is currently underway and is revealing that the specialty has progressed significantly since the original 2016-18 visits. Additionally, information is being gathered on what changes are proving effective in improving service delivery and elective recovery. This work is now heavily underpinned with regularly updated Model Hospital data that can be accessed by those working in the service (<https://model.nhs.uk/>).

Other workstreams are also proving to be invaluable sources of information and guidance on service improvement measures. These include work done by GIRFT in London on elective recovery, pathway guidance from the GIRFT Academy (<https://www.gettingitrightfirsttime.co.uk/bpl/urology/>) and generic projects that have looked at a range of issues from outpatient transformation to theatre productivity.

The purpose of this manual is to draw information into a single document for clinicians, service managers and those planning future service delivery at trust and system level. It is organised in a way which mirrors the patient journey through a urology service. It describes how services might develop in order to meet current and future challenges and provides directions to resources that will help those who are tasked with commissioning or making such changes.

As mentioned above, there should be a continued move towards planning services on the basis of systems, rather than individual trusts. This principle was one of the key recommendations of the 2018 GIRFT National Specialty Report, which argued for the development of Urology Area Networks (UANs) (Appendix 2). Since then, the importance of ICSs has grown, which should underpin the move towards UAN working, and the use of UANs as a vehicle for specific aspects of the post-pandemic urology regeneration.

There are two further NHS agendas that warrant attention and cut across all NHS activity – the need to address long-term health inequality and the requirement for the NHS to help in the drive to a net zero carbon economy. As urology recovers and develops, it is incumbent on everyone to look for ways in which the recovery can align with these two important challenges. Ensuring equitable access to services comes from addressing geographical considerations, accessibility for those without good access to digital infrastructure and awareness of issues that affect particular groups within society. The potential to

have a positive impact on “green” issues comes from reducing the dependence on numerous face to face care episodes and increasing the efficiency with which equipment and physical estate is being used.

We believe that this manual sets out a strategic framework for the future development of urology services in England that will be widely supported across the NHS. It provides an opportunity to invest in the long-term future of the specialty in terms of equipment, estate and workforce-development as an alternative to restricting spending to short-term measures. GIRFT is grateful for the support and input to the development of this manual and strategy from the British Association of Urological Surgeons, the British Association of Urological Nurses, NHSE/I and others.

Delivering the changes proposed in this strategic framework will be a daunting prospect. It is reasonable to suggest that, for most departments, enacting this work will be a three-year programme of change and development. It will be essential that this is properly project-managed with prioritisation of key changes and executive level oversight to ensure progress is maintained and the recovery assured. Communication will be important so that all concerned are aware of the programme of change and have a chance to contribute. Continual monitoring of departmental and system metrics using the Model Health system will be needed to ensure that changes in practice are delivering measurable gains.

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About GIRFT and the GIRFT Academy

Getting It Right First Time (GIRFT) is an NHS programme designed to improve the quality of care within the NHS by reducing unwarranted variation. By tackling variation in the way services are delivered across the NHS, and by sharing best practice between trusts, GIRFT identifies changes that will help improve care and patient outcomes, as well as delivering efficiencies such as the reduction of unnecessary procedures and cost savings.

The GIRFT Academy has been established to provide easily accessible materials to support best practice delivery across specialties and adoption of innovations in care.

Importantly, the GIRFT Academy is led by frontline clinicians who are expert in the areas they are working on. This means advice is developed by teams with a deep understanding of their discipline, generated by the management of services on a daily basis.

The GIRFT programme is one element of the government's response to the recommendations of Lord Carter's report on operational productivity and performance in NHS acute trusts in England, published in 2016. The Carter Report highlighted the GIRFT programme within its theme on quality and efficiency, outlining the orthopaedic GIRFT pilots which identified the scale of benefit to tackling unwarranted variation.

For more information on the GIRFT programme, visit our website at:

www.gettingitrightfirsttime.co.uk

1. Strengthening the interface with primary care

High impact interventions:

- Develop an advice and guidance service, which is consistent and timely in action
- Identify points of access into secondary care urology services and ensure that all potential referrers are aware of how to use such access
- Work with primary care colleagues to mitigate factors that would increase inequity of access to urological services
- Provide effective, intelligent triage for all urology referrals
- Job plan time for senior clinicians to provide advice & guidance and referral triage
- Ensure that there is integration between secondary care and community-based services for catheter care and continence

Specialist advice & guidance and accessing urology services

Context: Advice & guidance is an application that sits within a range of platforms, of which the [NHS national eReferral system](#) (ERS) is the most widely used. It is intended to support a dialogue between primary and secondary care clinicians about individual patients, without necessarily requiring a referral to secondary care. There is variable uptake and sign-posting to advice & guidance across the NHS and each secondary care urology department needs to provide consistent guidance for primary care colleagues.

Clinicians must be job planned to run the service in a timely fashion; such work is considered direct clinical care (DCC). There is a need for BAUS and BAUN to work on developing and maintaining a library of standardised advice for the more common urological conditions. Where advice alone is insufficient, the advice platform should allow patients to be passed directly to the most appropriate secondary care service.

Developing advice & guidance

- Optimise stakeholder engagement
- Ensure sufficient capacity in order to deliver appropriate response times
- Provide clear and consistent guidance to primary care clinicians
- Define pathway entry points to urological care
- Communicate to raise awareness and understanding of how to access urological services
- Provide multiple communication channels between primary care and the specialist urology team

Realising the benefits of advice & guidance:

- Ensure patients can receive as much care as possible in a community setting
- Improve equitable patient access (via primary care providers) to advice & guidance
- Provide advice on treatment whilst the patient is waiting to be seen
- Ensure that patients access the correct provider and service for their needs, at the correct point in the investigation and treatment pathway
- Minimise rejection and re-direction of referrals
- Reduce unnecessary outpatient/ hospital visits for patients
- Ensure outpatient/diagnostic attendances add real value to the investigation and treatment of the patient's condition

Detailed information on the benefits and application of advice & guidance are provided in the GIRFT Academy Document 'Urology outpatient transformation: A practical guide to delivery' (https://www.gettingitrightfirsttime.co.uk/wp-content/uploads/2021/12/Urology_2021-12-10_Guidance_Outpatient-transformation.pdf)

The central role of intelligent triage within secondary care

Context: The traditional model of referring all patients who need secondary care input for a standard face-to-face outpatient appointment as a first point of contact is no longer fit for purpose. There is now a plethora of options for managing referrals for outpatient consultations, including:

- Provision of specialist advice and guidance alone
- Virtual (non-face-to-face) consultations
- Pre-investigation (e.g. prostate MRI or urinary flow rate testing)
- One-stop clinic appointments (combining a consultation with investigations),
- General face-to-face outpatient consultations and sub-specialty clinic face-to-face consultations.

Delivering the benefits: Getting the right patient to the right place at the right time is key to outpatient efficiency and improving patient experience, as well as time to diagnosis and treatment. Delays in the latter are known to be associated with poorer clinical outcomes in many conditions.

- Intelligent triage of referrals is an essential component of a contemporary urology service
- Services are now too varied and complex to expect primary care to navigate them unsupported
- Effective triage should be performed by senior clinicians with knowledge of the clinical condition and the services available
- Triage should be clearly timetabled and job-planned as direct clinical care time
- Triage should be adequately supported by the necessary IT and administrative infrastructure
- Time for triage can be built into the 'consultant of the week' model (see Section 6 on emergency care)

Integrating secondary care and community services

Context: NHS Community Service providers look after a large number of patients who have urological conditions. Despite this, in most of the country, there are very limited links between urology departments and those providing continence, catheter-care and palliative community services. Closer integration between secondary care urology departments and community services has great potential to improve patient experience and quality of care.

Delivering the benefits: There are a number of practical steps that will draw the services closer together:

- Ensure that clinical and managerial representatives of urology and community services meet regularly and have a remit to improve service integration
- Review catheter-care protocols and arrangements for trials without catheter in secondary and primary care
- Ensure that community continence services do not work in isolation from urologists, gynaecologists and colorectal surgeons, and their wider teams of specialist nurses and physiotherapists, who provide assessment and treatment of patients with incontinence problems
- Ensure that community palliative care practitioners are able to help manage practical problems, such as blocked nephrostomy tubes

2. Outpatient consulting

High impact interventions:

- Use the GIRFT Best Practice Academy Guide on Urology Outpatient Transformation document <https://www.gettingitrightfirsttime.co.uk/bpl/urology/> as the basis for a review of current outpatient organisation and increasing efficiency by
 - a. Expanding one-stop outpatient services
 - b. Optimising the use of remote consultation clinics
 - c. Minimising follow-up appointments using remote monitoring
 - d. Using patient-initiated follow up (PIFU)
- Ensure that there are policies in place that encourage the use of personalised outpatient follow up and minimise the risk of patients inappropriately remaining on secondary care follow up

Context: For many years, there has been an unquestioning acceptance that secondary care used a multi-step model that relied on face-to-face consultations interspersed with investigation or treatment episodes. This was easy to administer but inefficient for the NHS and inconvenient for the patient. Continuing with this approach is unsustainable. Furthermore, transformation in outpatient work has the potential to impact favourably on the “green” agenda. This is an area within urological activity which offers large reductions in patient journeys and “care miles”, which is a further reason for change to be enthusiastically pursued. The need critically to review outpatient follow up practice is recognised within overall NHS elective recovery planning. In particular, there is interest in personalising outpatient follow up, rather than relying on a single face-to-face model, and in actively supporting discharge of patients from secondary care.

Outpatient transformation in urology is the subject of an important GIRFT Academy guide, available [online](https://www.gettingitrightfirsttime.co.uk/bpl/urology/) (<https://www.gettingitrightfirsttime.co.uk/bpl/urology/>). The following paragraphs set out the core content of that document:

Outline: A patient-centric approach to healthcare should ensure that treatment and care is delivered in the right place, at the right time, by the most appropriate clinician. Outpatient transformation is critical to this agenda and, in urology, the GIRFT Academy team has identified five key components that will deliver maximum impact to patient experiences and outcomes, as well as supporting a sustainable NHS.

- **Specialty advice (advice and guidance) – please see Section 1 above:** empowering GPs to provide optimum urology support to patients in the community, aided by guidance from specialist urology teams
- **Remote consultation:** providing choice to patients about the way in which they interact with their treating clinical team
- **Personalised follow up - patient initiated follow up (PIFU):** using PIFU to empower patients to manage their health, with support from health services, by providing new solutions for contacting health providers, as and when patients choose. For example, following major cancer surgery or where repeated treatments may be required (e.g. botulinum toxin injections for overactive bladder treatment)
- **Remote monitoring (RM):** using remote monitoring of investigations to reduce low value follow up appointments and ensuring that patients only remain in secondary care follow up when such supervision is essential. For example, using tumour marker monitoring for cancer follow up.
- **One-stop outpatient services:** expanding the use of one-stop services to enable a larger cohort of urology outpatients to undergo clinical assessment, investigations and management-planning in a single visit to the outpatient department. For example, in the assessment of lower urinary tract symptoms.

These five elements help to strengthen opportunities for shared decision-making and patient empowerment, whilst minimising unnecessary and inefficient outpatient activity.

Key messages: good practice points

Optimising the use of remote consultation

- Consider patient suitability
- Ensure patient choice and secure patient consent if a remote consultation is agreed
- Ensure an appropriate clinic template is in place
- Embed a fully digitalised service with up-to-date hardware and software
- Review workforce deployment to deliver the best experience for patients and clinical teams
- Manage patient experience throughout the process of arranging, conducting and following up a remote consultation

Using patient initiated follow up (PIFU)

- Ensure that PIFU is an appropriate option for the patient, taking into account their personal circumstances
- Optimise patient communications
- Standardise the approach to delivering PIFU for all patients

Minimising follow up appointments using remote monitoring

- Following discussion with the patient, ensure that remote monitoring is an appropriate pathway, taking into account their personal circumstances
- Optimise the system for performing investigations, and accessing and reviewing results
- Create standard templates for communications with patients with flexibility to individualise information if necessary

Expanding one-stop outpatient clinics

- Provide patient information to manage expectations prior to the clinic attendance
- Ensure that investigation slots are efficiently used
- Match patient and clinician numbers to ensure that backlogs do not develop during the clinic session
- Ensure that a full range of investigations can be carried out, so that a minimum number of patients fall onto a multi-stage pathway
- Provide time for detailed counselling of patients after tests have been performed, so that they are able fully to absorb the information that is being given to them, and meet high standards of practice with regard to shared decision-making and consent

Ensuring efficient discharge from secondary care services

Context: GIRFT clinical visits have identified that many urology departments have the potential significantly to reduce the numbers of patients who are seen on follow up. Lower discharge rates are more common where patients are seen by less senior medical staff or by specialist nurses.

Delivering the benefits: A first step is to review new to follow up ratio data. Historically, urology services provided an average of two follow up appointments for each new patient seen. A greater than 1:2 ratio strongly suggests that too many patients remain on follow up and that efficiencies should be readily achieved.

Beyond this, there is a need to ensure that there is agreement on the criteria for continued patient follow up for some of the larger groups of patients who are under review. These include patients with raised prostate specific antigen (PSA) levels, patients with stable prostate cancer, those with renal calculi and patients with lower urinary tract symptoms. Discharge policies for such patients should be disseminated to all members of staff who see follow up patients. Some clinicians have adopted a policy of reviewing all of a clinic's cases with the doctors and nurses who will be seeing the patients during the session before the clinic actually gets underway, in order to discuss likely management plans and discharge criteria. Alternatively, an end of clinic review of patient management can be used as a way of ensuring consistency with regard to follow up and discharge. These are powerful tools for optimising and standardising outpatient care, and ensuring the delivery of training in the outpatient setting.

3. Outpatient investigation and treatment

High impact interventions:

- Make use of standardised diagnostic and treatment protocols and pathways where these have been developed by recognised expert groups
- Develop urology investigation unit facilities, where these do not already exist
- Incorporate innovations in outpatient treatments, including trans-perineal prostate biopsy, trans-urethral laser ablation of bladder tumours, peno-scrotal surgery and technologies for the relief of bladder outlet obstruction
- Ensure equitable patient access to urological outpatient investigation and treatment across the Urology Area Network footprint
- Ensure that urology investigation units are managed in a way which promotes efficient control of waiting lists, has the flexibility to expand the portfolio of interventions and supports workforce development

Context: Modern urological practice relies heavily on a portfolio of outpatient investigations and treatments. Investigations include urine tests, tests of lower urinary tract function (urodynamics), endoscopic urinary tract examinations, prostatic biopsy and an array of imaging modalities. Treatments delivered in an outpatient setting include tuition in catheter management, removal and changes of ureteric stents, instillation of intra-vesical therapies, therapeutic injections into the bladder wall, biopsy or destruction of bladder tumours, procedures to treat bladder outlet obstruction, peno-scrotal surgery and extracorporeal shock wave lithotripsy (ESWL) to treat urinary tract stones. The majority of these can be delivered in a urology investigation unit (UIU).

Development of UIUs aligns well the review recommendations from Professor Sir Mike Richards on NHS diagnostics capacity (NHS Long Term Plan): Diagnostics: Recovery and Renewal (<https://www.england.nhs.uk/publication/diagnostics-recovery-and-renewal-report-of-the-independent-review-of-diagnostic-services-for-nhs-england/>). This initiative aims to increase the availability of diagnostic services, in the face of a demand/capacity mismatch with the development of community diagnostic hubs (CDH). It explicitly supports the use of UIUs and the expansion of one-stop urology services. GIRFT believes that it would be counter-productive simply to increase diagnostic test capacity, rather than to incorporate wider service development in this initiative.

The investigation and management of the majority of patients with urological cancer is supported by evidence-based protocols. These pathways help to provide consistent, appropriate and efficient care. There is a need to develop similar protocols for common “benign” urological conditions. Researching and building these pathways will require wide consultation and professional involvement.

The Urology Investigation Unit

The design and layout of a UIU will vary, depending on anticipated workload and the estate which is available for either a new-build or adaptation. A UIU will typically consist of the following component parts:

- A reception and waiting area
- A minimum of two procedure rooms with associated facilities (including laser-proofing)
- Rooms suitable for the use of non-ionising imaging (USS) and clinical measurements (for example, urodynamic testing)
- Radiation-proofed rooms if considering ESWL, video-urodynamics or other X-ray investigations
- Consultation rooms
- Administration space, including bookings teams and waiting list management
- Separate patient and staff changing facilities
- Toilet facilities

There may be advantages in co-locating a UIU with other urology facilities such as an urgent assessment unit, outpatient clinics or inpatient wards. 'Off-site' solutions in non-acute settings have also proven to be highly effective, often with additional benefits for patients and staff in terms of ease of access, parking and a lower acuity clinical setting that creates a less stressful experience for those attending. They also have the advantage of being 'cold' sites with regard to COVID-19 infection control measures. These facilities are entirely aligned with the concept of community diagnostic hubs.

Other potential benefits of a UIU are:

- Efficient waiting list management – see below
- Excellent patient experience
- Benefits from having urology staff working together in a single facility – a vibrant hub for urology and been shown to aid staff recruitment and retention.
- Suitable for providing one-stop outpatient clinics, where consultations and investigations are carried out during a single patient attendance.

Ensuring timely care for urgent and cancer patients: Because a UIU is managed by the urology service itself, it is possible to closely track waiting times for investigations and treatments and provide a greater degree of autonomy over the use of UIU sessions to meet fluctuating demand for different interventions. Additional evening or weekend sessions are also relatively easy to organise, as compared to making such arrangements in shared facilities.

The expanding range of investigations and treatments: It is important to recognise that the scope and volume of UIU work continues to expand with an increasing migration of procedures from a theatre setting to a procedure room. Planning UIU capacity will need to account for these ongoing developments in urological care in order to future-proof the facilities. The following procedures can now be delivered in an out-patient UIU setting:

- Trans-urethral laser ablation or resection of bladder tumours (TULA)
- Bladder outlet procedures – including prostatic urethral lift and aquablation
- Trans-perineal prostatic biopsy
- Minor peno-scrotal operations, including local anaesthetic circumcision and vasectomy.

Planning UIU capacity and workforce development on a network basis: Large numbers of patients will access UIU care, many on multiple occasions. It is therefore appropriate to plan the location of UIUs with full account taken of access for the population being served. Urological services will increasingly be planned on the basis of the needs of the population served by several trusts, working together as a Urology Area Network (UAN), rather than using individual trust footprints. Care is needed to ensure that new UIU developments are sited so that the whole UAN population is able to access care without undue inconvenience. It is increasingly recognised that such planning must explicitly take account of the need to ensure that population health inequalities are not being exacerbated.

It would seem reasonable to suggest that the large majority of the population being served should be able to access a UIU that is within, say, 15 miles or 40 minutes travel time from their homes. It is also important to reaffirm that any new community-based diagnostic facilities (community diagnostic hubs or CDHs) that are developed to serve the needs of urology should do so in a way which supports the one-stop clinic and UIU models of outpatient care.

UIUs provide a productive training environment for urological nurses and other clinical practitioners, enabling extension of their repertoire of diagnostic and therapeutic procedures. There is potential for an 'academy' model of training to be offered within UIUs to healthcare professionals from across the UAN. It is vital that UIUs continue to provide excellence in training during the recovery phase from the pandemic.

4 Supporting patients who are waiting for care

High impact interventions:

- Organise regular clinician validation of waiting lists, supported by efficient IT, administration and job planning
- Ensure that patient prioritisation is based on clinical need, e.g. appropriately prioritising patients with indwelling catheters who are awaiting surgery
- Actively address problems created by very long waits, e.g. using ring-fenced lists to ensure that maximum waiting times are not breached
- Ensure patients are aware of when and where to seek further help in the event that new symptoms emerge or their condition deteriorates
- Provide waiting patients with points of contact for dealing with administrative or clinical questions, and information about how to manage their condition while waiting for treatment
- Provide waiting patients with advice on how to optimise their health ahead of an operation

Context: There is a realisation that, unfortunately, some patients will be waiting for treatments for significantly longer than is desirable, and that there is a continuing duty of care to such people. Management of people on waiting lists needs to be an active, not passive, process.

It is important to recognise that waiting list validation and management should extend beyond those who are waiting for surgical procedures. Large numbers of patients are waiting for care on non-admitted pathways. Validation of these waiting lists, combined with the use of personalised outpatient care approaches, has the potential to reduce the number of people waiting for clinic and test appointments, while providing good patient experience. This type of service transformation will, inevitably, require the input of senior clinicians and, as a result, will need to be appropriately job-planned.

Waiting list validation

The following factors mean that waiting lists will need regular validation to ensure that the most clinically urgent patients are treated first and that inter-current medical problems are accounted for:

- A change in the patient's index urological condition
- A change in the patient's general health
- A change in the expected time spent on the waiting lists (more protracted than initially thought)
- A change in access to treatment facilities – this could be due to improved access or new constraints on a service

Clinician input into waiting list validation should be structured within a department (timetabled into job plans as DCC) and must be supported by good IT and administrative infrastructure. As validation processes mature, there will be opportunities to triage the work between clinicians and administrative staff.

Prioritisation for treatment during the pandemic has been based around the FSSA guidance (https://fssa.org.uk/covid-19_documents.aspx) but now needs to become more nuanced as waiting lists and waiting times have surpassed initial expectations. Cancer patients should, rightly, be prioritised, but there are other groups that will suffer significant harm from undue waits. In urology, men waiting for bladder outflow tract surgery who have in-dwelling catheters, those needing urgent stone surgery and people with ureteric stents should all be assigned a high priority for treatment. Departments should strongly consider implementing a clinical standard whereby all catheterised men waiting for surgery are offered treatment within an agreed number of days of, for example, a diagnosis of urinary retention.

There is also a need to recognise that, even for the least urgent conditions, there should be agreed maximum waiting times. It has been recognised in urology that the pandemic effectively stopped the delivery of surgery to some groups of patients, such as those awaiting complex andrology operations.

This has had the disadvantages of temporarily de-skilling some surgeons, and preventing training taking place for subspecialist trainees.

My Planned Care and continuing care for patients who are waiting

My Planned Care is an NHSE/I programme that is being developed that will develop better ways of supporting patients who are waiting for care. While the programme will look at a range of possible initiatives, a key element will be the development of information materials that will help patients to manage their condition while they await treatment, and educate them about when and where to seek further help, in the event that new symptoms emerge or their condition deteriorates.

In urology, the largest groups waiting for surgery are men with bladder outflow obstruction who are waiting for prostate surgery, and men waiting for circumcision. As part of pilot work, groups are developing supporting material for these two groups of men.

While the My Planned Care initiative will provide useful national guides, there is a need for urology departments to start to meet the needs of waiting patients immediately. Attention should be paid to ensuring that people are aware of possible red flag symptoms that should alert them to the need for medical review, and have points of contact for dealing with either an administrative or a medical question.

A further issue that arises when there is a significant interval between someone going on a waiting list and their treatment date is the risk that there will be a change in their general health. Patients on waiting lists should be provided with advice about maintaining general fitness, weight management and control of chronic conditions, such as diabetes and hypertension, in order to reduce the risks of their surgery being disrupted or unsuccessful.

5 Delivering urological surgery

High impact interventions:

- On a Urology Area Network (UAN) basis, actively support the development and use of High Volume/Low Complexity (HVLC) surgical hubs
- Ensure that any work carried out in independent sector facilities is subject to the same review and standards as NHS facility work, and contributes to surgical training
- Establish a “daycase by default” approach for suitable urological procedures, meeting GIRFT standards for bladder outflow surgery, bladder tumour resection and ureteroscopy
- Maximise the use of local anaesthesia for urological procedures
- Ensure timely access to shock wave lithotripsy (acute and planned) for suitable patients across the UAN
- Develop an outpatient service for transurethral laser ablation/resection of bladder tumours in each unit
- Review benchmarking data and ensure that complex surgery provision complies with nationally recognised process and outcome standards, including unit and surgeon volume, length of stay and complication rates
- Ensure that urology theatre productivity meets GIRFT standards

The surgical “intensity gradient” in urology

Urology is a surgical specialty which has been at the forefront of using technological innovation to reduce the impact of surgical interventions on patients. For example, open operations to treat urinary tract stones have been replaced by ever-more sophisticated endoscopic surgery or completely non-invasive shock wave lithotripsy (ESWL). Robot-assisted surgery is now in widespread use in the specialty.

This approach continues to provide major opportunities for reducing morbidity for patients, increasing patient throughput and limiting the use of hospital beds and operating theatre time. Moving patients down a surgical intensity gradient from, at one end, major open surgical procedures to, at the other extreme, local anaesthetic outpatient procedures is one of the cornerstones of the strategy to meet the demand for urological care in the post-pandemic period.

It is vital that surgical trainees are provided with training that covers the full range of procedures, right across the intensity gradient. Training must keep pace with the evolution of urological practice, which is accelerating as a result of the pandemic. Active monitoring of log books and trainee experience is essential. Almost every operation, regardless of complexity or setting, has the potential to offer a training opportunity and it is vital that training is routinely incorporated into the recovery of elective services.

New models for providing high volume/low complexity surgical care

From early in the pandemic, it was recognised that existing main hospital services would be unable to deal with the demands of emergency, urgent and cancer patients, in addition to dealing with an increasing backlog of less urgent surgery. This led to the development of a programme to look at new ways of delivering high quality, high throughput services for high-volume/low-complexity (HVLC) surgery. For urology, with its high numbers of HVLC patients, this is particularly pertinent; addressing the HVLC issue is a further cornerstone of a recovery strategy for urological surgery.

While the approach to HVLC work is multi-faceted (see the GIRFT National HVLC Guide: <https://www.gettingitrightfirsttime.co.uk/bpl/hvlc/>), a major feature is the development of elective surgical hubs that are tailored to delivering HVLC surgery at volume, and at high efficiency. There is an urgent need for UANs to quantify their HVLC work which is already on waiting lists or is projected to arise in the future. This will allow planning of the potential urology usage of HVLC hub facilities. For an average

UAN, it is reasonable to suggest that between ten and fifteen hub operating lists could be devoted each week to HVLC work, thereby freeing up capacity in other hospital facilities.

Work has already been undertaken to standardise surgical pathways for HVLC procedures. There are five standardised urology pathways. See: <https://www.gettingitrightfirsttime.co.uk/bpl/pathways/#urology>.

Effective HVLC hub working will require workforce development, administrative support, patient information and support, and links with community services. In addition, investment in, or re-siting of, equipment will be needed in order to enable the full range of urology HVLC procedures to be undertaken; this will include access to image-intensifiers, lasers and technology for treating bladder outflow obstruction. Urologists and urology managers will need to be proactive in setting up HVLC hubs.

Urological surgery carried out in independent sector facilities

It is inevitable that many urology departments will have to augment their access to NHS facilities with work in independent sector hospitals. It is essential that such work is carried out in a way which is integrated with the department's NHS hospital work. This means that protocols, pathways and standards are shared and enforced in both environments. Selection of patients to the independent sector should avoid "cherry-picking" in case selection. Finally, the independent sector should be accessible to urological trainees so that training is not negatively affected by the use of the independent sector.

Opportunities for increased use of day surgery

Since the publication of the GIRFT Urology National Specialty Report, there has been a demonstrable increase in the proportion of urology patients being managed on a day case basis, often for commonly-performed procedures. This shift has reduced the use of inpatient beds for elective urology surgery.

Based upon national variation in clinical practice, three index operations offer a large opportunity for further shifts to day case pathways:

- TURBT - bladder tumour resection (for cases which are not suitable for TULA)
- Male bladder outflow obstruction surgery
- Ureteroscopy

The relevant GIRFT Best Practice Academy Guides (<https://www.gettingitrightfirsttime.co.uk/bpl/urology/>) on bladder cancer management, bladder outflow obstruction management and the care of patients with acute urinary tract stones, provide further detail of how day case rates can be increased. Case reports from urology departments that have successfully increased day surgery rates are provided. Likewise, the GIRFT National Day Surgery Delivery Pack (<https://www.gettingitrightfirsttime.co.uk/bpl/day-surgery/>) offers more generic guidance on optimising the delivery of day surgery.

It is important to note that increasing day case rates is usually possible through changes to staff training, policies and procedures. However, maximising day case usage will require investment, which should take place on the basis of the needs of the wider UAN, rather than on a trust-by-trust basis, in order to avoid unnecessary duplication of resources and services.

For bladder outflow tract surgery, there needs to be consideration of the range of treatment modalities that a UAN should offer, and in which hospitals equipment should be sited. Support is available through the Medical Technology Funding Mandate programme (<https://www.england.nhs.uk/aac/what-we-do/how-can-the-aac-help-me/the-medtech-funding-mandate/>) for many of these newer technologies. The aim of the programme is to facilitate procurement of equipment and commissioning of services. The network of Academic Health Science Networks (AHSN) will be providing support to networks in terms of developing the business cases and commissioning discussions for provision of these new technologies. Health Innovation Manchester AHSN will be the lead organisation for this work.

A further issue of major importance is that of how to provide services for timely removal of urinary catheters following surgery. Discharging home some patients with catheters in situ is a key step in increasing daycase rates. However, it is vital that there are facilities, either in the community or at

hospital, for timely removal of the catheter. Ensuring that patients are well-informed about managing their catheter, that advice is immediately available if needed, and that an excellent catheter-removal service is in place, are critical issues that must be addressed before a discharge-with-catheter approach is adopted.

Opportunities for increased use of local anaesthetic techniques

There is variation across England in the proportion of patients being offered appropriate operations under local anaesthetic. Increasing the use of local anaesthesia holds the potential to improve patient experience, increase patient throughput and reduce the need for general anaesthetic theatre lists and pre-operative assessment. It is also relevant to note that using local, rather than general, anaesthesia has environmental benefits. There are two stand-out opportunities: bladder tumour ablation or resection, and circumcision.

TULA: Advances in laser technology have led to the development of local anaesthetic laser ablation or resection of bladder tumours (TULA). These procedures can be carried out in an outpatient setting, typically in a urology investigation unit (UIU). The procedures appear to be better-tolerated than diathermy ablation and has scope to treat larger tumours, with the added advantage that anti-coagulation does not need to be stopped. This procedure also lends itself to the biopsy and cautery of 'red patches' in the bladder – a large proportion of such procedures are still done under GA in England and the routine use of this practice should be discontinued and replaced with a local anaesthetic approach. This approach is suitable for a proportion of bladder tumours and is described in more detail in the GIRFT Good Practice Academy Guide "Towards better care for people with bladder cancer" (https://www.gettingitrightfirsttime.co.uk/wp-content/uploads/2022/01/Urology_2022-01-12_Guidance_Bladder-cancer.pdf). There is now a strong case to support a roll-out of this technology, moving a large number of bladder cancer patients from general anaesthetic surgery to an outpatient local anaesthetic procedure. As a minimum, each urology unit in England should implement a TULA service, with larger units considering a TULA service on multiple sites where their geography covers a number of hospitals.

Circumcision: This procedure lends itself to the use of local anaesthetic, particularly in older men. There are examples across England where a local anaesthetic approach is the default and is used to treat in excess of 95% of men undergoing circumcision. However, many urologists continue to rely on general anaesthesia for the procedure, despite the excellent outcomes and patient experience reported by those using local anaesthetic. There is an opportunity to move substantial numbers of patients to local anaesthetic circumcision, with obvious benefits in terms of use of resources. Such a shift in practice will need to be supported by high quality patient information materials and additional training for surgeons who are not familiar with using local anaesthetic for circumcision. The operation can be safely performed in a suitable procedure room, rather than in a fully-equipped operating theatre, releasing theatre capacity for patients requiring surgery under a general or regional anaesthetic.

Increasing the use of non-invasive treatments

The NHS has invested in the provision of lithotripters for the treatment of urinary tract stones. However, this resource remains under-utilised because of poor pathways for inter-trust transfer of care. This problem affects both acute and elective ESWL.

There is a need for ESWL provision to be reviewed on a UAN basis to ensure that the capital investment in lithotripters is providing maximum patient and economic benefit. One barrier that must be overcome is that of staffing. Working across a UAN, staffing models should be developed that will allow ready access to ESWL, thereby increasing lithotripter use and diverting patients away from ureteroscopy and other surgical approaches.

Further guidance can be found in the GIRFT Best Practice Academy guide "Towards better care for patients with acute urinary tract stones" (https://www.gettingitrightfirsttime.co.uk/wp-content/uploads/2022/01/Urology_2022-01-12_Guidance_Acute-stones.pdf).

Opportunities for increasing theatre productivity

It has long been recognised that theatre productivity varies greatly between NHS hospitals. GIRFT has been instrumental in developing theatre data dashboards to allow trusts to monitor performance against national standards ([London S \(gettingitrightfirsttime.co.uk\)](https://www.gettingitrightfirsttime.co.uk)). GIRFT visits have provided anecdotal evidence of deteriorating productivity as a result of pandemic-related protocols and poor staff morale. Using theatre dashboards to benchmark performance will be a key early step for trusts. Outliers with poor theatre productivity will be readily identified, allowing detailed analysis and quality improvement work to be put in place.

There are a number of aspects of theatre productivity enhancement that are important. Firstly, there are estimates of the numbers of different procedures that are expected to be carried out on an operating list. This provides an opportunity to benchmark a trust's theatre productivity against a national standard. Secondly, there is support for widening the working scope of different members of the workforce. Urology has already been innovative in the way that, for example specialist nurses undertake many invasive procedures and operating department assistants contribute to robot-assisted surgical operations. However, it is clear that this approach can be broadened and further innovation, with appropriate governance in place, will be supported.

6 Delivering high quality and efficient emergency care

High impact interventions:

- Ensure that hands-on consultant input is central to emergency care
- Ensure that primary care colleagues have ready access to emergency and urgent urological advice
- Ensure that hot clinics are available to help reduce avoidable admissions to hospital
- Consider establishing a Urology Assessment Unit
- Review and adopt relevant pathway improvements from the GIRFT Academy Guides, such as the actions in the acute urinary tract stone management guide

Although there is a strong focus on the need to manage unmet elective need and waiting list backlogs, it is important to recognise that efficient, well-organised emergency care services will maximise the resources that are available for elective care. GIRFT departmental deep-dive re-visits are showing that there has been substantial progress in the care of emergency urology patients. However, there remain many units with more work to do in order to optimise emergency care.

Hands-on consultant involvement in urological emergency care

Direct involvement of consultants in urology emergency care is now the expected standard of care and should follow the principles outlined below:

- A 'consultant of the week' model is widely adopted as the current standard of care
- This provides daily consultant ward rounding, senior decision-making and continuity of care
- The consultant should be freed of their normal elective commitments
- Timetabling may include 'hot clinics' and emergency operating lists
- Daily provision of specialist advice and referral triage by consultants can ensure timely support for primary care colleagues
- This model offers excellent opportunities for teaching the trainee workforce

Providing emergency and urgent advice, and alternatives to admission

For too long, it has been accepted that emergency urology care follows a model where all patients with emergency urology conditions are sent for hands-on urology assessment by the on-call urology team. For many patients, this approach is inappropriate and alternative ways of receiving assistance can provide excellent outcomes and better patients experience:

- Ensure that primary care have access, via telephone or email, to urgent clinical advice
- Manage suitable patients on non-admitted pathways with appropriate clinical advice
- This will include protocols agreed with the Emergency Department for conditions such as uncomplicated ureteric colic and urinary retention
- This may include assessment in a 'hot clinic' or Assessment Unit
- If a patient requires attendance at the hospital, or admission to hospital, this should be organised without the need for a further referral from primary care.
- A unit should run at least two hot clinics per week, in order to avoid waits to be seen of more than a few days. The clinic needs to be supported by nurses with relevant urological expertise

Flexibility is needed, with respect to the way hot clinics are organised. They can be used not only to divert potential emergency admissions, but also to allow safe, early discharge of selected inpatients who can leave hospital with the safety net of guaranteed early clinic review in place. For example, where a wound check is required or a drain needs to be removed. Once again, it is vital that hot clinics are viewed as training opportunities for doctors, nurses and associates.

Urology Assessment Units

A number of urology departments have developed Urology Assessment Units (UAUs) where emergency patients undergo assessment that allows a decision to be made, either to admit them for inpatient emergency care or to discharge them home with on-going outpatient care, if needed.

Particular success has been reported where urology specialist nurses undertake the initial assessment of patients in the UAU. Many acutely attending urology patients have problems that can be well-managed using protocolised care, or with relatively straightforward interventions, such as changing a catheter or flushing a nephrostomy tube. This allows appropriate patients to be managed by urology nurses, without involving on-call urology doctors.

Having a designated UAU facility allows further valuable extended-roles to be put in place. For example, in some departments, specialist nurses who are staffing the UAN are also responsible for taking calls from patients on an advice line that is made available, for example, to post-operative patients who might have concerns following discharge from hospital. Such units also provide excellent opportunities for training, which should not be overlooked.

A further role for UAUs is to provide an alternative to a hot clinic appointment for people who require early assessment following discharge from hospital or after attendance in the emergency department or on the UAU itself.

Acute stone services

Context: The need to improve the care of patients presenting with acute urinary tract stone problems, such as ureteric colic patients with severe pain and possible obstructed drainage of urine from a kidney, has been widely acknowledged by UK urologists as an area requiring focused attention. Trusts need to ensure that there is adequate access to emergency theatre facilities and that these are laser-enabled, in terms of both equipment and staffing.

This topic has recently been looked at in depth, resulting in the publication of the GIRFT Best Practice Academy Guide: Towards better care for patients with acute urinary tract stones (https://www.gettingitrightfirsttime.co.uk/wp-content/uploads/2022/01/Urology_2022-01-12_Guidance_Acute-stones.pdf). Key quality actions in the document are:

Provision of an effective Acute Stone Service

- Define the membership of the Acute Stone Service, and their roles
- Develop standard operating procedures for the service
- Plan workforce development to build up service expertise and resilience

Ensuring a patient-centred approach with improved shared decision-making and access to a full range of treatments

- Review sources of patient information and access to patient-decision aids to enable fully informed shared decision-making
- Ensure patients have acute lithotripsy available with timely access, if needed
- Ensure patients have primary ureteroscopy available with timely access, if needed

Provide prompt and responsive diagnostic and interventional radiology services, and support for network-level interaction

- Review arrangements for emergency CT scanning of patients with suspected acute urinary tract stones
- Ensure that investigation protocols build in protections against patients being exposed to inappropriate ionising radiation

Ensuring early diagnosis and treatment of infection with expedited definitive stone treatment

- Ensure that all staff managing acute stone patients are aware of the risks of the combination of urinary obstruction and infection
- Ensure that the pathways followed by a patient with urinary obstruction deliver effective treatment within appropriate timescales

- Ensure that protocols are in place that guarantee 24/7 access to interventional radiology services within the urology area network

Avoiding placement of temporising ureteric stents with deferred definitive treatment of an obstructing stone

- Ensure that emergency ureteric stent placement is not used as a temporising measure when definitive stone treatment is the appropriate approach

Using stone service resources effectively

- Establish protocols that enable suitable acute stone patients to be managed at home, with appropriate support
- For patients who return for ureteroscopic surgery, use day case pathways as the default option

Urinary retention services

The GIRFT analysis of national data and departmental visits have identified the management of patients with urinary retention as a further area that deserves specific attention. It is widely accepted that men with urinary retention are often subjected to long, multi-stage care pathways which leave them either severely symptomatic or living with an indwelling catheter for excessive periods of time. There is a need for every urology department to review their approach to this condition and re-engineer the service to provide early decision-making, streamlined pathways and timely delivery of surgical treatment, where that is needed.

7 Supporting a system-based recovery

High impact interventions:

- Identify and formalise the Urology Area Network (UAN) arrangement for every urology unit
- Establish and support the administrative and managerial arrangements that will underpin UAN working
- Ensure provision of adequately funded clinician input
- Work on practical areas of networking in order to realise some early benefits
- Ensure that staff are “passported” to work across the UAN
- Ensure that bids for estate or equipment are consistent with the strategic vision of the UAN

There is no doubt that it is no longer possible to plan and organise comprehensive urology services on the basis of the population footprint of average sized NHS hospital trusts. A larger population base is needed to support many sub-specialist services, to facilitate workforce development and to maximise value for money from investment in equipment and estate. For these reasons, the concept of Urology Area Networks (UANs) was developed in the 2018 GIRFT Urology National Specialty Report.

Urology Area Networks

UANs are groups of between one and four trusts that collaborate in order to provide near-comprehensive urology services in a clinically-effective and resource-efficient way. Efforts have been made, through GIRFT and BAUS, to map the make-up of UANs across England. This has been a critical step, as collaborative working can only be reliably developed once all-concerned know which trusts are working together. The current understanding of this map of UANs is set out in Appendix 2. It is acknowledged that is not yet a definitive picture as not all trusts are engaged in UAN development, so that some UANs have yet to be agreed and formalised. The organisation of trusts into UANs is largely consistent with the country’s distribution of Integrated Care Systems (ICs), but there are some UANs that straddle ICs boundaries.

It is abundantly clear that not all UANs will offer all sub-specialist services. For example, services for the rarer urological cancers are organised on a regional basis. In addition, UANs inevitably have somewhat porous boundaries with some cross-referral of patients between UAN districts, either through patient choice or clinical need.

Establishing a UAN: The benefits of UAN collaboration will only be realised if UAN working is underpinned by clinician commitment, and managerial and administrative support. A UAN therefore needs to be a formal entity, with appropriate oversight and governance arrangements. These issues are explored in more detail in the GIRFT guide to establishing a UAN (Getting It Right in Urology: <https://www.gettingitrightfirsttime.co.uk/wp-content/uploads/2020/09/GIRFT-Urology-Innovations-OCT2020.pdf>).

It is important to establish early practical impacts of UAN working. These might include passporting of staff (including trainees) to allow individuals to work on all of the UAN hospital sites, developing agreed protocols that cover all of the UAN departments, improving UAN-wide access to fixed-site lithotripters and developing unified services for smaller sub-specialties, such as female, neurological and andrological urology.

The benefits of networking in urology

There are many potential benefits of working within a UAN arrangement. These include:

Sustaining and developing sub-specialist services

GIRFT deep-dive visits have revealed the patchy and variable availability of sub-specialist services, particularly for andrology, male reconstructive urology, female urology and neurological urology. Without

access to a large population base, these services aren't viable. This problem is overcome by developing such services on a UAN-wide basis.

Even where there are existing sub-specialist services there are benefits to networking in enhancing service-resilience. For example, by avoiding having a service supported by a single surgeon, enabling more robust multi-disciplinary team working and the avoidance of duplication of services where several nearby units carry out small volumes of complex operations.

Delivering mutual aid

The post-pandemic waiting list backlog is known to be very variably distributed. Some trusts have been able to avoid a large build-up of work, while others have almost insurmountable backlogs. Mutual aid is the process of using inter-trust collaboration better to match capacity and demand across a region. UAN working greatly facilitates the use of mutual aid as there is an established culture of inter-trust movement of patients and staff.

Workforce retention and development

A UAN has a role in ensuring that an effective and resilient urology service can be provided across an area. Retaining and enhancing the urological workforce is fundamental to achieving this aim. Posts can be made more attractive to potential candidates by addressing issues, such as on-call intensity and access to a subspecialty practice, by developing job plans that include working in more than one trust and rationalising on-call work.

It is vital that new generations of doctors, nurses and allied professionals are attracted into urology. Establishing high quality, well-structured training programmes is facilitated by drawing on training opportunities from across a UAN, rather than from within a single trust.

Equipment and estate procurement and use

There is a need to make full use of the capital that has been invested in existing estate and equipment. Rational use of facilities, without unnecessary duplication of services, can be enhanced by designing services that meet patient needs across a UAN. GIRFT deep-dive visits have shown that there are substantial problems in terms of under-utilisation of some equipment, notably some fixed-site lithotripters, while a lack of equipment is leading to inefficiency and poor patient choice in other cases. For example, the patchy availability of new technologies for treating male bladder outflow obstruction is limiting the use of day surgery for such work.

It is anticipated that there will be further injections of capital to help treat the post-pandemic backlog. It is incumbent on all concerned to ensure that such funding is used as a true investment which will produce long-term benefits, rather than being restricted to spending on short-term measures, such as waiting list initiatives. In order to produce compelling bids, that will be able to demonstrate robust expectations of long-term benefit, evidence that there will be UAN-wide gains is likely to be an important consideration. For example, a bid for development of a new Urology Investigation Unit will be strengthened by being able to demonstrate how it would meet unmet need by filling a gap in the distribution of such units across a UAN, not just within a trust catchment area.

As always, planning needs to take into account the importance of using investment to reduce inequality of access to services and target improving outcomes in deprived areas. Working on a UAN footprint will aid the delivery of the reducing inequalities agenda.

8 Supporting the urological workforce

High impact interventions:

- Ensure mechanisms are in place to improve staff wellbeing across the urological workforce and mitigate risk of post-pandemic burnout, e.g. by supporting flexible working patterns, where appropriate
- Develop a UAN-wide strategy for workforce retention that is applicable to all staff groups. Focussing on those who are considering leaving the profession and addressing disincentives that are contributing to their decision-making

The pandemic's impact on the NHS workforce is, of course, one of the critical factors that will determine the speed and success of service-recovery. Staff welfare and morale need to be actively addressed as one of the key priorities within any strategy for re-establishing services. This is an area which is critical for urology, where there were existing concerns about the lack of workforce resilience, in terms of numbers of staff, prior to the onset of the pandemic. The following paragraphs set out some of the ways in which the urology workforce can be supported and developed.

Supporting the urological workforce

The impact of the pandemic imposed a significant strain on all healthcare workers. It is important to recognise the extent to which nursing and theatre staff have been re-deployed and placed under considerable, persisting strain. Rebuilding a team ethos will be needed in many urology departments. It would seem short-sighted to expect this to happen as an "organic", passive process. Active measures to re-establish cohesion in the urology workforce might include holding specific team-development days and training sessions. The workload involved in building such initiatives could be spread more widely by setting them up on a UAN basis, rather than their being self-contained within each urology unit.

There is no doubt that urologists in training have been particularly badly affected by the pandemic, with many lost training opportunities adding to the more general impacts of COVID-19. The following paragraphs signpost generic support for all staff, but are also important in supporting trainees.

The GMC National Training Survey 2021 indicates that 18% of urology trainees and 14% of trainers are at high risk of burnout, both higher than the national average. Looking at junior doctors, possibly exacerbated by the pandemic, there has also been a shift in working patterns, with more opting for flexible training. The most recent data from HEE estimates that 9% of urology trainees are working less than full time (LTFT), compared with 3% in 2015. In 2019/20, 6.6% took a year out of programme. This may be on account of a range of personal and professional reasons, such as improved wellbeing, better work-life balance or opportunities to develop portfolio careers.

It is important to ensure that mechanisms are in place to actively address staff welfare, as well as support different ways of working. There are a number of ongoing initiatives that aim to improve the health, wellbeing and working lives of all staff. Examples of these are:

- The NHS Health and Wellbeing Framework provides a toolkit for NHS organisations to embed a culture of health and wellbeing (<https://www.england.nhs.uk/publication/nhs-health-and-wellbeing-framework/>).
- The NHS Staff and Learners' Mental Wellbeing Commission has developed a series of recommendations based on reviewing evidence of good practice where the health and wellbeing of staff and learners has been made an organisational priority: (<https://www.hee.nhs.uk/sites/default/files/documents/NHS%20%28HEE%29%20-%20Mental%20Wellbeing%20Commission%20Report.pdf>)
- The Enhancing Junior Doctor Working Lives programme was established by HEE in 2016 to address issues that are having a negative impact on the quality of life of doctors in training. The fifth progress report is in development and includes initiatives such as no longer requiring eligibility

criteria to work LTFT, Out of Programme Pause and Flexible Portfolio training. (<https://www.hee.nhs.uk/sites/default/files/documents/EJDWL%202021%20Progress%20Report.pdf>)

- Wellbeing webpages are available via HEE and the BMA, to signpost learners and trainees to support. They are available nationally and locally, including regional Professional Support Units. (<https://www.hee.nhs.uk/coronavirus-covid-19/wellbeing>)
(<https://www.bma.org.uk/advice-and-support/your-wellbeing>)

Strategies for retaining staff

There is concern that the rate at which staff leave the NHS and retire from practice will accelerate in the post-pandemic period. It is particularly important that flexibility is shown in the approach to staff who are considering leaving urology posts. Retire and return, and other approaches, can enable people to find a way of continuing to contribute, and avoid either leaving or working on under a cloud of symptoms of “burn-out”.

There is a need to take a proactive approach to identifying the issues that are making professional life more frustrating and difficult for those who are considering leaving the profession. Addressing such issues is likely to encourage staff to continue to contribute, and to do so with a greater degree of professional satisfaction and well-being.

9 Developing the urological workforce

High impact interventions:

- Develop a UAN-wide strategy for workforce development applicable to nursing and allied health workers, staff and associate specialists, trainee urologists and consultants
- Be proactive in developing and implementing strategies to overcome any pandemic-induced training deficits across all aspects of the urology curriculum
- Ensure all urology departments focus on integrating service and training recovery, e.g. by ensuring trainee involvement in HVLC hub activity as well as exposure to high complexity/low volume procedures
- Ensure that a high priority is given to providing a robust appraisal service for all staff

Supporting urological training

The current generation of surgical trainees has lost many training opportunities as a result of the need to cover unfilled rotas and through the cancellation of much elective surgery. It is estimated that over 2.2 million fewer elective operations have taken place since March 2020. It is crucial that we act now to mitigate the effects of the pandemic on trainees – not only are they critical for current service delivery, but delays in the training pipeline will lead to unfilled consultant posts and a demoralised workforce.

A proactive approach needs to be taken to prioritise training, with all urology departments focused on integrating service and training recovery. The Joint Committee of Surgical Training (JCST) has released Maximising Training guidance, which highlights the importance of surgical training and provides practical solutions for everyone involved in surgical services. (<https://www.jcst.org/key-documents/>). We can also learn from other specialties who have implemented innovative solutions: Health Education England have shared examples of best practice as part of their COVID-19 Training Recovery Programme (<https://www.hee.nhs.uk/covid-19/training-recovery-case-studies>).

Recommended interventions to restore urological training include:

- Creating an individualised training plan following a 1:1 conversation between a trainee and Educational Supervisor/ TPD – this could include work schedule planning to ensure that there are regular dedicated outpatient, theatre, ward round and MDT training opportunities
- Ensuring training takes place in all settings where NHS patients are seen, including the independent sector
- Enabling movement of trainees within UANs to facilitate acquisition of curriculum competencies, ensuring equitable access to subspecialty exposure such as robotics and paediatrics.
- Optimising the use of technology in educational delivery such as simulation training and virtual teaching programmes
- Using UIUs as an ideal training environment for trainees early in the training pathway to gain core diagnostic and therapeutic skills
- Adopting a mindset where “every case is a training case” with all operating lists having a trainee allocated to them. Some additional ways in which training can be optimised in theatre include:
 - o Creating themed operating lists so that trainees can learn by repetition
 - o Involving trainees in planning of theatre lists to allow selection of appropriate cases
 - o Doubling up trainees to allow individuals at different stages of training to benefit from different parts of a case
 - o Incorporating training into the theatre briefing at the start of every operating list
 - o Increasing learning opportunities through trainee involvement in weekend and evening theatre lists, where possible
- HVLC hubs provide an excellent opportunity to align service and training recovery and may also allow opportunities for involvement in quality improvement projects

- Regular, robust departmental teaching
- Maximising learning opportunities during on-call and emergency take – this could be facilitated by aligning a consultant of the week with a registrar of the week to maintain continuity and accelerate learning
- Creating a ‘Chief Registrar’ role, providing an opportunity for leadership development and assistance in bridging the gap between service delivery and training needs

Supporting Urology Specialist Nurses and Allied Professionals

Urology has an excellent record in developing the roles of specialist nurse and allied professionals. Specialist nurses in particular now deliver a substantial proportion of outpatient assessment, investigation and treatment work. The GIRFT Urology National Specialty Report identified the need to structure the training of specialist nurses for enhanced roles in urology, and move to ensure that sufficient numbers of nurses were being attracted to the specialty. This remains work in progress but must be seen as a continuing priority.

As described above, there is merit in designing training programmes for nurses and allied health professionals on a UAN-wide basis in order to maximise the breadth and quality of such training. Developing an “academy” approach to cross-UAN training is particularly attractive. The development of UIUs and Urology Assessment Units provides facilities that are particularly well adapted to providing training to specialist nurses and associates.

Supporting Specialty, Associate Specialist and Locally Employed Doctors

For many years, Staff and Associate Specialist (SAS) doctors have made up a large part of the urology workforce. Too often, the potential for these doctors further to develop their contribution has not been taken. This has led to frustration for some SAS doctors and a loss to the NHS through the underdevelopment of this important resource. The projected shortfall in consultant numbers means that there is an even greater need to encourage career progression for SAS doctors. Such progression can be through accreditation with a Certificate of Eligibility for Specialist Registration (CESR) or the development of focussed areas of independent practice.

Measures to support and develop SAS doctors include:

- The provision of formal educational supervision within the unit with regular appraisal
- Access to study leave funding and courses, including regional teaching and training sessions
- Flexibility in the working week to gain the necessary range of clinical experience
- Passporting within a UAN to facilitate broadening experience and expertise
- Provision of opportunities to develop and participate in audit, quality improvement projects and research
- Development of managerial experience and appointment to appropriate leadership roles

Reinforcing staff appraisal

The routine appraisal of all NHS staff has become a key mechanism for ensuring that the all employees have the opportunity to reflect on their personal contribution and, critically, on their ability to develop further knowledge and skills that will allow them to offer more, and increase their job-satisfaction. However, because the value of appraisal is not immediately obvious, there is a continuing risk that delivering high-quality appraisals is undervalued.

It is essential that a high priority is given to ensuring that appraisals take place and that they are of high-quality. Traditional boundaries between professional groups are increasingly blurred, particularly in urology, and extended role working is now commonplace. However, these workforce developments are not obvious to all members of the urology team. Appraisal is an avenue to expanding the ambition of those who work in the specialty.

10 Supporting urological research

High impact interventions:

- Review current trust and UAN research infrastructure in terms of job plans, workforce and estate
- Develop an active strategy to maintaining, or enhancing, the contribution to the national research effort
- Ensure that patient participation in research is facilitated by using new technologies, such as remote consultations
- Ensure that clinical colleagues across the UAN are regularly updated with a list of open clinical trials, entry criteria and the contact details of those running the study

Urology, as a specialty, has made a substantial and successful contribution to the national research effort. In particular, there has been strong recruitment into national clinical trials, especially those conducted through the National Institute for Health Research. Units that have been especially successful have a combination of strong clinical leadership in research and a research infrastructure with expert research nurses and allied professionals.

There is a risk that post-pandemic pressures will push research contributions down urology departments' agendas. This risk needs to be acknowledged and actively managed. This will involve research funding being protected, largely through continuing recruitment of patients into clinical trials, and the maintenance of protected research time for clinicians. In the long-term, maintaining research infrastructure will be cheaper and more efficient than having to rebuild damaged research capacity.

The re-evaluation and re-setting of services that the pandemic has necessitated is an opportunity for urology units to look at their existing research activity and to examine ways in which it can be made more efficient and further expanded. There is an opportunity for research-successful departments to share their recipe for success with units that wish to contribute more effectively. Consideration should be given to:

- Ensuring that research staff have appropriate contracts in order to provide access to HVLC surgical hubs within the Urology Area Network (UAN) in order to screen lists and undertake consent/research activities (including in the private sector if applicable)
- Inviting colleagues across the UAN to participate in recruiting and planned studies, especially where patients may be seen or treated in a different location to usual
- Circulating research findings, guideline updates, and new evidence to promote, support and implement recommended changes to clinical practice across the UAN

11 Additional good practice case studies

Previous GIRFT Urology publications have included a number of illustrative case studies which provide examples of good or innovative clinical practice. These can be found in the GIRFT Good Practice Handbook and in the GIRFT Academy series of urology guides (<https://www.gettingitrightfirsttime.co.uk/bpl/urology>).

The GIRFT team will welcome similar short case studies from colleagues that report quality improvement initiatives. These, and further commissioned studies, will be included in future editions of this manual.

12 Additional information

Recommended document	Link or reference	Overview
GIRFT Urology National Specialty Report	https://www.gettingitrightfirs.time.co.uk/girft-reports/	A comprehensive review of urology services in England, including wide-ranging recommendations for the future development of the specialty.
GIRFT Best Practice Academy Guide on Outpatient Transformation	https://www.gettingitrightfirs.time.co.uk/bpl/urology/	A practical guide to “modernising” urological outpatient activity, with recommendations that should lead to greater service efficiency.
GIRFT Best Practice Academy Guide: Towards better care for patients with bladder cancer	https://www.gettingitrightfirs.time.co.uk/bpl/urology/	A practical guide to improving the care provided to bladder cancer patients, including proposals to reduce day case and inpatient operation numbers, and reduce waiting times for treatment.
GIRFT Best Practice Academy Guide: Towards better care for patients with bladder outlet obstruction	https://www.gettingitrightfirs.time.co.uk/bpl/urology/	A practical guide to improving the management of patients with bladder outflow obstruction, including recommendations to increase the use of day surgery
GIRFT Best Practice Academy Guide: Towards better care for patients with acute urinary tract stones	https://www.gettingitrightfirs.time.co.uk/bpl/urology/	A practical guide to improving the care of patients with acute urinary tract stone problems, including proposals to increase the quality of care, while reducing avoidable operations.
GIRFT HVLC Guide	https://www.gettingitrightfirs.time.co.uk/bpl/hvlc/	A generic GIRFT guide that establishes principles for re-establishing and improving surgical care for patients undergoing common, but relatively straightforward procedures.
GIRFT HVLC update	https://www.gettingitrightfirs.time.co.uk/bpl/hvlc/	An update that builds on the use of HVLC surgical hubs and ways of improving operating theatre efficiency.
GIRFT Getting It Right In Urology: Innovations, good practice and guidelines for establishing a urology area network	https://www.gettingitrightfirs.time.co.uk/bpl/urology/	A two-part publication providing a detailed discussion on the issues to address in setting up a Urology Area Network and, secondly, a series of case studies that illustrate innovation in delivering urology services.
NHS Delivery plan for tackling the COVID-19 backlog of elective care	https://www.england.nhs.uk/coronavirus/publication/delivery-plan-for-tackling-the-covid-19-backlog-of-elective-care/	A publication that sets out the broad NHS approach to tackling the post-pandemic backlog of elective care.
National day surgery delivery pack	https://www.gettingitrightfirs.time.co.uk/bpl/day-surgery/	A definitive guide to delivering increasing volumes of day surgery operations.
London COVID-19 Deliberation	https://www.england.nhs.uk/london/our-work/patient-and-public-involvement-reports/london-covid-19-deliberation-report/	A report of a large survey of opinion in London, providing a patient voice to the issues.
Clearing the backlog caused by the pandemic	https://committees.parliament.uk/work/1414/clearing-the-backlog-caused-by-the-pandemic/	A Health and Social Care Select Committee report, covering the issues that need to be addressed in rebuilding care after the pandemic.
Journal of Clinical Urology series on quality improvement	https://journals.sagepub.com/doi/pdf/10.1177/20514158211062469	A series of articles that describe how urology quality improvement projects and programmes should be approached.
National Clinical Validation Programme: Outpatient/Non admitted Waiting List Operational Guide	Elective Care Recovery and Transformation Team (In preparation)	Official NHS guidance on outpatient and non-admitted waiting list validation.
Provider Guidance to Plan a Personalised Outpatient Model	Elective Care Recovery and Transformation Team (In preparation)	NHS guidance on using new models of outpatient follow up to reduce the need for standard outpatient follow up appointments

Med Tech Funding Mandate Policy 2022/23	https://www.england.nhs.uk/publication/medtech-funding-mandate-policy-2022-23-guidance-for-nhs-commissioners-and-providers-of-nhs-funded-care/	Guidance on medical technology adoption in bladder outlet surgery
Referral Assessment Service – NHS e-Referral guidance	https://digital.nhs.uk/services/e-referral-service/document-library/referral-assessment-services	A guide to Referral Assessment Services (RAS)
Advice and Guidance services	https://www.england.nhs.uk/publication/advice-and-guidance-high-impact-intervention-guides/	Short guides designed to help teams get the most from Advice and Guidance services by setting out practical advice, key actions and information.
Health and Wellbeing Framework	https://www.england.nhs.uk/publication/nhs-health-and-wellbeing-framework/	Toolkit to support NHS organisations to embed a culture of health and wellbeing
NHS Staff and Learners' Mental Wellbeing Commission recommendations	https://www.hee.nhs.uk/sites/default/files/documents/NHS%20%28HEE%29%20-%20Mental%20Wellbeing%20Commission%20Report.pdf	The NHS Staff and Learners' Mental Wellbeing Commission has developed a series of recommendations based on reviewing evidence of good practice where the health and wellbeing of staff and learners has been made an organisational priority
Enhancing Junior Doctor Working Lives	https://www.hee.nhs.uk/sites/default/files/documents/EJDWL%202021%20Progress%20Report.pdf	Established by HEE in 2016 to address issues that are having a negative impact on the quality of life of doctors in training. The fifth progress report is in development and includes initiatives such as no longer requiring eligibility criteria to work LTFT, Out of Programme Pause and Flexible Portfolio training
BMA Wellbeing webpages	https://www.hee.nhs.uk/coronavirus-covid-19/wellbeing https://www.bma.org.uk/advice-and-support/your-wellbeing	Wellbeing webpages are available via HEE and the BMA, to signpost learners and trainees to support available nationally and locally, including regional Professional Support Units.
HEE best practice examples as part of COVID-19 Training Recovery Programme	https://www.hee.nhs.uk/covid-19/training-recovery-case-studies	Case studies to support recovery of training.

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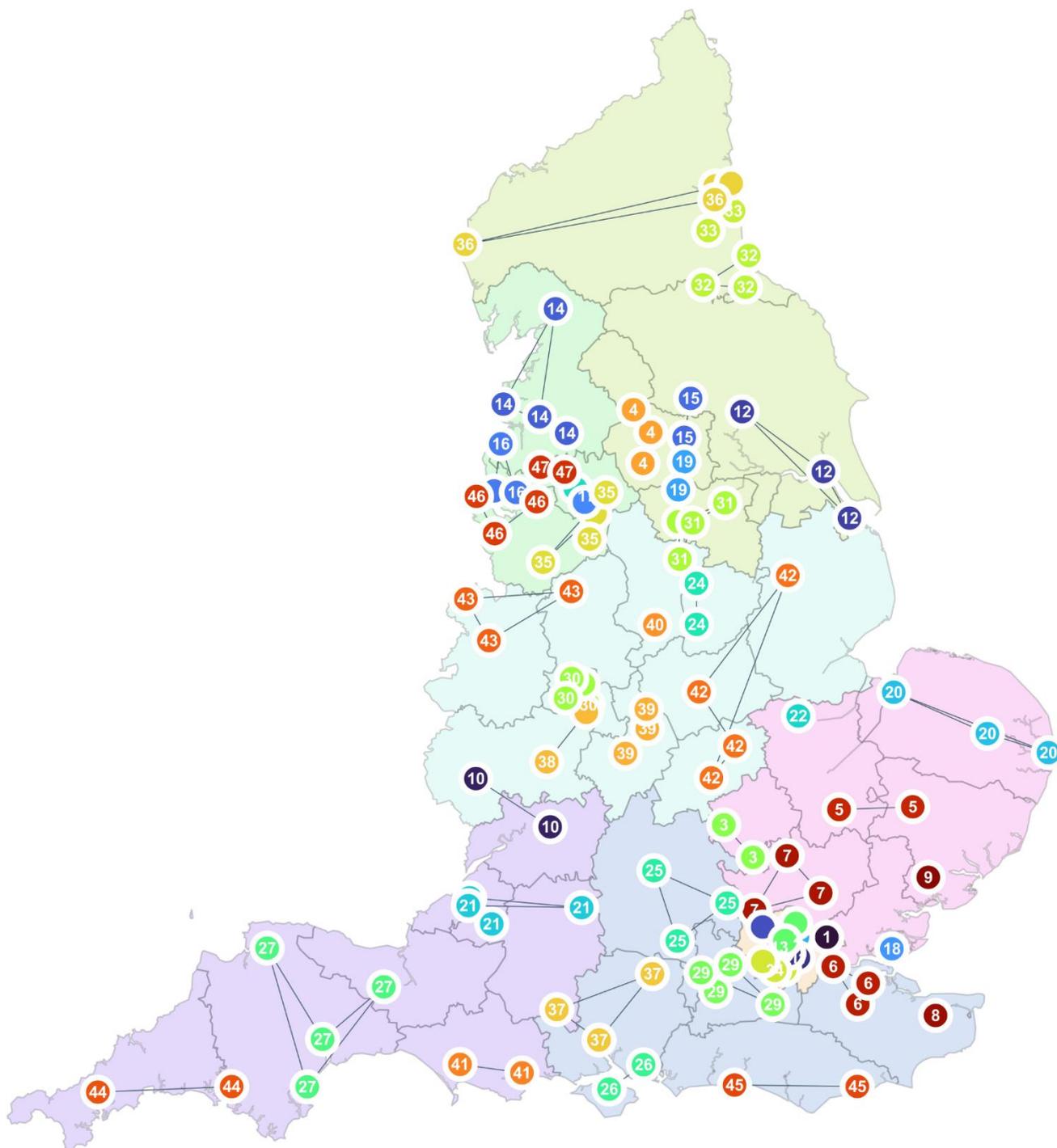
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Appendix 1: Core recommendations from the GIRFT Urology National Specialty Report (2018)

1. Develop a structured training curriculum for specialist urological nurses and establish accredited training departments.
2. Review specialist nursing job plans within trusts and ensure that the nursing team has the appropriate mix of grades of staff to ensure that specialist nurses are as productive as possible.
3. Increase the provision of Urological Investigations Units (UIUs), providing a dedicated resource for urological outpatient care.
4. Review follow-up rates against 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 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 across the specialty to providing appropriate 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 is collected that is relevant and has 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.

Appendix 2: Urology Area Networks in England

Note: This table sets out GIRFT's current understanding of the likely arrangement of trusts into UANs, based on a GIRFT consultation with trusts and a BAUS survey. It is published with the recognition that not all of the collaborative trust groupings have been agreed, let alone formalised. The table is therefore subject to future change. However, it demonstrates that those commissioning and investing in urology services will, increasingly, be in discussion with approximately 47 UANs, rather than about 130 individual trusts.



1	Barking, Havering and Redbridge University Hospitals NHS Trust
2	Barts Health NHS Trust; Homerton University Hospital NHS Foundation Trust
3	Bedfordshire Hospitals NHS Foundation Trust; Milton Keynes University Hospital NHS Foundation Trust
4	Bradford Teaching Hospitals NHS Foundation Trust; Calderdale and Huddersfield NHS Foundation Trust; Airedale NHS Foundation Trust
5	Cambridge University Hospitals NHS Foundation Trust; West Suffolk NHS Foundation Trust
6	Dartford and Gravesham NHS Trust; Maidstone and Tunbridge Wells NHS Trust; Medway NHS Foundation Trust
7	East and North Hertfordshire NHS Trust; West Hertfordshire Hospitals NHS Trust
8	East Kent Hospitals University NHS Foundation Trust
9	East Suffolk and North Essex NHS Foundation Trust
10	Gloucestershire Hospitals NHS Foundation Trust; Wye Valley NHS Trust
11	Guy's and St Thomas' NHS Foundation Trust; Lewisham and Greenwich NHS Trust; King's College Hospital NHS Foundation Trust
12	Hull and East Yorkshire Hospitals NHS Trust; Northern Lincolnshire and Goole NHS Foundation Trust; York Teaching Hospital NHS Foundation Trust
13	Imperial College Healthcare NHS Trust; The Royal Marsden NHS Foundation Trust; Chelsea and Westminster Hospital NHS Foundation Trust; London North West University Healthcare NHS Trust; The Hillingdon Hospitals NHS Foundation Trust
14	Lancashire Teaching Hospitals NHS Foundation Trust; East Lancashire Hospitals NHS Trust; Blackpool Teaching Hospitals NHS Foundation Trust; University Hospitals Of Morecambe Bay NHS Foundation Trust
15	Leeds Teaching Hospitals NHS Trust; Harrogate and District NHS Foundation Trust
16	Liverpool University Hospitals NHS Foundation Trust; St Helens and Knowsley Hospitals NHS Trust; Southport and Ormskirk Hospital NHS Trust
17	Manchester University Hospitals NHS Foundation Trust; The Christie NHS Foundation Trust
18	Mid and South Essex NHS Foundation Trust
19	Mid Yorkshire Hospitals NHS Trust; Barnsley Hospital NHS Foundation Trust
20	Norfolk and Norwich University Hospitals NHS Foundation Trust; The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust; James Paget University Hospitals NHS Foundation Trust
21	North Bristol NHS Trust; Royal United Hospitals Bath NHS Foundation Trust; University Hospitals Bristol and Weston NHS Foundation Trust; Great Western Hospitals NHS Foundation Trust
22	North West Anglia NHS Foundation Trust
23	Northern Care Alliance NHS Foundation Trust
24	Nottingham University Hospitals NHS Trust; Sherwood Forest Hospitals NHS Foundation Trust
25	Oxford University Hospitals NHS Foundation Trust; Buckinghamshire Healthcare NHS Trust; Royal Berkshire NHS Foundation Trust
26	Portsmouth Hospitals NHS Trust; Isle Of Wight NHS Trust
27	Royal Devon and Exeter NHS Foundation Trust; Northern Devon Healthcare NHS Trust; Torbay and South Devon NHS Foundation Trust; Taunton and Somerset NHS Foundation Trust; Yeovil District Hospital NHS Foundation Trust
28	Royal Free London NHS Foundation Trust; The Whittington Health NHS Trust; North Middlesex University Hospital NHS Trust; University College London Hospitals NHS Foundation Trust
29	Royal Surrey County NHS Foundation Trust; Ashford and St Peter's Hospitals NHS Foundation Trust; Surrey and Sussex Healthcare NHS Trust; Frimley Health NHS Foundation Trust
30	Sandwell and West Birmingham Hospitals NHS Trust; Walsall Healthcare NHS Trust; The Royal Wolverhampton NHS Trust; The Dudley Group NHS Foundation Trust
31	Sheffield Teaching Hospitals NHS Foundation Trust; Chesterfield Royal Hospital NHS Foundation Trust; The Rotherham NHS Foundation Trust; Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

32	South Tees Hospitals NHS Foundation Trust; North Tees and Hartlepool NHS Foundation Trust; Darlington (County Durham and Darlington NHS Foundation Trust)
33	South Tyneside and Sunderland NHS Trust; Durham (County Durham and Darlington NHS Foundation Trust)
34	St George's University Hospitals NHS Foundation Trust; Croydon Health Services NHS Trust; Epsom and St Helier University Hospitals NHS Trust; Kingston Hospital NHS Foundation Trust
35	Stockport NHS Foundation Trust; East Cheshire NHS Trust; Tameside Hospital NHS Foundation Trust; Mid Cheshire Hospitals NHS Foundation Trust
36	The Newcastle Upon Tyne Hospitals NHS Foundation Trust; Northumbria Healthcare NHS Foundation Trust; North Cumbria University Hospitals NHS Trust; Gateshead Health NHS Foundation Trust
37	University Hospital Southampton NHS Foundation Trust; Hampshire Hospitals NHS Foundation Trust; Salisbury NHS Foundation Trust
38	University Hospitals Birmingham NHS Foundation Trust; Worcestershire Acute Hospitals NHS Trust
39	University Hospitals Coventry and Warwickshire NHS Trust; George Eliot Hospital NHS Trust; South Warwickshire NHS Foundation Trust
40	University Hospitals of Derby and Burton NHS Foundation Trust
41	University Hospitals of Dorset NHS Foundation Trust; Dorset County Hospital NHS Foundation Trust
42	University Hospitals Of Leicester NHS Trust; United Lincolnshire Hospitals NHS Trust; Northampton General Hospital NHS Trust; Kettering General Hospital NHS Foundation Trust
43	University Hospitals of North Midlands; Robert Jones and Agnes Hunt Orthopaedic and District Hospital NHS Trust; Shrewsbury and Telford Hospital NHS Trust
44	University Hospital Plymouth Hospitals NHS Trust; Royal Cornwall Hospitals NHS Trust
45	University Hospitals of Sussex NHS Foundation Trust; East Sussex Healthcare NHS Trust
46	Wirral University Teaching Hospital NHS Foundation Trust; Countess Of Chester Hospital NHS Foundation Trust; Warrington and Halton Hospitals NHS Foundation Trust
47	Wrightington, Wigan and Leigh NHS Foundation Trust; Bolton NHS Foundation Trust