- Andrology
- Uro-oncology
- GPwSI (general urology clinic)
- Haematuria Assessment and Diagnostics
- Histology Clinics
- Urodynamics

Current Sessions

Outpatient, day surgery and inpatient theatre sessions are given in Table 1.

Table 1: Current Urology Sessions

	Craigavon	South Tyrone	Banbridge	Armagh	Total
Consultant Led OPs					
General	2.75 per week[1]	1 per month	2 per month	2 per month	4 per week
Stone Treatment	1 weekly				1 week

ICATS	Weekly	Personnel
Prostate Assessment	1.5	Specialist Nurse & Registrar
Prostate Biopsy	1	Consultant Urologist/Radiologist & Specialist Nurse
Prostate Histology	1.5	Specialist Nurse & Consultant/Registrar
LUTS	3	Specialist Nurse & Registrar
Haematuria	2	Specialist Nurse & Registrar
Andrology	2.5	GPwSI & Nurse Lecturer
General Urology/Uro Oncology	2.5	GPwSI
	14	

Main Theatres (CAH)	Weekly	
	6	3 all day lists

	Craigavon	South Tyrone
Day Surgery		
GA	1 weekly[2]	1 monthly
Flexible Cystoscopy	1.5 weekly[3]	
Lithotripsy	2 weekly	

1) 1 consultant led outpatient clinic at CAH is every week except the 3rd week in the month
2) Numbers treated on the weekly GA list at Craigavon are restricted by anaesthetic cover
3) 2 lists/1 list on alternate weeks

Current Activity

In 2009/10 the integrated urology service delivered the core service shown in Table 2. In house additionality and independent sector activity has also been included in the table. It should be noted that in 2009/10 240 new outpatient attendances at the Stone Treatment Centre were erroneously recorded as review attendances. This mistake has been corrected in the figures in Tables 2 and 3 below.

Table 2: 2009/10 Actual Activity for the Urology Service

		Core Activity	IHA	IS	Totals
2009/10	Cons Led New OP	850	474	0	**1324**
	ICATS/Nurse Led New OP	1220	30		**1250**
	Total New OP	2070	504	0	**2574**
	Cons Led Review OP	2151	70	0	**2221**
	ICATS/Nurse Led Rev OP	1509	0	0	**1509**
	Total Review	3660	70	0	**3730**
	Day Case	1502	3	383	**1888**
	Elective FCE	1199	29	140	**1368**
	Non Elective FCE	629	0	0	**629**

Activity by consultant for 2009/10 is provided in Table 3.

Table 3: Activity by Consultant for 2009/10

		Mr Young	Mr O'Brien	Mr Akhtar[2]	All Core Activity
2009/10	New OP	482	174	193	**849**
	Review OP	724	903	327	**1954**
	Total OP	1206	1077	520	**2803**
	Day Case	696	452	354	**1502**
	Elective FCE	380	512	307	**1199**
	Non Elective FCE	233	210	186	**629**
	FCEs + DCs	**1309**	**1174**	**847**	**3330**
	Day Case Rates [1]	65%	47%	54%	56%

[1] INCLUDES flexible cystocopies (M45) and DCs/FCEs with no primary procedure recorded.
[2]Mr Akhtar undertakes an alternative weekly biopsy list at Thorndale. These patients are recorded under ICATS.

Notes:
1) Source is Business Objects
2) Day case and elective FCEs exclude in house additionality (3 DCs & 29 FCEs) and also independent sector activity (383 DCs and 140 FCEs)
3) Outpatient Activity is consultant led only & has been counted on specialty of clinic. It excludes in house additionality (474 new, 70 review).
4) There were an **additional 1 new and 197 review** attendances which have not been allocated to a particular consultant as they were recorded under 'General Urologist'.

There is a substantial backlog of patients awaiting review at consultant led clinics. The Trust has submitted a plan to deal with this backlog and implementation of this plan is in progress.

Pre-operative Assessment

Pre operative assessment is already well established. All elective patients are sent a pre-assessment questionnaire and those patients who require a face to face assessment are identified from these. For urology the percentage is high due to the complexity of the surgery and also the nature of the patient group who tend to be older patients with high levels of co-morbidity. It is not possible to provide the number of urology patients who come to hospital for a pre-assessment appointment as all patients are recorded under a single speciality.

Between 1 Apr 09 and 31 Dec 09 692 of 853 elective episodes had a primary procedure recorded. Of the 692, 404 (**58.4%**) were admitted on the day their procedure was carried out. A surgical admission ward was established in July 2009. It closes at 9pm each evening (so beds are not 'blocked'). This has enabled significant improvements to be made in the numbers of patients being admitted on the day of surgery, in part because consultants have confidence that a bed will be available for their patient. Figures have improved further since December 2009 and across all surgical specialties between 85% and 100% of patients are now admitted on the day of their surgery.

Suspected Urological Cancers

It is not feasible to extract the numbers of suspected urological cancers. However, the figure can be estimated using the numbers of patients attending for prostate and haematuria assessment in 2009/10 – 434.

The urology team multi disciplinary meetings (MDMs) are already established. A weekly MDT meeting is held and it is attended by consultant urologists, consultant radiologist, consultant pathologist, specialist nurses, and cancer tracker. The first part of the meeting is the local MDT meeting and the local team then link in with the regional MDT meeting.

The Southern Trust provides chemotherapy only for prostate and bladder cancer patients (at Craigavon Hospital). Chemotherapy for all other cancers and radiotherapy for all cancers is provided by Belfast Trust. The Trust is transferring all radical pelvic operations to Belfast Trust.

3. Benchmarking of Current Service

It is the Trust's intention to use the opportunity of additional investment in the urology service to enhance the service provided to patients and to improve performance as demonstrated by Key Performance Indicators such as length of spell, new to review ratios and day case rates.

The Regional Health and Social Care Board (HSCB) has provided comparative data for the Trusts in Northern Ireland. Table 4 below provides a summary of the Trust's performance compared to the regional position.

Table 4: Regional Benchmarking

		2006/07	2007/08	2008/09	2009/10
New : Review Ratio	All Trusts	1.96	2.03	1.79	1.68
	SHSCT	**4.04**	**3.27**	**3.28**	**2.09**
Day Case Rates	All Trusts	50.1	48.5	49.8	48.5
	SHSCT	**43.8**	**45.5**	**48.8**	**40.0**
Average LOS (elective)	All Trusts	3.7	3.5	3.4	2.9
	SHSCT	**3.7**	**4.3**	**3.9**	**2.7**
Average LOS (non elective)	All Trusts	4.8	4.7	4.6	4.4
	SHSCT	**4.5**	**4.8**	**4.6**	**4.7**

1) Data for 2009/10 is up to the end of February 2010

2) Day cases exclude flexible cystoscopies and uncoded day cases (Prim Op M70.3 and Sec Op 1 Y53.2 also excluded)

Table 5 compares the Southern Trust's average length of spell for specific Healthcare Resource Groups (HRGs) with the Northern Ireland peer group for the period 1st January – 31st December 2009 for elective and non elective admissions.

Table 5: Peer Group Comparison for Length of Spell (Northern Ireland Peer Jan 09 – Dec 09)

HRG v3.5	Spells	SHSCT LOS	Peer LOS
L55 - Urinary Tract Findings <70 without complications & comorbidities	11	3.5	0.3
L32 - Non-Malignant Prostate Disorders	16	3.6	2
L21 - Bladder Minor Endoscopic Procedure without complications & comorbidities	670	0.3	0.1
L14 - Bladder Major Open Procedures or Reconstruction	4	11	6.7
L98 - Chemotherapy with a Urinary Tract or Male Reproductive System Primary Diagnosis	3	4.3	0.5
P21 - Renal Disease	13	1.8	0.7
L28 - Prostate Transurethral Resection Procedure <70 without complications & comorbidities	21	4.4	3.1
L52 - Renal General Disorders >69 or with complications & comorbidities	9	5.9	3.7
L69 - Urinary Tract Stone Disease	37	2.3	1.9
L22 - Bladder or Urinary Mechanical Problems >69 or with complications & comorbidities	28	6.7	3.2
L02 - Kidney Major Open Procedure >49 or with complications & comorbidities	34	9.5	7.8
L25 - Bladder Neck Open Procedures Male	11	6.4	4.8
L08 - Non OR Admission for Kidney or Urinary Tract Neoplasms <70 without complications & comorbidities	5	2	1.3
L07 - Non OR Admission for Kidney or Urinary Tract Neoplasms >69 or with complications & comorbidities	20	9.1	8.4
L27 - Prostate Transurethral Resection Procedure >69 or with complications & comorbidities	78	5.3	4.2
L17 - Bladder Major Endoscopic Procedure	77	4.7	3.8
L03 - Kidney Major Open Procedure <50 without complications & comorbidities	9	5.7	4.8
L13 - Ureter Intermediate Endoscopic Procedure	91	2.3	1.6
L10 - Kidney or Urinary Tract Infections <70 without complications & comorbidities	61	4.2	3
L43 - Scrotum Testis or Vas Deferens Open Procedures <70 without complications & comorbidities	45	1.4	1.2
L23 - Bladder or Urinary Mechanical Problems <70 without complications & comorbidities	16	2.2	1.9

The British Association of Day Surgery (BADS) produces targets for short stay and day case surgery for the various surgical specialties. The Trust compared its performance to the BADS targets for 2008/09 (clinical coding is complete) and 2009/10 (clinical coding is incomplete) and submitted an analysis of its performance in version 0.2 of the Implementation Plan.

The Trust recognises that there is the potential to improve the performance of the urology service and will take this forward through the development of the new service model.

4. Demand for Team South Urology Service

The Trust has agreed the methodology for calculating the outpatient demand for the service with the Performance Management and Service Improvement Directorate, based on the actual activity for 2009/10. It is important that when the demand and the capacity of the current and future services are being calculated, that the **whole service** is considered. A significant amount of both new and review activity is undertaken within the ICATS service. However the service is not an independent ICATS service. Consultants triage all urology referrals and decide which are suitable to be treated at ICATS clinics. They also supervise the clinics. Table 6 presents the projected demand for **outpatient slots** for the overall service.

It has been assumed that the Trust's proposal to manage the review backlog will be funded separately and the capacity required to eradicate the backlog has not been included in the demand analysis.

Using actual activity for 2009/10 as a proxy for demand:

Table 6: Projected Outpatient Activity for Team South

	New Attendances	Notes
2009/10 Actual Consultant Led	1084	1
2009/10 Actual Stone Treatment Centre	240	2
2009/10 Actual ICATS	1250	3
2009/10 Fermanagh referrals	318	4
DNA rate @ 3%	87	5
Growth @ 12%	357	6
Total **SLOTS**	**3336**	
2009/10 Actual Newry & Mourne	610	7
DNA rate @ 3%	18	
Growth @ 12%	75	
	704	

Notes:

1) Actual attendances at consultant led clinics, as shown in Table 6 of the Trust's Implementation Plan. In house additionality is included.

2) In 2009/10 240 Stone Treatment Clinic new attendances were recorded as review.

3) Actual attendances at ICATS clinics.

4) Fermanagh referral figure was taken from the Board's model (it is lower than the SHSCT original estimate).

5) The same DNA rate was used as in the Board's model. The actual DNA rate in 2009/10 was 5.5%.

6) The same growth rate was used as in the Board's model.

7) A General Surgeon based at Daisy Hill Hospital also sees urology patients. It is estimated that 610 new attendances at his clinics in 2009/10 were urology patients. **Capacity for the future needs to be built into the service model for these referrals although this work will continue to be undertaken by the General Surgeon.**

For the purposes of calculating the required outpatient sessions 3336 new attendance slots has been used (ie excluding Newry and Mourne demand).

Projected inpatient and daycase activity has not been changed since the submission of version 0.2 of the Trust's Implementation Plan. It is summarised in Table 7 overleaf.

Table 7: Projected Activity for Team South

		2009/10 Actual Activity					
		Core Activity	**IHA**	**IS**	**Growth in WL**	**SHSCT Activity to be Provided**	**Team South Capacity Required [3]**
2009/10	Day Case	1502	3	383	47	1935	**2283**
	Elective FCE	1199	29	140	28	1396	**1647**
	Non Elective FCE	629	0	0		629	**742**

1) Source is Business Objects
2) 2009/10 breaches have been used to estimate growth in waiting list for day cases and FCEs
3) 18% added for Fermanagh, based on population size relative to SHSCT population

5. Proposed Service Model

The proposed service model will be an integrated consultant led and ICATS model. The Trust has submitted the proposed pathways, as requested to the Performance Management and Service Improvement Directorate.

The main acute elective and non elective inpatient unit for Team South will be at Craigavon Area Hospital with day surgery being undertaken at Craigavon, South Tyrone, and the Erne Hospitals (availability of sessions to be confirmed). Day surgery will also continue to be provided at Daisy Hill by a Consultant Surgeon. It is planned that staff travelling to the Erne will undertake an outpatient clinic and day surgery/flexible cystoscopy session in the same day, to make best use of time.

There is potential to have outpatient clinics held at Craigavon, South Tyrone, Armagh Community Hospital and Erne Hospital. Outpatient clinics will also continue to be provided at Daisy Hill by a Consultant Surgeon. All outpatient referrals will be directed to Craigavon Area Hospital and they will be triaged on a daily basis. Suspected cancer referrals will be appropriately marked and recorded. For patients being seen at the Erne Hospital it is anticipated that Erne casenotes will be used with a copy of the relevant notes being sent to Craigavon Area Hospital when elective admission is booked. The details of this process have to be agreed with the Western Trust.

Nurse led sessions will be provided over 48 weeks with consultant led sessions being provided over 42 weeks. Due to the limited availability of theatre capacity, particularly in main theatres, a 3 session operating day is currently being discussed.

The projected demand from Tables 6 and 7 was used to calculate the number of sessions which will be required to provide the service. These are summarised in Table 8 below with the detail of the calculations provided as Appendix 1.

Table 8: Weekly Sessions for New Service Model

	Weekly Sessions	Weeks	Personnel
Consultant Led OPs			
General	5.5	42	
Stone Treatment	1.5	42	
ICATS			
Prostate Assessment	1.5	48	Registrar & Specialist Nurse
Prostate Biopsy [1]	1	48	Consultant Urologist/ Radiologist & Specialist Nurse
Prostate Histology [2]	1	48	Specialist Nurse & Consultant/Registrar
LUTS	3	48	Specialist Nurse & Registrar
Haematuria	1	48	Specialist Nurse & Registrar
Andrology/General Urology/Uro-oncology	5	42	GPwSI & Nurse Lecturer
Urodynamics	1.5	48	GPwSI
	14		
Main Theatres	9	42	
Day Surgery			
GA	4	42	
Flexible Cystoscopy	3	42	
Lithotripsy	2	42	

The detail of job plans is to be agreed with the existing Consultants but they will be based around the sessions identified in Table 8. The expected weekly consultant led sessions, which are subject to confirmation and agreement with consultants, are given in Table 9 overleaf.

Table 9: Proposed Consultant Led Sessions

	Weekly Sessions
Outpatients (including Stone Treatment)	
Craigavon	4.5
South Tyrone	1.5
Armagh	0.5
Erne	0.5
Total OPD	**7**
Prostate Biopsy	1
Day Surgery	
CAH	1
STH	1.5
Erne	0.5
Lithotripsy	2
Total Day Surgery	**5**
Main Theatre	**9**

The Trust accepts the need to move towards delivering activity volumes at outpatient clinics which comply with BAUS guidelines and has made good progress in this regard. The original consultant templates enabled the Trust to deliver the outpatient volumes in 2009/10 which are shown in Table 10.

Table 10: Draft Outpatient Volumes at Consultant Clinics in 2009/10

		Core Activity
200910	Consultant Led New OP	850
	Consultant Led Review OP	2151
	Total Activity	3001

Revised templates which provide significantly more new outpatient capacity have been agreed with the consultant urologists and these have been implemented. They are shown in Table 11 overleaf.

Table 11: Current Consultant Templates (Recently Revised and Extended)

Consultant	Location	Day	Frequency	Sessions/ Annum	Travel Time	New	Review	New/ Annum	Review/ Annum
Mr Young	BBP	Mon am	Monthly	10	45	6	6	60	60
	ACH	Mon am	Monthly	10	50	6	6	60	60
	CAH (STC)	Mon am	Weekly	42	0	5	15	210	630
	CAH	Fri pm	1,2,4 & 5	32	0	5	7	160	224
Mr O'Brien	BBP	Mon am	Monthly	10	45	5	7	50	70
	ACH	Mon am	Monthly	10	50	5	7	50	70
	CAH	Tues pm	Weekly	42	0	5	7	210	294
Mr Akhtar	CAH	Mon pm	Weekly	42	0	4	7	168	294
	STH	Tues pm	Monthly	10	60	6	3	60	30
Total Annual Slots								**1028**	**1732**

These templates will be used initially as the basis of the new (5 consultant) service model giving a projected capacity of 1533 new and 2310 review appointments at consultant clinics, subject to the agreement of consultant job plans (Table 12 overleaf). It is anticipated that an overall new to review ratio across the service (consultant led and ICATS) of 1:2 will be achieved initially.

Following the appointment and commencement of all new staff, within 12 – 18 months the Trust anticipates aligning all consultant templates with the BAUS guidelines. Draft templates which are subject to agreement with the consultants, are shown in Table 13 overleaf. Travelling time has been accommodated within the templates. The new to review ratio across the service (consultant led and ICATS) will be reduced to the recommended 1:1.5.

Table 12: Draft Initial Consultant Outpatient Templates for 5 Consultant Model (for first 12 – 18 months)

Consultant	Location	Day	Frequency	Sessions/ Annum	Travel Time	New	Review	New/ Annum	Review/ Annum
Consultant 1	CAH	Fri am	2/Month	21	0	6	8	126	168
	STH	Thurs pm	2/Month	21	60	5	8	105	168
	Stone Centre	Mon am	2/Month	21	0	6	11	126	231
Consultant 2	CAH	Tues pm	Weekly	42	0	6	8	252	336
	ACH	Mon am	Monthly	10.5	50	5	8	52.5	84
	Erne	Mon pm	Monthly	10.5	60	5	8	52.5	84
Consultant 3	CAH	Mon pm	2/Month	21	0	6	8	126	168
	STH	Tues pm	2/Month	21	60	5	8	105	168
Consultant 4	CAH	Fri am	2/Month	21	0	6	8	126	168
	ACH	Mon am	Monthly	10.5	50	5	8	52.5	84
	Erne	Mon pm	Monthly	10.5	60	5	8	52.5	84
Consultant 5	CAH	Mon pm	2/Month	21	0	6	8	126	168
	STH	Thurs pm	2/Month	21	60	5	8	105	168
	Stone Centre	Mon am	2/month	21	0	6	11	126	231
Total Annual Slots								**1533**	**2310**

Table 13: Draft Final Consultant Outpatient Templates for 5 Consultant Model

Consultant	Location	Day	Frequency	Sessions/ Annum	Travel Time	New	Review	New/ Annum	Review/ Annum
Consultant 1	CAH	Fri am	2/Month	21	0	6	9	126	189
	STH	Thurs pm	2/Month	21	60	5	8	105	168
	Stone Centre	Mon am	2/Month	21	0	6	11	126	231
Consultant 2	CAH	Tues pm	Weekly	42	0	6	9	252	378
	ACH	Mon am	Monthly	10.5	50	5	8	52.5	84
	Erne	Mon pm	Monthly	10.5	60	5	8	52.5	84
Consultant 3	CAH	Mon pm	2/Month	21	0	6	9	126	189
	STH	Tues pm	2/Month	21	60	5	8	105	168
Consultant 4	CAH	Fri am	2/Month	21	0	6	9	126	189
	ACH	Mon am	Monthly	10.5	50	5	8	52.5	84
	Erne	Mon pm	Monthly	10.5	60	5	8	52.5	84
Consultant 5	CAH	Mon pm	2/Month	21	0	6	9	126	189
	STH	Thurs pm	2/Month	21	60	5	8	105	168
	Stone Centre	Mon am	2/month	21	0	6	11	126	231
Total Annual Slots								**1533**	**2436**

6. Timetable for Implementation

Task	Timescale
Submission of Team South Implementation Plan	23 June 10
Approval to Proceed with Implementation from HSCB	July 10
Completion of Job Plans/Descriptions for Consultant Posts	End July 10
Completion of Job Plans/Descriptions for Specialist Nurses	End July 10
Consultant Job Plans to Specialty Advisor	End July 10
Advertisement of Consultant Posts	September 10
Advertisement of Specialist Nurse Posts	September 10
New Consultants and Specialist Nurses in post	February 11

The timetable was based on the expected timescales for approval to proceed to recruit when the Implementation Plan was initially submitted in June. The Trust will update it when there is further clarification with regard to timescale for approval to proceed with implementation.

APPENDIX 1

Calculation of Sessions Required for Team South

Calculation of Sessions Required for Team South

Prostate Pathway (Revised)

A reduction from the current 4 appointments to 3 appointments is planned in the current service model with the assessment and prostate biopsy taking place on the same day (for appropriate patients).

1st appointment – the patient will be assessed by the specialist nurse (patient will have ultrasound, flow rate, U&E, PSA etc). A registrar needs to be available for at least part of the session eg to do DRE, take patient off warfarin etc. 5-6 patients can be seen at an assessment clinic (limited to a maximum of 6 by ultrasound). In the afternoon appropriate patients from the morning assessment would have a biopsy. 4-6 patients can be biopsied in a session (though additional biopsy probes will need to be purchased). Not all patients will need a biopsy and the session will be filled with those patients from previous weeks who did not have a biopsy on the same day as their assessment (because they needed to come off medication, wanted time to consider biopsy etc). Based on 2009/10 figures it is estimated that 69% of patients will require biopsy (218)

321 patients @ 5 per session = 64 sessions per annum = 1.4 assessment sessions per week.

225 cases for biopsy @ 5 per session = 45 sessions per annum. 1 biopsy session per week should therefore suffice (over 48 weeks).

The majority of patients with benign pathology will be given their results by telephone (Specialist Nurse time needs to be built in to job plans for this).

2nd appointment will be to discuss the test results – patients with positive pathology and those patients with benign pathology who are not suitable to receive results by telephone. It is estimated that 40% of patients who have had biopsy will have positive pathology (using 40% this would be 90 patients). Adding on 10% for those patients with benign pathology who will need to come in for their results gives a figure of 100 patients needing a second appointment. These patients will be seen by a consultant or registrar.

3rd appointment will be discussion of treatment with the estimated 90 patients per annum, following MDT. The consultants would prefer to see their own patients and feel that the appropriate model is for each to have a weekly 'Thorndale session' to do:

- 2nd and 3rd prostate appointments,
- Check urodynamic results/patients
- Other urgent cases.

LUTS

419 new patients. The new to review ratio is 1:0.8, therefore there will be approximately 336 reviews.

419 new patients @ 4 per session = 105 sessions

336 reviews @ 8 per session = 42 sessions

103 + 42 = 147 sessions per annum = **3 sessions per week** (over 48 weeks)

Registrar input is required.

Haematuria (Revised)

Currently ultrasound, history, bloods, urines etc done by the Specialist Nurse/Radiographer. Patients come back to DSU to have flexi carried out by a Registrar.

This will move to a 'one stop' service with the flexi being done on the same day in Thorndale (by a Registrar). 5 patients per session (may be a slightly longer session than normal) have been agreed.

241 new patients @ 5 per session = 48.2 sessions = **1 per week** (over 48 weeks)

Note – some patients will require IVP. The view of the clinical staff is that it may be rather onerous for the older patient to have this along with the other investigations done on the same day. However this will be considered further and the potential for protected slots discussed with Radiology.

Andrology/General Urology ICATS

For planning purposes it has been agreed to use a new to review ratio of 1:1.5 with 3 new and 5 review at a clinic. It is assumed that sessions will only run over 42 weeks.

639 @ 3 news per session = 213 sessions = **5 per week** (over 42 weeks)

Urodynamics

These will be located alongside consultant clinics.

306 cases at 5 per all day session = 61 all day sessions. 1.5 per week will be built in to the service model.

Time will also need to be built into the Specialist Nurses' job plans to pre assess the patients (this may not need to be face to face) as there otherwise would be a high DNA rate for this service.

Consultant Clinics

1405 new patient slots are required at consultant clinics, including the capacity to review urodynamics results/patients. The table below provides the draft outpatient clinic templates for the 5 consultant model. These templates will provide a capacity for 1533 new and 2310 review outpatient slots initially as shown below. Following the appointment and commencement of all new staff, within 12 – 18 months the Trust anticipates increasing the templates to provide 1533 new and 2436 review slots.

	Weekly Sessions	Annual New Slots	Annual Review Slots
CAH	3	756	1008
STH	1.5	315	504
Armagh	0.5	105	168
Erne	0.5	105	168
Stone Treatment	1	252	462
Totals	**6.5**	**1533**	**2310**

Stone Treatment

311 attendances @ 6 news = 52 sessions. 1.3 session per week will be required.

Day Cases

Flexible Cystoscopy

Based on the current day case rates 2283 day cases (including flexible cystoscopies) would be undertaken.

2008/09 activity has been used to apportion flexible cystoscopies etc, as coding is incomplete for 2009/10.

1243 flexible cystoscopies were carried out as day cases (primary procedure code = M45) and this was 56% of the total daycases (2203), in 2008/09.

It has therefore been assumed that 56% of 2283 cystoscopies will be required = 1279. 237 of these will be done in Thorndale (Haematuria service), leaving1042.

Numbers on lists vary between 6 -10, depending on where the list is undertaken, and whether any patients who have MRSA are included on the list. An average of 8 per list has been used for planning purposes.

1042 @ 8 per list = 131 lists = **3 flexi list per week** (over 48 weeks)

Lithotripsy

268 day cases were carried out in 2008/09. This was 12.2% of the total day cases. Assuming 12.2% of 2283 will be lithotripsy gives a requirement for 279.

279 @ 4 per session = 70 sessions. This equates to 1.5 per week if delivered over 48 weeks (will required a second consultant with SI in stone treatment) and 2 per week if delivered over 42 weeks.

Other Day Cases

The day case rate for specific procedures will be increased (assuming suitable sessions and appropriate equipment can be secured).

In 2008/09 2203 day cases and 1273 elective FCEs were carried out (3476 in total and a day case rate of 63.4%). If the British Association of Day Surgery recommended day case rates had been achieved for the basket of procedures for urology in 2008/09 then an additional 215 day cases would have been carried out increasing the total day case rate from 63.4% to 69.6%

For Team South we have projected 2283 day cases and 1647 FCEs (Day case rate of 58%). If a day case rate of 69.6% is applied to the total elective activity of 3930 then this changes the mix to 2735 day cases and 1195 elective FCEs.

Of the 2735 day cases:

- 1279 are flexible cystoscopies;
- 279 are lithotripsy
- 103 had no procedure (add 18% to account for Fermanagh region) = 121
- 279 are introduction of therapeutic substance in to bladder + 18% = 329

This leaves 727 day cases to be carried out. Some will be done in dedicated day surgery sessions and some will be more suited to main theatre via the elective admissions ward (in case an overnight stay is required). 4 patients are normally done in dedicated day surgery sessions at present but consultants feel that this could be increased to 5.

727 @ 5 per list = 146 lists = 3.1 lists (over 48 weeks). To maximise the potential to treat patients on a day case basis, 4 weekly lists are planned .

Inpatients

1195 elective FCEs are projected. A limited number of patients may not have a procedure carried out. However some non elective cases are added to elective theatre lists. The numbers of procedures carried out on a list also varies significantly and on occasions a single complex case can utilise a whole theatre list. For the purposes of planning, 3 cases per list has been taken as an average.

1195 @ 3 per list = 399 lists = 9 lists (over 48 weeks).

Health and Social Care Board

REGIONAL REVIEW OF ADULT UROLOGY SERVICES

April 2010 (Update)

(Update)

This document makes a total of 26 Recommendations, which are set out in Table 1 below.

Recommendation	Update 15 April 2010
1. Unless Urological procedures (particularly operative 'M' code) constitute a substantial portion of a surgeon's practice (s)he should cease undertaking any such procedures. Any Surgeon continuing to provide such Urology services should do so within a formal link to a Urology Unit/Team.	Only the Urologist's in the Southern Trust undertake these urological procedures.
2. Trusts should plan and consider the implications of any impending retirements in General Surgery, particularly with regard to the transfer of "N" Code work and the associated resources to the Urology Team	The Trust will keep this under review as Consultant Surgeons retire and make appropriate plans to transfer the "N" code work to urologists.
3. A separate review of urinary continence services should be undertaken, with a view to developing an integrated service model in line with NICE Guidance. (Section 2 – Introduction and Context, pg 5)	The Trust need to undertake this review and to take into account the service pathways from Primary Care to both Urology and Gynae services. **Action: Group to be set up to take this forward**
4. Trusts must review the process for internal Consultant to Consultant referrals to Urology to ensure that there are no undue delays in the system.	This process was reviewed by the Trust last Summer and is in place.

5. Northern Ireland Cancer Network (NICaN) Urology Group in conjunction with Urology Teams and Primary Care should develop and implement (by September 2009) agreed referral guidelines and pathways for suspected Urological Cancers.	The Trust has a number of representatives that sit and attend meetings for this Group and have been involved in the discussion in respect to the referral guidelines and pathways. The Trust commenced its formal Multi-disciplinary Team meetings on 1 April on Thursday afternoons were suspected and confirmed urological cancer pathways and referrals are discussed.
6. Deployment of New Consultant posts (both vacancies and additional posts arising from this review) should take into account areas of special interest that are deemed to be required in the service configuration model.	The Trust will take this into account when preparing job descriptions and job plans.
7. Urologists, in collaboration with General Surgery and A&E colleagues, should develop and implement clear protocols and care pathways for Urology patients requiring admission to an acute hospital which does not have an acute Urology Unit. (Section 3 –Current Service Profile, pg 5).	The Trust have commenced work on this, for example patients presenting with Urinary Tract Retention. These have been shared with A&E and a meeting is planned for beginning of May to get agreement on this and then implementation. The Trust will continue to work on other protocols and care pathways.
8. Urologists, in collaboration with A&E colleagues, should develop and implement protocols/care pathways for those patients requiring direct	The Trust have commenced work on this, for example

transfer and admission to an acute Urology Unit. (Section 3 –Current Service Profile, pg 5).	patients presenting with Urinary Tract Retention. These have been shared with A&E and a meeting is planned for beginning of May to get agreement on this and then implementation. The Trust will continue to work on other protocols and care pathways
9. Trusts should ensure arrangements are in place to proactively manage and provide equitable care to those patients admitted under General Surgery in hospitals without Urology Units (e.g. Antrim, Daisy Hill, Erne). Arrangements should include 7 day week notification of admissions to the appropriate Urology Unit and provision of urology advice/care by telephone, electronically or in person, also 7 days a week. (Section 3 –Current Service Profile, pg 5).	This recommendation will be actioned as part of the implementation of the review and will include representatives from Urology, A&E and General Surgeons from the those hospitals that do not have a Urology Unit. **Action:- Meeting to be set up to include all as mentioned above to take this forward**
10. In undertaking the ICATS review, there must be full engagement with secondary care Urology teams, current ICATS teams, as well as General Practitioners and LCGs. In considering areas of Urology suitable for further development they should look towards erectile dysfunction, benign prostatic disease, LUTS and continence services. The review should also take into account developments elsewhere within the UK and in particular developments within PCTs in relation to shifting care closer to home. (Section 3 –Current Service Profile, pg 5).	This recommendation has commenced as from week beginning 5 April the protected Urology Thursday slot will look at each of the ICATS services. 8th April looked at Andrology and it was agreed that this service would be split in two and one part will deal with erectile dysfunction. Today the discussions were concentrating on benign prostatic disease. Notes from these meetings will be available and then discussions and recommendations from these will be implemented.

	Action: these weekly meetings to continue
11. Trusts (Urology departments) will be required to evidence (in their implementation plans) delivery of the key elements of the Elective Reform Programme.	The Trust currently adhere to key elements of the Elective Reform Programme, for example, IEAP, pre-op assessment, monitor admission on day of surgery, etc and through weekly dashboard reports etc will be able to evidence. For example the Trust are also looking at methods of operation e.g. TURP to increase day surgery and recognise that some investment is required for equipment to meet these targets and other of the key elements are being taken into consideration for Urology.
12. Trust Urology Teams must as a matter of urgency redesign and enhance capacity to provide single visit outpatient and assessment (diagnostic) services for suspected urological cancer patients. (Section 5 – Performance Measures, pg 6).	This redesign is all part of the protected 'Thursday' meetings and are currently aiming through Thorndale unit to facilitate a single visit for suspected urological cancer patients. we are currently drawing up a timetable at what will be discussed at each of these meetings so as to assist in taking forward these recommendations
13. Trusts should implement the key elements of the elective reform programmed with regard to admission on the day of surgery, pre-operative assessment and increasing day surgery rates.	This is currently on-going as per recommendation 11

14. Trusts should participate in a benchmarking exercise of a set number of elective (procedure codes) and non-elective (diagnostic codes) patients by Consultant and by hospital with a view to agreeing a target length of stay for these groups of patients. (Section 5 – Performance Measures, pg 6).	This point will part of the implementation plan and still needs to be actioned with Consultants. Mr Mark Fordham is visiting the Trust on 13 May and can be included in discussions with the Urologists.
15. Trusts will be required to include in their implementation plans, an action plan for increasing the percentage of elective operations undertaken as day surgery, redesigning their day surgery theatre facilities and should work with Urology Team in other Trusts to agree procedures for which day care will be the norm for elective surgery. (Section 5 – Performance Measures, pg 6).	This point will part of the implementation plan and still needs to be actioned with Consultants along with their colleagues in other Trusts
16. Trusts should review their outpatient review practice, design other methods/staff where appropriate and subject to casemix/complexity issues reduce new: review ratios to the level of peer colleagues.	This has partially commenced in the Dr Rodgers, General Practitioner with Specialist Interest (GPWSI) attends Mr Young's weekly CAH outpatient clinic to see reviews. Also Shirley Tedford the Urology Nurse Co-ordinator has started to do chart, letter and results reviews on review patients and then discusses their outcome with the consultants and agrees the best pathway for them.
17. Trust must modernise and redesign outpatient clinic templates and admin/booking processes to ensure their capacity for new and review patients and to prevent backlogs occurring in the future.	The admin/booking processes are in place. As part of the whole review each Urologist will be met to

	discuss their clinic templates and ensure that there is enough capacity for the new and review. This will also depend on the availability of Registrars/Junior Staff to assist at the clinics as there had been a deficit for a while. **Action: On-going**
18. The NICaN Group in conjunction with each Trust and Commissioners should develop and implement a clear action plan with timelines for the implementation of the new arrangements/enhanced services in working towards compliance with IOG. (Section 7 – Urological Cancers, pg 6).	This is on-going with representatives of the Trust attending and actioning recommendations from the NICaN group
19. By March 2010, at the latest, all radical pelvic surgery should be undertaken on a single site, in BCH, by a specialist team of surgeons. The transfer of this work should be phased to enable BCH to appoint appropriate staff and ensure infrastructure and systems are in place. A phased implementation plan should be agreed with all parties. (Section 7 – Urological Cancers, pg 6).	There is ongoing discussions taking place regarding this recommendation
20. Trusts should ensure that surgeons carrying out small numbers (<5 per annum) of either radical pelvic operation, make arrangements to pass this work on to more specialised colleagues, as soon as is practicably possible, (whilst a single site service is being established).(Section 7 – Urological Cancers, pg 6).	There is ongoing discussions taking place regarding this recommendation

21. To deliver the level of activity from 2008/09 and address the issues around casemix and complexity it is recommended that the number of Consultant Urologists is increased to 23 wte. (Section 8 – Clinical Workforce Requirements, pg 6).	A business case needs to be prepared for two additional Consultant Urologists for the Southern Trust to include their support and any equipment required in order that they will take into account specialist interests as per Recommendation 6. Work has commenced on team job plans and job descriptions will now have to be drawn up.
22. Urology Teams must ensure that current capacity is optimised to deliver the number FCEs by Consultant as per BAUS guidelines (subject to casemix and complexity). This may require access to additional operating sessions up to at least 4 per week (42 weeks per year) and an amendment to job plans. (Section 8 – Clinical Workforce Requirements, pg 6).	Work has commenced on team job plans and job descriptions will now have to be drawn up. Discussions need to take place with Theatres to identify the additional operating sessions and take into account the other sites within the catchment area.
23. At least 5 Clinical Nurse Specialists (cancer) should be appointed (and trained). The deployment of these staff within particular teams will need to be decided and Trusts will be required to develop detailed job plans with caseload, activity and measurable outcomes agreed prior to implementation. A further review and benchmarking of cancer CNS's should be undertaken in mid 2010. (Section 8 – Clinical Workforce Requirements, pg 6).	Job plans, job descriptions will have to be developed as part of the implementation plan.

24. Urology services in Northern Ireland should be reconfigured into a 3 team model, to achieve long term stability and viability. (Section 9 – Service Configuration Model, pg 7).	Agreement that this is part of the implementation plan
25. Teams North and East (Northern, Western, Belfast and South Eastern Trusts) should ensure that prior to the creation of the new Teams, there are clear, unambiguous and agreed arrangements in place with regard to Consultant on-call and out of hours arrangements. (Section 9 – Service Configuration Model, pg 7).	Not applicable to this Trust
26. Each Trust must work in partnership with the other Trust/s within the new team structure to determine and agree the new arrangements for service delivery, including inter alia, governance, employment and contractual arrangements for clinical staff, locations, frequency and prioritisation of outreach services, areas of Consultant specialist interest based on capacity and expertise required and catchment populations to be served. (Section 9 – Service Configuration Model, pg 7).	Meeting being set up for beginning of May with the Western Trust to begin to work in partnership to discuss the implementation plan.

UROLOGY REVIEW SUMMARY OF RECOMMENDATIONS
(Southern Trust)

Section 2 – Introduction and Context

	Recommendation	Update	Update – August 2013
1 P8	Unless Urological procedures (particularly operative 'M' code) constitute a substantial proportion of a surgeon's practice, (s)he should cease undertaking any such procedures. Any Surgeon continuing to provide such Urology services should do so within a formal link to a Urology Unit/Team.	Completed.	Completed
2 P9	Trusts should plan and consider the implications of any impending retirements in General Surgery, particularly with regard to the transfer of "N" Code work and the associated resources to the Urology Team.	The Trusts and the associated urology teams will need to assess the implications of any pending retirements, particularly with the regard to the transfer of 'N' code work.	Completed
3 P10	A separate review of urinary continence services should be undertaken, with a view to developing an integrated service model in line with NICE Guidance.	The Trusts have been advised to review their own urinary continence services to ensure they are integrated across the urology team. A separate review of urinary continence services is to be undertaken by the Board through the LCGs.	This work has commenced and is being taken forward by OPCC

Section 3 – Current Service Profile

	Recommendation	Update	Update – August 2013
4 P15	Trusts must review the process for internal Consultant to Consultant referrals to Urology to ensure that there are no undue delays in the system.	The Trusts have been advised to review their internal processes for Consultant to Consultant referrals and streamlined as appropriate.	This work is complete. After each outpatient attendance and outcome sheet is completed and this allows for an immediate consultant to consultant referral to be made
5 P15	Northern Ireland Cancer Network (NICaN) Urology Group in conjunction with Urology Teams and Primary Care should develop and implement (by September 2009) agreed referral guidelines and pathways for suspected Urological Cancers.	The NICaN Standard Working Policy for Urological Cancer MDTs was formally signed off at the NICaN Urology Group on 8 October 2009. The Referral Guidelines were completed in May 2007 and have not been revised. The Board is currently working with NICaN to agree referral guidance for suspected urological cancer.	The Trust has representatives sitting on the NICaN group to take this recommendation forward
6 P17	Deployment of new Consultant posts (both vacancies and additional posts arising from this review) should take into account areas of special interest that are deemed to be required in the service configuration model.	The teams will take into account the demand for both core and special interest urology, in the recruitment of new urology consultants.	Completed and an additional interview took place on 8 August for a replacement for Consultant who went to Belfast.
7 P17	Urologists, in collaboration with General Surgery and A&E colleagues, should develop and implement clear protocols and care pathways for Urology patients requiring admission to an acute hospital which does not have an acute Urology Unit.	The Board has developed Regional Pathways for the following conditions: o Diagnosis and Management of an acutely obstructed kidney with sepsis	Trust representatives attended the group set up to discuss and take this forward with the Board.

		○ Diagnosis and Management of Acute Urinary Retention ○ Diagnosis and Management of Suspected Renal Colic ○ Haematuria ○ Lower Urinary Tract System (LUTS) male only ○ Prostate ○ Testicular Cancer	
8 P17	Urologists, in collaboration with A&E colleagues, should develop and implement protocols/care pathways for those patients requiring direct transfer and admission to an acute Urology Unit.	The teams have been advised to develop pathways with A&E colleagues, including the details of the expected standards for the urological input and the timely transfer and admission to an acute Urology Unit.	This is still work in process and is currently in draft for sign off by Emergency Department colleagues.
9 P18	Trusts should ensure arrangements are in place to proactively manage and provide equitable care to those patients admitted under General Surgery in hospitals without Urology Units (e.g. Antrim, Daisy Hill, Erne). Arrangements should include 7 day week notification of admissions to the appropriate Urology Unit and provision of urology advice/care by telephone, electronically or in person, also 7 days a week.	The teams have been advised to established appropriate arrangements to manage urology patients admitted under general surgery without urology units. notify the appropriate urology unit of the patient, how the urology advice will be provided and within what agree timescale. This has included – the 7 day notification of admission be arranged, the 7 day access to advice, either electronically or via telephone, including, as required, weekend ward rounds or transfer of the patient.	This is currently in place between Daisy Hill and South West Acute Hospitals

10 P20	In undertaking the ICATS review, there must be full engagement with secondary care Urology teams, current ICATS teams, as well as General Practitioners and LCGs. In considering areas of Urology suitable for further development they should look towards erectile dysfunction, benign prostatic disease, LUTS and continence services. The review should also take into account developments elsewhere within the UK and in particular developments within PCTs in relation to shifting care closer to home.	The teams have outlined their current arrangements for Urology ICATS. The Board continues to work with the Trusts to ensure the effective use of ICATS services across the overall patient pathway. This should include the consideration of the following options: o direct to diagnostics o to direct treatment on an inpatient/daycase list o for return to primary care with advice on further management o to hospital Consultant outpatients	Due to the shortage of Middle-grade doctors and the retirement of the General Practitioner with Specialist Interest (GPwSI) the Urology Team have commenced a review of the ICATS service provided within the Trust.

Section 4 – Capacity, Demand and Activity

	Recommendation	Update	Updated August 2013
11 P23	Trusts (Urology departments) will be required to evidence (in their implementation plans) delivery of the key elements of the Elective Reform Programme.	The team Implementation Plans included the key elements of the Elective Reform Programme including; Pre Operative Assessment Admission on the day of surgery Day surgery rates by Consultant Average LOS by procedure Number and % of cancelled operations for both clinical and non clinical reasons The Board is continuing to monitor these areas of improvement.	This is a continuous monitoring process within the Directorate/Division and Urology Team.

Section 5 – Performance Measures

	Recommendation	Update	Updated August 2013
12 P27	Trust Urology Teams must as a matter of urgency redesign and enhance capacity to provide single visit outpatient and assessment (diagnostic) services for suspected urological cancer patients.	The team should outline the expected number of suspected cancer patients referred per week and what location it is proposed these should be sent to. The teams are recommended to triaged referrals on a daily basis, provided sufficient capacity for suspected urological cancers and introduce one stop clinics.	The Team have introduced one-stop clinics for Prostate Red Flags and Haematuria Red Flags and both these clinics are working well. A new process has been put in place to triage red-flag letters in that these are brought on a daily-basis to the consultant on call
13 P13	Trusts should implement the key elements of the elective reform programme with regard to admission on the day of surgery, pre-operative assessment and increasing day surgery rates.	The Trusts continue to take steps to implement the key elements or the elective reform programme and highlight any potential constraints to achievement, and what steps will be taken to overcome these. These include improvements in the Admission on the day of surgery, default to day surgery and effective POA for all urology patients. The BADS directory identifies 28 urology operations (M and N codes) which could be done as day surgery. The Board continues to work with Trusts to improve the levels.	All patients are now admitted on day of surgery except if they have been identified by the Consultant or Anaesthetist of needing to be admitted the day before. All patients that can be done as a daycase are identified at the outpatient clinic and recorded as being able to be done as a daycase. We are continuing to work at increasing our daycase rates
14 P29	Trusts should participate in a benchmarking exercise of a set number of elective (procedure codes) and non-elective (diagnostic codes) patients by Consultant and by hospital with a view to agreeing a target length of stay for these groups of patients.	The Trusts urology teams will participate in the Boards benchmarking processes.	The Trust are happy to participate with the Board regarding benchmarking processes.

15 P30	Trusts will be required to include in their implementation plans, an action plan for increasing the percentage of elective operations undertaken as day surgery, redesigning their day surgery theatre facilities and should work with Urology Team in other Trusts to agree procedures for which day care will be the norm for elective surgery.	The average Consultant Urological Surgeon and team should be performing between 1000 – 1250 inpatient and day patient FCEs per annum. (page 41 Review).	This is ongoing work
16 P31	Trusts should review their outpatient review practice, redesign other methods/staff (telephone follow-up/nurse) where appropriate and subject to casemix/complexity issues reduce new:review ratios to the level of peer colleagues.	A urologist working on their own should see 7 new and 7 review patients up to a maximum of 20 per clinic. (page 40/41 of Review). The national new to review ratio is 1:2.1. It is accepted their will be some variation due to case mix/complexity. The teams are continuing to take actions to deal with those teams who are an outlier from this level, and to achieve a performance in the upper quartile, at 1:1.5 The teams are continuing to implement new models for review and patient initiated review for some groups of patients.	Clinic templates have been changed to reflect the agreed SBA levels and all consultants that are in post are working to these levels
17 P32	Trusts must modernise and redesign outpatient clinic templates and admin/booking processes to ensure they maximise their capacity for new and review patients and to prevent backlogs occurring in the future.	The team implementation plan should explain the booking processes for patients and how these will be change to reflect the new team model. This should include the following information; where should the referrals be sent to, how will these be triaged on a daily basis, how will both new and review patients be partially booked, how will patient notes be generated and transferred across the team locality,	This is work in progress particularly between the Craigavon and SWAH and is almost complete.

Section 7 – Urological Cancers

	Recommendation	Update	Progress August 2013
18 P37	The NICaN Group in conjunction with each Trust and Commissioners should develop and implement a clear action plan with timelines for the implementation of the new arrangements/enhanced services in working towards compliance with IOG.	The teams have continued to implement Urology team MDMs. The teams are continuing to ensure IOG compliance, including oncology input to the MDM, and the pathway for oncology and radiotherapy treatments.	This is working well as MDM's are held every Thursday with a link into Belfast Trust
19 P38	By March 2010, at the latest, all radical pelvic surgery should be undertaken on a single site, in BCH, by a specialist team of surgeons. The transfer of this work should be phased to enable BCH to appoint appropriate staff and ensure infrastructure and systems are in place. A phased implementation plan should be agreed with all parties.	NICaN has formally issued the Urology MDM Working Policy, October 2009. All radical pelvic operations have now transferred to the Belfast City Hospital.	Complete
20 P38	Trusts should ensure that surgeons carrying out small numbers (<5 per annum) of either radical pelvic operation, make arrangements to pass this work on to more specialised colleagues, as soon as is practicably possible, (whilst a single site service is being established).	All radical pelvic operations are now transferred to the Belfast City Hospital.	Complete

Section 8 – Clinical Workforce Requirements

	Recommendation	Update	Progress August 2013
21 P41	To deliver the level of activity from 2008/09 and address the issues around casemix and complexity it is recommended that the number of Consultant Urologists is increased to 23 wte.	The Trusts have outlined the details of the expected activity per team. The Board has agreed the volumes of activity associated with 23 wte consultants across the region.	2 New Consultants had been appointed and were in post, however one has since left to take up post in Belfast and the Trust have advertised and are interviewing on 8 August

22 P41	Urology Teams must ensure that current capacity is optimised to deliver the number FCEs by Consultant as per BAUS guidelines (subject to casemix and complexity). This may require access to additional operating sessions up to at least 4 per week (42 weeks per year) and an amendment to job plans.	The Board has agreed volumes of activity per team consistent with the BAUS recommendations. The teams have implemented changes to the consultant job plans to implement the team model.	Once the fifth consultant has been appointed and taken up post the team will move to the 5-team job plan
23 P43	At least 5 Clinical Nurse Specialists (cancer) should be appointed (and trained). The deployment of these staff within particular teams will need to be decided and Trusts will be required to develop detailed job plans with caseload, activity and measurable outcomes agreed prior to implementation. A further review and benchmarking of cancer CNS's should be undertaken in mid 2010.	The teams have appointed additional CNS posts. The teams have provided the detailed job plans for each of the existing Urology CNS both cancer and non cancer. The Board continues to work to standardise how this activity is recorded. The Board and PHA are undertaking a review of cancer CNS posts across the region.	The Trust are considering this as part of the review of ICATS and will take into consideration any recommendations form the Board and PHA review

Section 9 – Service Configuration Model

	Recommendation	**Update**	**Progress August 2013**
24 P44	Urology services in Northern Ireland should be reconfigured into a 3 team model, to achieve long term stability and viability.	The elements of the team model were included on Page 45 of the Review. The Board continues to work with each of the Trusts to reconfigure the services into a 3 team model to achieve long term stability. This will include the redirection of referrals across LCGs to utilisation of capacity and support the delivery of waiting times targets.	Complete
25	Teams North and East (Northern, Western, Belfast and South Eastern Trusts) should	The teams have agreed arrangements for out of hours and	Complete

P46	ensure that prior to the creation of the new Teams, there are clear, unambiguous and agreed arrangements in place with regard to Consultant on-call and out of hours arrangements.	Consultant on call. These are linked to recommendations 7 and 8.	
26 P46	Each Trust must work in partnership with the other Trust/s within the new team structure to determine and agree the new arrangements for service delivery, including inter alia, governance, employment and contractual arrangements for clinical staff, locations, frequency and prioritisation of outreach services, areas of Consultant specialist interest based on capacity and expertise required and catchment populations to be served.	The teams have agreed new team arrangements and structures across the relevant Trusts. The Board continues to work with the Trusts to support the team structures and new arrangements. .	Ongoing in conjunction with Board

UROLOGY REVIEW SUMMARY OF RECOMMENDATIONS
(Southern Trust)

Section 2 – Introduction and Context

	Recommendation	Update for stocktake
1 P8	Unless Urological procedures (particularly operative 'M' code) constitute a substantial proportion of a surgeon's practice, (s)he should cease undertaking any such procedures. Any Surgeon continuing to provide such Urology services should do so within a formal link to a Urology Unit/Team.	General Surgery team in DHH undertake M codes specifically bladder tumour resection this is done by one General Surgeon with a specific specialism in urology and who partakes in MDT. Note: Daisy Hill Hospital have stopped performing TURP's
2 P9	Trusts should plan and consider the implications of any impending retirements in General Surgery, particularly with regard to the transfer of "N" Code work and the associated resources to the Urology Team.	General Surgeons in CAH and DHH are gradually transferring N codes over at referral source; for example, this surgical team now provides the vasectomy service, the effect of which releases more slots for our Urology team's day surgery list. Fermanagh Work is still and will remain with general surgery in Fermanagh, however Team South are getting referrals on specialist services and we are happy to continue with this arrangement.
3 P10	A separate review of urinary continence services should be undertaken, with a view to developing an integrated service model in line with NICE Guidance.	This work was commenced in 2012 and was being led by OPPC Directorate with Acute input. With the introduction of revised guidelines in Sept 2013 this will be revisited and completed and this may be helped by the appointment of our 6th Consultant who has an interest in Female Urology

Section 3 – Current Service Profile

	Recommendation	Update for stocktake
4 P15	Trusts must review the process for internal Consultant to Consultant referrals to Urology to ensure that there are no undue delays in the system.	This is work in progress with the biggest issue being delays in typing however there is emphasis being put on the importance of identifying at clinic other *consultant to consultant* referrals so that these letters can be picked up through digital dictation. Triage and MDT delays are a factor also to be considered and further streamlining of activity is ongoing.

5 P15	Northern Ireland Cancer Network (NICaN) Urology Group in conjunction with Urology Teams and Primary Care should develop and implement (by September 2009) agreed referral guidelines and pathways for suspected Urological Cancers.	. NICaN Issue
6 P17	Deployment of new Consultant posts (both vacancies and additional posts arising from this review) should take into account areas of special interest that are deemed to be required in the service configuration model.	Consultant turnover only just settled with a consistent one-person deficit to date. Consideration will also be given to planning future replacements for those due to retire.
7 P17	Urologists, in collaboration with General Surgery and A&E colleagues, should develop and implement clear protocols and care pathways for Urology patients requiring admission to an acute hospital which does not have an acute Urology Unit.	Although there were meetings held with members from various Trusts to define care pathways, this was not followed through or funded by HSCB; this has halted completion of this project. There is little evidence of use of the aforementioned pathways instead traditional routes of referral appear to be used. We are hoping to move towards a consultant of the week model and this should improve such aspects of improved care both for quality and timeliness of treatment.
8 P17	Urologists, in collaboration with A&E colleagues, should develop and implement protocols/care pathways for those patients requiring direct transfer and admission to an acute Urology Unit.	As above This will not take too much to address, currently there is easy access by phone for advice and arrangement of transfer7-days per week. We receive such referrals from DHH and SWAH, and the current arrangements appear satisfactory but could be enhanced by printed pathways.
9 P18	Trusts should ensure arrangements are in place to proactively manage and provide equitable care to those patients admitted under General Surgery in hospitals without Urology Units (e.g. Antrim, Daisy Hill, Erne). Arrangements should include 7 day week notification of admissions to the appropriate Urology Unit and provision of urology advice/care by telephone, electronically or in person, also 7 days a week.	As above 7 and 8
10	In undertaking the ICATS review, there must be full engagement with secondary care Urology teams, current	ICATS in SHSCT has fallen apart due to middle grade doctor and GPwSI staffing issues. This has resulted in a deficit in

P20	ICATS teams, as well as General Practitioners and LCGs. In considering areas of Urology suitable for further development they should look towards erectile dysfunction, benign prostatic disease, LUTS and continence services. The review should also take into account developments elsewhere within the UK and in particular developments within PCTs in relation to shifting care closer to home.	activity. In the longer term parts of this model do not appear to be sustainable in SHSCT. Our nursing team are not completely in a position to fill this void alone. We have tried unsuccessfully on several occasions to fill or retain the middle grade post which has resulted in intermittent ICATS clinic provision which then results in a long waiting list appearing for such services. The Urology team are in the process of redesigning these clinic services. The GP services have not to date engaged adequately in the redesign of these services.

Section 4 – Capacity, Demand and Activity

	Recommendation	**Update for stocktake**
11 P23	Trusts (Urology departments) will be required to evidence (in their implementation plans) delivery of the key elements of the Elective Reform Programme.	This remains an issue due to the deficit in staffing both at consultant and middle-grade level. However there are areas such as Day of Admission, Pre-operative Assessment that have improved and the Team are delivering on.

Section 5 – Performance Measures

	Recommendation	**Update for stocktake**
12 P27	Trust Urology Teams must as a matter of urgency redesign and enhance capacity to provide single visit outpatient and assessment (diagnostic) services for suspected urological cancer patients.	The Trust have recently invested in expanding the Urology Outpatient Unit (Thorndale) and this has meant that we can redesign our services uncompromised by other activities in outpatients. Examples are aspects of Haematuria and Prostate clinics can be accommodated on a single visit. But issues with demand still remain a challenge.
13 P13	Trusts should implement the key elements of the elective reform programme with regard to admission on the day of surgery, pre-operative assessment and increasing day surgery rates.	The Elective Admission Ward and preoperative assessment service have been a major advantage to the Urology service in that patients are admitted on day of surgery with few cancellations on the day of surgery, which previously had been an issue to due to lack of beds, and patients being unfit. The standalone day surgery unit in CAH and STH limits the type of patients that can have their surgery carried out in these specific day units and therefore means that the main theatre lists have to be used for the rest of the day case patients which is not a good use of theatre time and limits the

		team to what they can record as a daycase
14 P29	Trusts should participate in a benchmarking exercise of a set number of elective (procedure codes) and non-elective (diagnostic codes) patients by Consultant and by hospital with a view to agreeing a target length of stay for these groups of patients.	Not undertaken as yet, but willing to partake in when we have full team in place.
15 P30	Trusts will be required to include in their implementation plans, an action plan for increasing the percentage of elective operations undertaken as day surgery, redesigning their day surgery theatre facilities and should work with Urology Team in other Trusts to agree procedures for which day care will be the norm for elective surgery.	As above number 13.
16 P31	Trusts should review their outpatient review practice, redesign other methods/staff (telephone follow-up/nurse) where appropriate and subject to casemix/complexity issues reduce new:review ratios to the level of peer colleagues.	Trusts have implemented a defined clinic template which is dependent on clinic type (e.g general or specific clinic such as Haematuria, prostate, stones etc...) The Trust are currently implementing the proposed NICaN cancer projects which should help from 2014 onwards. With the difficulties in the ICATS services we are redefining our nurse-led clinics. Clinics are consultant only with no junior support and therefore ensures that patients are not being reviewed inappropriately The Trust have attempted to engage GP's to help with reviewing patients in the community but to date there has been a reluctance from the GP colleagues to take this on.

17 P32	Trusts must modernise and redesign outpatient clinic templates and admin/booking processes to ensure they maximise their capacity for new and review patients and to prevent backlogs occurring in the future.	The Urology departments DNA rate is always below 5% and this is due to the booking system. However there is still a major problem with backlog reviews which is both for cancer and non-cancer patients. This is not being solved within the existing templates and the Urology team are struggling with this as the clinic template is weighed in favour of new to review ratio which is 1:1.5 as per original review.

Section 7 – Urological Cancers

	Recommendation	**Update for stocktake**
18 P37	The NICaN Group in conjunction with each Trust and Commissioners should develop and implement a clear action plan with timelines for the implementation of the new arrangements/enhanced services in working towards compliance with IOG.	NICaN issue
19 P38	By March 2010, at the latest, all radical pelvic surgery should be undertaken on a single site, in BCH, by a specialist team of surgeons. The transfer of this work should be phased to enable BCH to appoint appropriate staff and ensure infrastructure and systems are in place. A phased implementation plan should be agreed with all parties.	Complete
20 P38	Trusts should ensure that surgeons carrying out small numbers (<5 per annum) of either radical pelvic operation, make arrangements to pass this work on to more specialised colleagues, as soon as is practicably possible, (whilst a single site service is being established).	Complete

Section 8 – Clinical Workforce Requirements

	Recommendation	Update for stocktake
21 P41	To deliver the level of activity from 2008/09 and address the issues around casemix and complexity it is recommended that the number of Consultant Urologists is increased to 23 wte.	Still ongoing and hopefully resolved by the summer.
22 P41	Urology Teams must ensure that current capacity is optimised to deliver the number FCEs by Consultant as per BAUS guidelines (subject to casemix and complexity). This may require access to additional operating sessions up to at least 4 per week (42 weeks per year) and an amendment to job plans.	Operating session time is limited and impeding meeting the 31 and 62 day cancer targets. This has a knock on affect for the non-cancer patients who are waiting in access of the 13 week target and this is therefore resulting in patient complaints. The Team always endeavours to backfill theatre lists to ensure optimisation of all theatre time.
23 P43	At least 5 Clinical Nurse Specialists (cancer) should be appointed (and trained). The deployment of these staff within particular teams will need to be decided and Trusts will be required to develop detailed job plans with caseload, activity and measurable outcomes agreed prior to implementation. A further review and benchmarking of cancer CNS's should be undertaken in mid 2010.	On the back of the NICaN pathways the Trust are currently reviewing the CNS and their roles.

Section 9 – Service Configuration Model

	Recommendation	Update for stocktake
24 P44	Urology services in Northern Ireland should be reconfigured into a 3 team model, to achieve long term stability and viability.	Complete
25 P46	Teams North and East (Northern, Western, Belfast and South Eastern Trusts) should ensure that prior to the creation of the new Teams, there are clear, unambiguous and agreed arrangements in place with regard to Consultant on-call and out of hours arrangements.	No Comment
26 P46	Each Trust must work in partnership with the other Trust/s within the new team structure to determine and agree the new arrangements for service delivery, including inter alia,	This is not complete due to the delay in recruitment of the full teams.

	governance, employment and contractual arrangements for clinical staff, locations, frequency and prioritisation of outreach services, areas of Consultant specialist interest based on capacity and expertise required and catchment populations to be served.	

UROLOGY REVIEW SUMMARY OF RECOMMENDATIONS
(Southern Trust)

Section 2 – Introduction and Context

	Recommendation	Update for stocktake
1 P8	Unless Urological procedures (particularly operative 'M' code) constitute a substantial proportion of a surgeon's practice, (s)he should cease undertaking any such procedures. Any Surgeon continuing to provide such Urology services should do so within a formal link to a Urology Unit/Team.	General Surgery team in DHH undertake M codes specifically bladder tumour resection this is done by one General Surgeon with a specific specialism in urology and who partakes in MDT. Note: Daisy Hill Hospital have stopped performing TURP's
2 P9	Trusts should plan and consider the implications of any impending retirements in General Surgery, particularly with regard to the transfer of "N" Code work and the associated resources to the Urology Team.	General Surgeons in CAH and DHH are gradually transferring N codes over at referral source; for example, this surgical team now provides the vasectomy service, the effect of which releases more slots for our Urology team's day surgery list. Fermanagh Work is still and will remain with general surgery in Fermanagh, however Team South are getting referrals on specialist services and we are happy to continue with this arrangement.
3 P10	A separate review of urinary continence services should be undertaken, with a view to developing an integrated service model in line with NICE Guidance.	This work was commenced in 2012 and was being led by OPPC Directorate with Acute input. With the introduction of revised guidelines in Sept 2013 this will be revisited and completed and this may be helped by the appointment of our 6th Consultant who has an interest in Female Urology

Section 3 – Current Service Profile

	Recommendation	Update for stocktake
4 P15	Trusts must review the process for internal Consultant to Consultant referrals to Urology to ensure that there are no undue delays in the system.	This is work in progress with the biggest issue being delays in typing however there is emphasis being put on the importance of identifying at clinic other *consultant to consultant* referrals so that these letters can be picked up through digital dictation. Triage and MDT delays are a factor also to be considered and further streamlining of activity is ongoing.

5 P15	Northern Ireland Cancer Network (NICaN) Urology Group in conjunction with Urology Teams and Primary Care should develop and implement (by September 2009) agreed referral guidelines and pathways for suspected Urological Cancers.	. NICaN Issue
6 P17	Deployment of new Consultant posts (both vacancies and additional posts arising from this review) should take into account areas of special interest that are deemed to be required in the service configuration model.	Consultant turnover only just settled with a consistent one-person deficit to date. Consideration will also be given to planning future replacements for those due to retire.
7 P17	Urologists, in collaboration with General Surgery and A&E colleagues, should develop and implement clear protocols and care pathways for Urology patients requiring admission to an acute hospital which does not have an acute Urology Unit.	Although there were meetings held with members from various Trusts to define care pathways, this was not followed through or funded by HSCB; this has halted completion of this project. There is little evidence of use of the aforementioned pathways instead traditional routes of referral appear to be used. We are hoping to move towards a consultant of the week model and this should improve such aspects of improved care both for quality and timeliness of treatment.
8 P17	Urologists, in collaboration with A&E colleagues, should develop and implement protocols/care pathways for those patients requiring direct transfer and admission to an acute Urology Unit.	As above This will not take too much to address, currently there is easy access by phone for advice and arrangement of transfer7-days per week. We receive such referrals from DHH and SWAH, and the current arrangements appear satisfactory but could be enhanced by printed pathways.
9 P18	Trusts should ensure arrangements are in place to proactively manage and provide equitable care to those patients admitted under General Surgery in hospitals without Urology Units (e.g. Antrim, Daisy Hill, Erne). Arrangements should include 7 day week notification of admissions to the appropriate Urology Unit and provision of urology advice/care by telephone, electronically or in person, also 7 days a week.	As above 7 and 8
10	In undertaking the ICATS review, there must be full engagement with secondary care Urology teams, current	ICATS in SHSCT has fallen apart due to middle grade doctor and GPwSI staffing issues. This has resulted in a deficit in

P20	ICATS teams, as well as General Practitioners and LCGs. In considering areas of Urology suitable for further development they should look towards erectile dysfunction, benign prostatic disease, LUTS and continence services. The review should also take into account developments elsewhere within the UK and in particular developments within PCTs in relation to shifting care closer to home.	activity. In the longer term parts of this model do not appear to be sustainable in SHSCT. Our nursing team are not completely in a position to fill this void alone. We have tried unsuccessfully on several occasions to fill or retain the middle grade post which has resulted in intermittent ICATS clinic provision which then results in a long waiting list appearing for such services. The Urology team are in the process of redesigning these clinic services. The GP services have not to date engaged adequately in the redesign of these services.

Section 4 – Capacity, Demand and Activity

	Recommendation	**Update for stocktake**
11 P23	Trusts (Urology departments) will be required to evidence (in their implementation plans) delivery of the key elements of the Elective Reform Programme.	This remains an issue due to the deficit in staffing both at consultant and middle-grade level. However there are areas such as Day of Admission, Pre-operative Assessment that have improved and the Team are delivering on.

Section 5 – Performance Measures

	Recommendation	**Update for stocktake**
12 P27	Trust Urology Teams must as a matter of urgency redesign and enhance capacity to provide single visit outpatient and assessment (diagnostic) services for suspected urological cancer patients.	The Trust have recently invested in expanding the Urology Outpatient Unit (Thorndale) and this has meant that we can redesign our services uncompromised by other activities in outpatients. Examples are aspects of Haematuria and Prostate clinics can be accommodated on a single visit. But issues with demand still remain a challenge.
13 P13	Trusts should implement the key elements of the elective reform programme with regard to admission on the day of surgery, pre-operative assessment and increasing day surgery rates.	The Elective Admission Ward and preoperative assessment service have been a major advantage to the Urology service in that patients are admitted on day of surgery with few cancellations on the day of surgery, which previously had been an issue to due to lack of beds, and patients being unfit. The standalone day surgery unit in CAH and STH limits the type of patients that can have their surgery carried out in these specific day units and therefore means that the main theatre lists have to be used for the rest of the day case patients which is not a good use of theatre time and limits the

		team to what they can record as a daycase
14 P29	Trusts should participate in a benchmarking exercise of a set number of elective (procedure codes) and non-elective (diagnostic codes) patients by Consultant and by hospital with a view to agreeing a target length of stay for these groups of patients.	Not undertaken as yet, but willing to partake in when we have full team in place.
15 P30	Trusts will be required to include in their implementation plans, an action plan for increasing the percentage of elective operations undertaken as day surgery, redesigning their day surgery theatre facilities and should work with Urology Team in other Trusts to agree procedures for which day care will be the norm for elective surgery.	As above number 13.
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HSC Public Health Agency

Urology Review Response Template for Nursing Information

Name of Trust: Southern

Information Required	Response
• How many CNS nurses in urology in acute and community settings?	2 Specialist Nurses in Acute Please note that the acute nurses are responsible for both benign and cancer services, e.g. prostate and haematuria, urodynamics Lower Urinary Tract Clinics etc.
• How many CNS work alongside consultant led services?	2 Specialist Nurses in Acute
• Number of Job plans developed for each CNS urology posts in HSCT?	2 Job Plans have been developed
• What access to training and professional development have CNS have in the past year including access relating to specific approved national college training courses?	Attended internal Mandatory Training Attended British Association of Urological Nurses (BAUN) Conference were they were able to partake in training sessions on Biopsy/Cystoscopy etc..
• What is the current WTE CNS for continence services both in community and acute settings? • What specialist qualifications do they have?	There are none specifically for continence services in Acute although one of the Specialist Nurses who is 0.8WTE carries out LUTs Clinics

HSC Public Health Agency

• What level of nurses look after urinary stomas in the community, stoma specialists or urology specialists continence specialists?	Not applicable to Acute
• Are all District nursing staff training in catheter care and assessment for replacement / insertion?	Not applicable to Acute
• What services exist specifically for nursing support for people including Adolescents with brain injury spinal injury and the elderly in community who require catheter care?	Not applicable to Acute
• Please provide a summary of the national audit of continence care carried out in your HSCT in 2010 and any developments to meet the recommendations and actions.	This is being led by the Community
• Do your HSCT attend any regular meetings/forums for urology specialist nurses in Northern Ireland?	Attend the Regional NICAN meetings and both Specialist Nurses in Acute are members of British Association of Urological Nurses (BAUN) and they attend conferences and relevant meetings in relation to this forum

Thank you for your completion of this form. Please return to [redacted] before 28th April.

Southern Health and Social Care Trust

Quality Care - for you, with you

JOB DESCRIPTION

CONSULTANT UROLOGICAL SURGEON

December 2011

TITLE: Consultant Urological Surgeons

SPECIALTY: Urology

BASE: Craigavon Area Hospital

INTRODUCTION

These are two new posts which have been identified as part of the Regional Review of Adult Urological services and the successful candidates will join 3 other Consultants to provide the full range of inpatient and outpatient urological services. While the post will be mainly based at Craigavon Area Hospital, there are also existing and potential commitments to South Tyrone Hospital, Armagh Community Hospital, Daisy Hill Hospital Banbridge Polyclinic and Erne Hospital in Enniskillen. As a member of the Consultant team, the successful candidate will play a key role in the promotion of the service including the development and implementation of plans to enhance the urological service provided by the Trust.

PROFILE OF SOUTHERN HEALTH AND SOCIAL CARE TRUST

The Southern Health and Social Care Trust became operational on 1 April 2007 following the amalgamation of Craigavon Area Hospital Group Trust, Craigavon and Banbridge Community Trust, Newry & Mourne Trust and Armagh & Dungannon Health and Social Services Trust. Craigavon Area Hospital is the main acute hospital within the SHSCT, with other facilities on the Daisy Hill Hospital, Newry, Lurgan Hospital, South Tyrone Hospital, Dungannon and Banbridge Polyclinic sites.

Craigavon Area Hospital

Craigavon Area Hospital is the main acute hospital within the Southern Health and Social Care Trust and provides acute services to the local population and a range of services to the total Southern Trust area, covering a population of 324,000.

The current bed complement is distributed over the following specialties; General Surgery, Urology, General Medicine, Geriatric Acute, Dermatology, Haematology, Cardiology, Obstetrics, Gynaecology, Paediatrics, Paediatric Surgery, Paediatric Urology, Paediatric ENT, ENT, Intensive Care, Special Care Babies, Emergency Medicine (A&E), Trauma & Orthopaedics.

Many additional specialties are represented as outpatient services including Ophthalmology, Neurology, Maxillo-Facial and Plastic Surgery, Orthodontic and Special Dental Clinics.

In October 2001 The Macmillan Building opened and provides dedicated accommodation for Oncology and Haematology outpatient clinics and day procedures. It is also the designated Cancer Unit for the Southern Area and is one of the main teaching hospitals of Queen's University, Belfast.

The Emergency Medicine Department underwent major refurbishment in 2002 and a Medical Admissions Unit opened in March 2003. A new postgraduate medical centre and a Magnetic Resonance Imaging facility opened in 2004. The new Trauma and Orthopaedic Unit was officially opened in April 2010. This comprises of 2 adjoining Theatre Suites (1 Orthopaedic & 1 Trauma), an Admissions suite, 7 bedded recovery area and ancillary accommodation and a 15-bed ward.

Daisy Hill Hospital

Daisy Hill Hospital is a small district hospital based in the border city of Newry. It has a 24 hour Emergency Department, inpatient beds in Medicine, Surgery, Obstetrics (2000 deliveries per year) and Gynaecology, ENT and Paediatrics. There is a Coronary Care Unit, Surgical High Dependency Unit, a Day Procedure Unit and Radiography Department. The Wards, Outpatient Departments, Theatres and the Emergency Medicine Department are all modern, comfortable and extremely well equipped. The Professions Allied to Medicine (Physiotherapy, Occupational Therapy, Cardiology Investigation, Chiropody and Dietetics) are all on-site, together with a 24 hour Laboratory service.

An adult Sub-regional Haemodialysis Unit (about 100 patients on 3 times/week chemo dialysis) opened in the hospital in June 1998. A CT scanner is located in the X-Ray Department.

South Tyrone Hospital

A Rehabilitation Unit and Day Hospital for elderly patients is provided on the South Tyrone Hospital site. Radiology services are provided on site. Laboratory services are provided from Craigavon Area Hospital. A full range of outpatient services and Day Surgery are also provided on site. South Tyrone Hospital provides inpatient care of the elderly services and a comprehensive range of day surgery, day procedures outpatient, diagnostic and treatment support services for a range of specialties as follows:

- Theatre/Day Procedure Unit
- Support Services
- Respiratory Investigations
- Radiology Scanning Suite
- Minor Injuries Unit
- Medical Simulator
- GP Direct Access Service
- Care of the Elderly Services
- ECG Department
- Ambulatory Paediatric Service

Armagh Community Hospital

Armagh Community Hospital is a diagnostic and outpatient centre with a Doctor-led Minor Injuries Unit which operates Monday – Friday, 9am – 5pm. While it has a wide range of services it does not have any designated inpatient beds and does not undertake any day case surgery. A full range of AHP services is available including Speech and Language Therapy, Podiatry, Physiotherapy, Orthoptics and Audiology. Other available services include mental health, radiology and an outreach ambulance base.

Banbridge Polyclinic

Banbridge Polyclinic opened in March 1998 and provides a comprehensive range of

outpatient, diagnostic and treatment support services.

CURRENT STAFFING IN UROLOGY:

3 Consultants
2 Specialist Registrar

Supported by:

1 Lecturer Nurse Practitioners
2 Nurse Practitioners
1 GP with Specialist Interest in Urology

UROLOGICAL SERVICE

Urology is part of the Surgical Directorate, which comprises of the following specialities:

- General Surgery
- ENT
- Urology
- Orthodontics
- Trauma and Orthopaedics

The Directorate is headed by an Associate Medical Director, a Clinical Director and each Speciality also has a designated Lead Clinician.

The service provided at Craigavon Area Hospital encompasses the entire spectrum of urological investigation and management, with the main exceptions of radical pelvic surgery, renal transplantation and associated vascular access surgery, which are provided by the Regional Transplantation Service in Belfast. Neonatal, and infant urological surgery, provided by the Regional Paediatric Surgical Service in Belfast.

Craigavon Area Hospital has been designated as a Cancer Unit, its Urological Department being designated the Urological Cancer Unit for the Area population of 311,120. A wide spectrum of urological cancer management has been provided for some time. Cancer surgery includes orthotopic bladder reconstruction in the management of bladder cancer. Cancer management also includes intravesical chemotherapy for bladder cancer. Immunotherapy for renal cell carcinoma is also performed.

Craigavon is a pathfinder Trust for urology services with regard to the establishment of Integrated Clinical Assessment and Treatment Services (ICATS). This service is currently supported by 2 nurse practitioners and a GP with a special interest in urology. The following ICAT services are provided:

- LUTS
- Prostate Diagnostic (One-stop Clinic)
- Haematuria (One-stop Clinic)
- Urodynamics
- Oncology Review
- Andrology
- Stone Service

The department has a fixed site ESWL lithotripter with full facilities for percutaneous surgery and the department also have a holmium laser.

Flexible cystoscopy services are undertaken by Specialist Registrars on the Craigavon/Daisy Hill and South Tyrone sites.

Outreach outpatient clinics are currently provided in Armagh (10 miles from Craigavon) and Banbridge (12 miles from Craigavon) and South Tyrone Hospital (18 miles from Craigavon). Currently one of the General Surgeons in Daisy Hill Hospital who has an interest in Urology provides outpatient and daycase sessions in Daisy Hill Hospital. It is anticipated that further outreach services [outpatients/day surgery] will also be provided at Erne Hospital, Enniskillen in the future.

CLINICAL DIAGNOSTICS

There is access to a full range of clinical diagnostic facilities on the Craigavon Area Hospital Group Trust site.

The Department of Radiodiagnosis has up-to-date technology including a repertoire ranging from general radiological procedures, through to specialised radiological examinations of ultrasounds, nuclear medicine, MRI and CT scanning.

The hospital pathology department provides full laboratory facilities on Craigavon Area Hospital site, including biochemistry, haematology, microbiology and histopathology as an area service. A comprehensive pharmacy service exists at Craigavon Area Hospital.

There is also a full range of professions allied to medicine available including physiotherapy, occupational therapy, social services, dietetics.

OTHER FACILITIES

Secretarial support and office accommodation will be provided from within the Directorate.

LIBRARY AND TEACHING RESPONSIBILITIES

Craigavon Area Hospital has a Medical Education Centre with excellent library facilities provided in association with the Medical Library at the Queen's University, Belfast. There is access to electronic online medical databases, such as Med-line and Cochrane.

Regular teaching sessions take place in the Medical Education Centre and general practitioners are invited to participate in and attend meetings.

Craigavon Area Hospital is a recognised teaching hospital for the Queen's University Medical School and attracts a large number of undergraduates. Craigavon Area Hospital is responsible for undergraduate medical teaching for third year students onwards.

The post holder will be expected to participate in undergraduate and postgraduate teaching and general teaching within the Trust and partake in the urology SPR training scheme on a rota basis.

DUTIES OF THE POST (To include Personal Objectives)

The appointee will:

- Have responsibility for urological patients.
- Be expected to share in the on call rota with the existing post holders. While maintaining clinical independence he/she will be expected to work as a member of the urological unit. An emergency theatre is staffed and available 24 hours per day.
- Be expected to undertake administrative and audit duties commensurate with the post and associated with the care of patients and the efficient running of the department.
- Be expected to take a full part in the teaching of undergraduates and post graduates.

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SUPPORTING PROFESSIONAL ACTIVITY

You will:

- Be expected to undertake administrative and audit duties commensurate with the post and associated with the care of patients and the efficient running of the department.
- Work, where appropriate, with the development of Care Pathways.
- Be expected to take a full part in the teaching of undergraduates and postgraduates.

	Sessions **per week**
Direct Clinical Care to include: Main Theatre Day Surgery Outpatients	6.25
Ward Rounds	1.0
On Call	1.0
Patient Admin	1.0
SPA	1.5
	10.75

JOB PLAN REVIEW

This Job Plan is subject to review at least once a year by you and the Clinical Director before being approved by the Chief Executive. For this purpose, a copy of the current Job Plan (and Job Description, if appropriate), including an up-to-date work programme which may result from a diary exercise and objectives agreed at annual appraisal, together with note(s) provided by either side – of any new or proposed service or other developments need to be available. In the case of a new employee, a review of the Job Plan will take place 3 months after commencement and annually thereafter.

If it is not possible to agree a Job Plan, either initially or at an annual review, there are agreed procedures for facilitation and appeal with the final decision normally being accepted by the Trust Board.

MANAGEMENT ARRANGEMENTS

The Chief Executive has overall responsibility for Acute Services in the Southern Health and Social Care Trust. The Consultant appointed will have accountability to the Chief Executive through the Medical Director, the Associate Medical Director, the Clinical Director and the Lead Consultant for the appropriate and smooth delivery of the service.

QUALIFICATIONS AND EXPERIENCE

See Employee Profile.

EMPLOYING AUTHORITY

Southern Health and Social Care Trust.

TERMS AND CONDITIONS

- Employment will be on the Terms and Conditions of the New Consultant Contract.
- Salary Scale is currently equivalent to NHS Remuneration for Hospital Consultants.
- The appointment may be on the basis of either whole time, part time or job share.
- Annual leave will be 32 days per annum initially, rising to 34 days after 7 years' seniority plus 10 statutory and public holidays.
- The post will be superannuable unless the successful candidate decides to opt out of the scheme.
- The Trust is committed to Continuing Professional Development (CPD) and will provide adequate study leave and financial support.
- The successful candidate will be required to reside within a reasonable distance of Craigavon Area Hospital.
- The successful applicant will be required to undergo a Health Assessment in the Trust's Occupational Health Department, to establish fitness to undertake the duties attached to the post. He/she will be required to bring evidence of immunisations/vaccinations to this assessment.
- The post will be subject to termination at any time, by one months notice given on either side.

GENERAL REQUIREMENTS

The post holder must:

- Ensure the Trust's policy on equality of opportunity is promoted through his/her own actions and those of any staff for whom he/she has responsibility.

- Co-operate fully with the implementation of the Trust's Health and Safety arrangements, reporting any accidents/incidents/equipment defects to his/her manager, and maintaining a clean, uncluttered and safe environment for patients/clients, members of the public and staff.

- Adhere at all times to all Trust policies/codes of conduct, including for example:
    - Infection Control
    - Smoke Free policy
    - IT Security Policy and Code of Conduct
    - standards of attendance, appearance and behaviour

- All employees of the trust are legally responsible for all records held, created or used as part of their business within the Trust including patients/clients, corporate and administrative records whether paper-based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited exception, under the Freedom of Information act 2000 the Environmental Information Regulations 2004 and the Data Protection Acts 1998. Employees are required to be conversant with the Trusts policy and procedures on records management and to seek advice if in doubt.

- Represent the Trust's commitment to providing the highest possible standard of service to patients/clients and members of the public, by treating all those with whom he/she comes into contact in the course of work, in a pleasant, courteous and respectful manner.

- Understand that this post may evolve over time, and that this Job Description will therefore be subject to review in the light of changing circumstances.

- It is a standard condition that all Trust staff may be required to serve at any location within the Trust's area, as needs of the service demand.

ADDITIONAL POINTS

- From 1 January 1990 medical staff have not been required to subscribe to a Medical Defence Organisation. It should be noted, however, that the Trust's indemnity only covers the Trust's responsibilities and, therefore, the appointee is advised to maintain membership of a recognised professional defence organisation for any work which does not fall within the scope of the Indemnity Scheme.
- Canvassing will disqualify.
- Application forms can be obtained by contacting the Recruitment & Selection Department, Hill Building, St. Lukes Hospital site, Loughgall Road, Armagh, BT61 7NQ. Telephone number: (028) Personal Information redacted by USI
- For informal enquiries regarding this post please contact Mr Michael Young, Lead Clinician, Urological Surgeon, Craigavon Area Hospital, telephone Personal Information redacted by USI.
- You must clearly demonstrate on your application form how you meet the required criteria – failure to do so may result in you not being shortlisted.
- Candidates wishing to apply online can do so at www.HSCRecruit.com, alternatively application forms for the post may be downloaded and forwarded to the Recruitment & Selection Department.
- Applications should be made on the prescribed form, and must be returned to the Recruitment & Selection Department, **no later than 4:30pm on *****

- As part of the Recruitment & Selection process it may be necessary for the Trust to carry out an Enhanced Disclosure Check through Access NI before any appointment to this post can be confirmed.
- A shortlist of candidates for interview will be prepared on the basis of the information contained in the application form. It is therefore essential that all applicants demonstrate through their application how and to what extent their experience and qualities are relevant to this post and the extent to which they satisfy each criterion specified, including clarification around equivalent qualifications.
- Where there are large numbers of applicants, the panel reserves the right to include the Desirable criteria in the Essential Criteria for shortlisting purposes.
- Following interviews, a waiting list may be compiled for future permanent/temporary full-time/part-time/job share posts which may arise throughout the Trust initially within the next 6 months although some lists may be extended up to a maximum of 12 months.

WE ARE AN EQUAL OPPORTUNITIES EMPLOYER

EMPLOYEE PROFILE

POST: CONSULTANT UROLOGICAL SURGEON

FACTOR	MINIMUM CRITERIA	HOW INFORMATION WILL BE OBTAINED
QUALIFICATIONS & EXPERIENCE	**ESSENTIAL** Candidates must have: • full registration with the GMC (London)with Licence to Practice; • FRCS (UROL) or equivalent; • CCT in Urology or be within 6 months acquisition of same at the date of interview, or be accredited and already included on the GMC Specialist Register. **DESIRABLE** • Completed ATLS Certification; • Higher degree; • Have additional skills e.g. Uro-Oncology (Consultant 3 & 4) Stones (Consultant 5) • Have some formal training in teaching methods • Have management experience.	Application form and interview.
KNOWLEDGE & SPECIAL INTERESTS	Awareness of changes in the Health Service nationally and locally. Understanding of the implications of Clinical Governance. Knowledge of evidence based approach to clinical care. Knowledge of the role of the post. Interest in teaching.	Application form and interview.
SKILLS & APTITUDES	Ability to work well within a multidisciplinary team. Ability to lead and engender high standards of care. Ability to develop strategies to meet changing demands. Willingness to work flexibly as part of a team. Good communication and interpersonal skills. Ability to effectively train and supervise medical undergraduates and postgraduates.	Interview.
OTHER WORK RELATED REQUIREMENTS	Hold a full current driving licence valid for use in the UK and have access to a car on appointment.[1] Reside within a reasonable distance of Craigavon Area Hospital.	Application Form and interview.

[1] this criterion will be waived in the case of a suitable applicant who has a disability which prohibits them from driving but who is able to organise suitable alternative arrangements in order to meet the requirements of the post in full.

Southern Health and Social Care Trust

Quality Care - for you, with you

JOB DESCRIPTION

CONSULTANT UROLOGICAL SURGEON

October 2013

TITLE: Consultant Urological Surgeon

SPECIALTY: Urology

BASE: Craigavon Area Hospital

INTRODUCTION

This is a replacement post and the successful candidate will join four other Consultants to provide the full range of inpatient and outpatient urological services. While the post will be mainly based at Craigavon Area Hospital, there are also existing commitments to South Tyrone Hospital, Armagh Community Hospital, Daisy Hill Hospital, Banbridge Polyclinic and at the new South West Acute Hospital in Enniskillen. As a member of the Consultant team, the successful candidate will play a key role in the promotion of the service including the development and implementation of plans to enhance the urological service provided by the Trust. It is anticipated that the successful candidate will be able to provide a general urology service for elective and emergency care, though a subspecialty interest that would complement the unit would be advantageous.

PROFILE OF SOUTHERN HEALTH AND SOCIAL CARE TRUST

The Southern Health and Social Care Trust became operational on 1 April 2007 following the amalgamation of Craigavon Area Hospital Group Trust, Craigavon and Banbridge Community Trust, Newry & Mourne Trust and Armagh & Dungannon Health and Social Services Trust. Craigavon Area Hospital is the main acute hospital within the SHSCT, with other facilities on the Daisy Hill Hospital, Newry, Lurgan Hospital, South Tyrone Hospital, Dungannon and Banbridge Polyclinic sites.

Craigavon Area Hospital

Craigavon Area Hospital is the main acute hospital within the Southern Health and Social Care Trust and provides acute services to the local population and a range of services to the total Southern Trust area, covering a population of 324,000.

The current bed complement is distributed over the following specialties; General Surgery, Urology, General Medicine, Geriatric Acute, Dermatology, Haematology, Cardiology, Obstetrics, Gynaecology, Paediatrics, Paediatric Surgery, Paediatric Urology, Paediatric ENT, ENT, Intensive Care, Special Care Babies, Emergency Medicine (A&E), Trauma & Orthopaedics.

Many additional specialties are represented as outpatient services including Ophthalmology, Neurology, Maxillo-Facial and Plastic Surgery, Orthodontic and Special Dental Clinics.

In October 2001 The Macmillan Building opened and provides dedicated accommodation for Oncology and Haematology outpatient clinics and day procedures. It is also the designated Cancer Unit for the Southern Area and is one of the main teaching hospitals of Queen's University, Belfast.

The Emergency Medicine Department underwent major refurbishment in 2002 and a Medical Admissions Unit opened in March 2003. A new postgraduate medical centre and a Magnetic Resonance Imaging facility opened in 2004. The new Trauma and Orthopaedic Unit was officially opened in April 2010. This comprises of 2 adjoining Theatre Suites (1 Orthopaedic & 1 Trauma), an Admissions suite, 7 bedded recovery area and ancillary accommodation and a 15-bed ward.

Daisy Hill Hospital

Daisy Hill Hospital is a small district hospital based in the border city of Newry. It has a 24 hour Emergency Department, inpatient beds in Medicine, Surgery, Obstetrics (2000 deliveries per year) and Gynaecology, ENT and Paediatrics. There is a Coronary Care Unit, Surgical High Dependency Unit, a Day Procedure Unit and Radiography Department. The Wards, Outpatient Departments, Theatres and the Emergency Medicine Department are all modern, comfortable and extremely well equipped. The Professions Allied to Medicine (Physiotherapy, Occupational Therapy, Cardiology Investigation, Chiropody and Dietetics) are all on-site, together with a 24 hour Laboratory service.

An adult Sub-regional Haemodialysis Unit (about 100 patients on 3 times/week chemo dialysis) opened in the hospital in June 1998. A CT scanner is located in the X-Ray Department.

South Tyrone Hospital

A Rehabilitation Unit and Day Hospital for elderly patients is provided on the South Tyrone Hospital site. Radiology services are provided on site. Laboratory services are provided from Craigavon Area Hospital. A full range of outpatient services and Day Surgery are also provided on site. South Tyrone Hospital provides inpatient care of the elderly services and a comprehensive range of day surgery, day procedures outpatient, diagnostic and treatment support services for a range of specialties as follows:

- Theatre/Day Procedure Unit
- Support Services
- Respiratory Investigations
- Radiology Scanning Suite
- Minor Injuries Unit
- Medical Simulator
- GP Direct Access Service
- Care of the Elderly Services
- ECG Department
- Ambulatory Paediatric Service

Armagh Community Hospital

Armagh Community Hospital is a diagnostic and outpatient centre with a Doctor-led Minor Injuries Unit which operates Monday – Friday, 9am – 5pm. While it has a wide range of services it does not have any designated inpatient beds and does not undertake any day case surgery. A full range of AHP services is available including Speech and Language Therapy, Podiatry, Physiotherapy, Orthoptics and Audiology. Other available services include mental health, radiology and an outreach ambulance base.

Banbridge Polyclinic

Banbridge Polyclinic opened in March 1998 and provides a comprehensive range of

outpatient, diagnostic and treatment support services.

CURRENT STAFFING IN UROLOGY:

4 Consultants
Mr M Young
Mr A O'Brien
Mr A Glackin
Mr R Suresh
Vacant Post

2 SPR
2 Specialist Registrars (two vacant)

Supported by:

2 Nurse Practitioners
1 GP with Specialist Interest in Urology (vacant)

UROLOGICAL SERVICE

Urology is part of the Surgical Directorate, which comprises of the following specialities:

- General Surgery
- ENT
- Urology
- Orthodontics
- Trauma and Orthopaedics

The Directorate is headed by an Associate Medical Director, a Clinical Director and each Speciality also has a designated Lead Clinician.

The service provided at Craigavon Area Hospital encompasses the entire spectrum of urological investigation and management, with the main exceptions of radical pelvic surgery, renal transplantation and associated vascular access surgery, which are provided by the Regional Transplantation Service in Belfast. Neonatal, and infant urological surgery, provided by the Regional Paediatric Surgical Service in Belfast.

Craigavon Area Hospital has been designated as a Cancer Unit, its Urological Department being designated the Urological Cancer Unit for the Area population of 311,120. A wide spectrum of urological cancer management has been provided for some time. Cancer surgery includes orthotopic bladder reconstruction in the management of bladder cancer. Cancer management also includes intravesical chemotherapy for bladder cancer. Immunotherapy for renal cell carcinoma is also performed.

Craigavon is a pathfinder Trust for urology services with regard to the establishment of Integrated Clinical Assessment and Treatment Services (ICATS). This service is currently supported by 2 nurse practitioners and a GP with a special interest in urology. The following ICAT services are provided:

- LUTS

- Prostate Diagnostic (One-stop Clinic)
- Haematuria (One-stop Clinic)
- Urodynamics
- Oncology Review
- Andrology
- Stone Service

The department has a fixed site ESWL lithotripter with full facilities for percutaneous surgery and the department also have a holmium laser.

Flexible cystoscopy services are undertaken by Specialist Registrars on the Craigavon/Daisy Hill and South Tyrone sites.

Outreach outpatient clinics are currently provided in Armagh (10 miles from Craigavon) and Banbridge (12 miles from Craigavon) and South Tyrone Hospital (18 miles from Craigavon). Currently one of the General Surgeons in Daisy Hill Hospital who has an interest in Urology provides outpatient and daycase sessions in Daisy Hill Hospital. It is anticipated that further outreach services [outpatients/day surgery] will also be provided at Erne Hospital, Enniskillen in the future.

CLINICAL DIAGNOSTICS

There is access to a full range of clinical diagnostic facilities on the Craigavon Area Hospital Group Trust site.

The Department of Radiodiagnosis has up-to-date technology including a repertoire ranging from general radiological procedures, through to specialised radiological examinations of ultrasounds, nuclear medicine, MRI and CT scanning.

The hospital pathology department provides full laboratory facilities on Craigavon Area Hospital site, including biochemistry, haematology, microbiology and histopathology as an area service. A comprehensive pharmacy service exists at Craigavon Area Hospital.

There is also a full range of professions allied to medicine available including physiotherapy, occupational therapy, social services, dietetics.

OTHER FACILITIES

Secretarial support and office accommodation will be provided from within the Directorate.

LIBRARY AND TEACHING RESPONSIBILITIES

Craigavon Area Hospital has a Medical Education Centre with excellent library facilities provided in association with the Medical Library at the Queen's University, Belfast. There is access to electronic online medical databases, such as Med-line and Cochrane.

Regular teaching sessions take place in the Medical Education Centre and general practitioners are invited to participate in and attend meetings.

Craigavon Area Hospital is a recognised teaching hospital for the Queen's University Medical School and attracts a large number of undergraduates. Craigavon Area Hospital is responsible for undergraduate medical teaching for third year students onwards.

The post holder will be expected to participate in undergraduate and postgraduate teaching and general teaching within the Trust and partake in the urology SPR training scheme on a rota basis.

DUTIES OF THE POST (To include Personal Objectives)

The appointee will:

- Have responsibility for urological patients.
- Be expected to share in the on call rota with the existing post holders. While maintaining clinical independence he/she will be expected to work as a member of the urological unit. An emergency theatre is staffed and available 24 hours per day.
- Be expected to undertake administrative and audit duties commensurate with the post and associated with the care of patients and the efficient running of the department.
- Be expected to take a full part in the teaching of undergraduates and post graduates.

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SUPPORTING PROFESSIONAL ACTIVITY

You will:

- Be expected to undertake administrative and audit duties commensurate with the post and associated with the care of patients and the efficient running of the department.
- Work, where appropriate, with the development of Care Pathways.
- Be expected to take a full part in the teaching of undergraduates and postgraduates.

JOB PLAN REVIEW

This Job Plan is subject to review at least once a year by you and the Clinical Director before being approved by the Chief Executive. For this purpose, a copy of the current Job Plan (and Job Description, if appropriate), including an up-to-date work programme which may result from a diary exercise and objectives agreed at annual appraisal, together with note(s) provided by either side – of any new or proposed service or other developments need to be available. In the case of a new employee, a review of the Job Plan will take place 3 months after commencement and annually thereafter.

If it is not possible to agree a Job Plan, either initially or at an annual review, there are agreed procedures for facilitation and appeal with the final decision normally being

accepted by the Trust Board.

MANAGEMENT ARRANGEMENTS

The Chief Executive has overall responsibility for Acute Services in the Southern Health and Social Care Trust. The Consultant appointed will have accountability to the Chief Executive through the Medical Director, the Associate Medical Director, the Clinical Director and the Lead Consultant for the appropriate and smooth delivery of the service.

QUALIFICATIONS AND EXPERIENCE

See Employee Profile.

EMPLOYING AUTHORITY

Southern Health and Social Care Trust.

TERMS AND CONDITIONS

- Employment will be on the Terms and Conditions of the New Consultant Contract.
- Salary Scale is currently equivalent to NHS Remuneration for Hospital Consultants.
- The appointment may be on the basis of either whole time, part time or job share.
- Annual leave will be 32 days per annum initially, rising to 34 days after 7 years' seniority plus 10 statutory and public holidays.
- The post will be superannuable unless the successful candidate decides to opt out of the scheme.
- The Trust is committed to Continuing Professional Development (CPD) and will provide adequate study leave and financial support.
- The successful candidate will be required to reside within a reasonable distance of Craigavon Area Hospital.
- The successful applicant will be required to undergo a Health Assessment in the Trust's Occupational Health Department, to establish fitness to undertake the duties attached to the post. He/she will be required to bring evidence of immunisations/vaccinations to this assessment.
- The post will be subject to termination at any time, by one months notice given on either side.

GENERAL REQUIREMENTS

The post holder must:

- Ensure the Trust's policy on equality of opportunity is promoted through his/her own actions and those of any staff for whom he/she has responsibility.
- Co-operate fully with the implementation of the Trust's Health and Safety arrangements, reporting any accidents/incidents/equipment defects to his/her

manager, and maintaining a clean, uncluttered and safe environment for patients/clients, members of the public and staff.

- Adhere at all times to all Trust policies/codes of conduct, including for example:
  - Infection Control
  - Smoke Free policy
  - IT Security Policy and Code of Conduct
  - standards of attendance, appearance and behaviour

- All employees of the trust are legally responsible for all records held, created or used as part of their business within the Trust including patients/clients, corporate and administrative records whether paper-based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited exception, under the Freedom of Information act 2000 the Environmental Information Regulations 2004 and the Data Protection Acts 1998. Employees are required to be conversant with the Trusts policy and procedures on records management and to seek advice if in doubt.

- Represent the Trust's commitment to providing the highest possible standard of service to patients/clients and members of the public, by treating all those with whom he/she comes into contact in the course of work, in a pleasant, courteous and respectful manner.

- Understand that this post may evolve over time, and that this Job Description will therefore be subject to review in the light of changing circumstances.

- It is a standard condition that all Trust staff may be required to serve at any location within the Trust's area, as needs of the service demand.

ADDITIONAL POINTS

- From 1 January 1990 medical staff have not been required to subscribe to a Medical Defence Organisation. It should be noted, however, that the Trust's indemnity only covers the Trust's responsibilities and, therefore, the appointee is advised to maintain membership of a recognised professional defence organisation for any work which does not fall within the scope of the Indemnity Scheme.
- Canvassing will disqualify.
- Application forms can be obtained by contacting the Recruitment & Selection Department, Hill Building, St. Lukes Hospital site, Loughgall Road, Armagh, BT61 7NQ. Telephone number: (028) Personal Information redacted by USI .
- For informal enquiries regarding this post please contact Mr Michael Young, Lead Clinician, Urological Surgeon, Craigavon Area Hospital, telephone Personal Information redacted by USI .
- You must clearly demonstrate on your application form how you meet the required criteria – failure to do so may result in you not being shortlisted.
- Candidates wishing to apply online can do so at www.HSCRecruit.com, alternatively application forms for the post may be downloaded and forwarded to the Recruitment & Selection Department.
- Applications should be made on the prescribed form, and must be returned to the Recruitment & Selection Department, **no later than 4:30pm on *****
- As part of the Recruitment & Selection process it may be necessary for the Trust to carry out an Enhanced Disclosure Check through Access NI before any appointment to this post can be confirmed.

- A shortlist of candidates for interview will be prepared on the basis of the information contained in the application form. It is therefore essential that all applicants demonstrate through their application how and to what extent their experience and qualities are relevant to this post and the extent to which they satisfy each criterion specified, including clarification around equivalent qualifications.
- Where there are large numbers of applicants, the panel reserves the right to include the Desirable criteria in the Essential Criteria for shortlisting purposes.
- Following interviews, a waiting list may be compiled for future permanent/temporary full-time/part-time/job share posts which may arise throughout the Trust initially within the next 6 months although some lists may be extended up to a maximum of 12 months.

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EMPLOYEE PROFILE

POST: CONSULTANT UROLOGICAL SURGEON

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KNOWLEDGE & SPECIAL INTERESTS	Awareness of changes in the Health Service nationally and locally. Understanding of the implications of Clinical Governance. Knowledge of evidence based approach to clinical care. Knowledge of the role of the post. Interest in teaching.	Application form and interview.
SKILLS & APTITUDES	Ability to work well within a multidisciplinary team. Ability to lead and engender high standards of care. Ability to develop strategies to meet changing demands. Willingness to work flexibly as part of a team. Good communication and interpersonal skills. Ability to effectively train and supervise medical undergraduates and postgraduates.	Interview.
OTHER WORK RELATED REQUIREMENTS	Hold a full current driving licence valid for use in the UK and have access to a car on appointment.[1] Reside within a reasonable distance of Craigavon Area Hospital.	Application Form and interview.

[1] this criterion will be waived in the case of a suitable applicant who has a disability which prohibits them from driving but who is able to organise suitable alternative arrangements in order to meet the requirements of the post in full.

Corrigan, Martina

From: Young, Michael [redacted]
Sent: 12 November 2013 17:44
To: Corrigan, Martina
Subject: RE: ***REALLY REALLY URGENT*****SPECIALTY DOCTOR (clinical fellow) - UROLOGY - CAH - UPDATED 7 October 13

Why specialty advisor each time
If so yes to both

From: Corrigan, Martina
Sent: 12 November 2013 13:22
To: Young, Michael
Subject: RE: ***REALLY REALLY URGENT*****SPECIALTY DOCTOR (clinical fellow) - UROLOGY - CAH - UPDATED 7 October 13

Perfect -thanks – I assume this needs to go to specialty advisor (?????) and do you want to go with one or two posts?

Martina

Martina Corrigan
Head of ENT, Urology and Outpatients
Southern Health and Social Care Trust

Telephone: [redacted] (Direct Dial)
Mobile: [redacted]
Email: [redacted]

From: Young, Michael
Sent: 12 November 2013 12:59
To: Corrigan, Martina
Subject: RE: ***REALLY REALLY URGENT*****SPECIALTY DOCTOR (clinical fellow) - UROLOGY - CAH - UPDATED 7 October 13

The bit about bladder reconstruction after bladder cancer should be taken out

I think a bit on research would be good

This unit has a good track record of fellows completing research to MD level. There is a close relationship to Queens University Belfast and The University of Ulster for research links. Our charitable fund – CURE – Craigavon Urology Research and Education, has provided the funding to undertake such activities. This post can provide time for both research activity as well as urology exposure both of which are advantageous for future career interviews

Does this sound ok

MY

From: Corrigan, Martina
Sent: 11 November 2013 15:11
To: Young, Michael; [redacted]
Subject: ***REALLY REALLY URGENT*****SPECIALTY DOCTOR (clinical fellow) - UROLOGY - CAH - UPDATED 7 October 13

Importance: High

Hi Michael,

I thought that this post had been sorted and Debbie and the Board think that it is closing shortly!!! Can you have a look at this and let me know if you have any changes so that we can get this through to HR for advertising!

Also there are two applicants for the locum consultant post. Personal information redacted by USI. Are you happy that you, Aidan and I interview? And if so can we organise a date for the next few weeks??

Thanks and happy to come and see you tomorrow in theatres if need be……

Martina

Martina Corrigan
Head of ENT, Urology and Outpatients
Southern Health and Social Care Trust

Telephone: Personal Information redacted by USI (Direct Dial)
Mobile: Personal Information redacted by USI
Email: Personal Information redacted by USI

Corrigan, Martina

From: Burns, Deborah [redacted]
Sent: 06 November 2013 13:17
To: Corrigan, Martina; Trouton, Heather
Cc: Stinson, Emma M
Subject: RE: Approval of advertisement of post

Debbie Burns
Interim Director of Acute Services
SHSCT
Tel: [redacted]
Email: [redacted]

From: McCall, Honor
Sent: 06 November 2013 09:55
To: Burns, Deborah
Cc: Stinson, Emma M
Subject: RE: Approval of advertisement of post

Dear Mrs Burns

This post went to ad a few weeks ago but was only advertised as temporary as we had not received the specialty advisor approval at that time for the job description, this just came through last week. The permanent post will now appear in the Sunday Independent this Sunday and the Belfast Telegraph next Tuesday alongside the medical publications.

Apologies for any confusion.

With thanks
Honor

From: Burns, Deborah
Sent: 06 November 2013 06:30
To: McCall, Honor; Trouton, Heather; Corrigan, Martina
Cc: Stinson, Emma M
Subject: RE: Approval of advertisement of post

I am fully aware of the costs and already had this discussion with Malcolm Clegg – so I had hoped these had already been advertised. As previously explained at that time several weeks ago in the face of losing money and a consultant post form the service on a permanent basis this is very cost effective

Debbie Burns
Interim Director of Acute Services
SHSCT
Tel: [redacted]
Email: [redacted]

From: McCall, Honor
Sent: 05 November 2013 15:36
To: Burns, Deborah

Cc: Stinson, Emma M
Subject: Approval of advertisement of post

Dear Mrs Burns

When you were off last week approval was given for the permanent Consultant Urologist, CAH post to go to advert. Heather Trouton in your absence approved for this post to also be advertised in the Irish Medical Times and the Sunday Independent along side our usual publications of the British Medical Journal and the Belfast Telegraph.

I just wanted to make you aware of the costs as these are going to ad next week.

Irish Medical Journal £295 + vat
Sunday Independent 1396 euro + vat

I will go ahead and process these unless you have any objection.

Regards
Honor

Honor McCall
Medical Recruitment Officer
Southern Health and Social Care Trust
Hill Building
St Luke's Hospital Site
Loughgall Road
ARMAGH
BT61 7NQ

Tel: Personal Information redacted by USI
Email: Personal Information redacted by USI

Corrigan, Martina

From: Parks, Zoe [redacted]
Sent: 06 January 2012 17:26
To: Corrigan, Martina
Subject: RE: CONSULTANT UROLOGIST SURGEON december 2011

Martina,

I am not sure if the specialty advisor will be willing to approve the job description without an indicative job plan – can we discuss next week if possible?

Zoë Parks
Medical Staffing Manager
Southern Health & Social Care Trust
Craigavon Area Hospital
68 Lurgan Road, Portadown

Phone: [redacted]
Mobile: [redacted]
Fax: [redacted]
Email: [redacted]

From: Corrigan, Martina
Sent: 30 December 2011 14:03
To: Parks, Zoe
Cc: Mackle, Eamon; Trouton, Heather; Kerr, Joanne; Clegg, Malcolm
Subject: CONSULTANT UROLOGIST SURGEON december 2011

Zoe,

Please see attached job description for consultant 4 & 5 for urology. I had discussed the job plans with Mr Mackle and we have just included general information instead of a day by day job plan as there has been no final agreement on the job plans.

Can you have a look at this to ensure I have included everything that needs to be included and then can it be forwarded to Mr Patrick Keane, the Specialist Advisor for Urology based in Belfast Trust. As the Board are requiring an update on where we are at with this recruitment I would be grateful if this could be done as soon as possible.

Many thanks

Martina

Martina Corrigan
Head of ENT and Urology
Craigavon Area Hospital

Tel: [redacted] (Direct Dial)
Mobile: [redacted]
Email: [redacted]

Corrigan, Martina

From: Corrigan, Martina [redacted]
Sent: 11 January 2012 13:41
To: Kerr, Joanne
Subject: RE: *for urgent action* Correspondence from Mr A

Many thanks Joanne,

Was going to contact you about this anyway!

Just checking is there an E-Req raised for the other two urology posts? We hope to have the job plans finalised this week so I will insert them in the job descriptions and then we will send all three to the specialty advisor as we need to go to advert for all three.

Thanks

Martina

Martina Corrigan
Head of ENT and Urology
Craigavon Area Hospital

Tel: [redacted] (Direct Dial)
Mobile: [redacted]
Email: [redacted]

From: Kerr, Joanne
Sent: 11 January 2012 11:22
To: Corrigan, Martina
Subject: FW: *for urgent action* Correspondence from Mr A

Martina

I will raise an E-Req under Mr Mackle's pathway.

Once you have the job plan sorted can you send it through as it will have to go to the Royal College for approval.

Many thanks

Joanne

Joanne Kerr
Medical Staffing Officer
Medical Staffing Section
Southern Health and Social Care Trust
Tel: [redacted]
Fax: [redacted]
email: [redacted]
From: Parks, Zoe
Sent: 10 January 2012 19:46
To: Kerr, Joanne

Subject: Fw: *for urgent action* Correspondence from Mr A

Fyi

From: Trouton, Heather
To: Corrigan, Martina; Sterling, Carol
Cc: Parks, Zoe
Sent: Tue Jan 10 19:44:41 2012
Subject: FW: *for urgent action* Correspondence from Mr A

Martina

Can you please urgently do an e-req

Thanks

Heather

From: Stinson, Emma M
Sent: 10 January 2012 11:34
To: Trouton, Heather
Cc: Irwin, Laura J
Subject: *for urgent action* Correspondence from Mr A

Dear Heather

Further to Mr Akhtar's attached letter, please proceed urgently with advertisement for recruitment of Mr Akhtar's replacement.

Gillian

Emma Stinson
PA to Dr Gillian Rankin
Director of Acute Services
Southern Health and Social Care Trust
Admin Floor
Craigavon Area Hospital

Tel: Personal Information redacted by USI
Fax: Personal Information redacted by USI

Email: Personal Information redacted by USI
P Please consider the environment before printing this email

From: Personal Information redacted by USI
Sent: 10 January 2012 11:29
To: Stinson, Emma M
Subject: Message from Personal information redacted by USI

Corrigan, Martina

From: Young, Michael [redacted]
Sent: 16 January 2012 15:48
To: Mackle, Eamon
Cc: Corrigan, Martina
Subject: RE: Urology Job Plans

I was at banbridge this am

I am sorry but my proposals do meet the two clinics per week and the 0.5 dsu/ week.

The specialty adviser is to assess the two new posts only. So I do not see the problem.

Job plans with existing consultants can only be adjusted with consent

MY

From: Mackle, Eamon
Sent: 16 January 2012 12:22
To: Young, Michael
Subject: Fw: Urology Job Plans

Michael

As below

Eamon

From: Corrigan, Martina
To: Mackle, Eamon
Sent: Mon Jan 16 12:21:13 2012
Subject: Urology Job Plans
Dear Michael,

I couldn't get you this morning so I have had to email you. I met with Martina this morning to discuss job plans. Your proposal has attractions but unfortunately we couldn't match the times outlined with outpatient sessions and day surgery sessions. As per the 5 job plan you will note that not all sessions are weekly.

As we really need to process these job plans urgently I have therefore drafted 3 job plans from the 5 job plan template that we had shared with you and I will send to Malcolm today to put in the formal template so that they can be sent to the Specialty Advisor.

Once the jobs are up and running they can be revisited.

2x O/P
2x in Theatre

1 x Specialist clinic or Daycare list

? possible use of G.P. part of this Building?

What's appropriate to be done Daisy Hill & South Tyrone.

Three Urologist up to a mcmahon a TR. (Day Case).
everything else done in a centre.

EXTERNAL REVIEW OF UROLOGY SERVICES

FOR CRAIGAVON AREA HOSPITAL GROUP TRUST

Maybe consultant could attend DHH & support activity of R Brown.

Substantive post within 6 mths.

Equipment requirements)

LGID - X.Ray Machine
- Laser equipment
- TURPS equipment

Boards not to fund capital items not allowed. Money comes directly from department.

Report by:

Mr S McClinton MD FRCSI FRCSEd
Vice-President Scottish Urological Society
Member of Council, British Association of Urological Surgeons
Chairman, Urology Special Advisory Board, Royal College of Surgeons of Edinburgh

Urology - circle fund
- Mr Young urology fund

Draft 12-08-04

INDEX

Page

Appendices

Executive Summary

In April 2004 the Chief Executive of Craigavon Area Hospital (CAH) asked the Medical Director to carry out a review of the Urology service at CAH. The Medical Director established a review group, consisting of members of the management team and clinicians, to undertake a comprehensive review of Urology services within the Southern Health and Southern Services Board (SHSSB). The aim was to improve the service provided to the community and resolve some, if not all, of the challenges facing the current Urology service.

The key challenges adversely affecting the Urology services in SHSSB were seen as:

- Insufficient manpower or capacity to deliver a full Urological service.
- Increasing waiting times for outpatient, inpatient and day cases.
- Increasing emergency workload.

A decision was taken to engage an independent external advisor to carry out an impartial analysis of the Urology service and against the current backdrop, to make recommendations for a sustainable way forward. The external advisor carried out this analysis utilising:

- a series of one to one consultations with clinicians, nurses, managers and administrative staff (in May and July 2004)
- visits to all sites within SHSSB where Urology services are delivered
- three meetings of the entire Urology review group (in May, July and August 2004)

The information gathered was used to create a comparative analysis picture of what, under British Association of Urological Surgeons (BAUS) guidance and NHS norms, one should expect in terms of service delivery given the available resources and infrastructure. The external advisor has also looked in detail at Scotland and the Grampian region to establish expected capacity and demand figures for the SHSSB area and what best practices might be viable options for replication in the SHSSB area.

The outcome of this analysis is presented in this report and leads to the following proposals for a way forward

Give serious consideration to:

- Increased levels of staffing to address current critically low levels. This would require the following
  - Immediate appointment of locum Consultant to address waiting list issues and Consultant on-call rota
  - Increased use of available urology nurses to establish direct access clinics / telephone reviews
  - Appointment of a third Consultant Urologist and all appropriate support staff

- Redesign and modernise the Urology service and invest in creating additional capacity. This will require the team to draw up a long term strategy with actions aimed at an
  - Increase in inpatient bed capacity
  - Use of day case capacity at South Tyrone hospital
  - Reduction in the new/review ratio at outpatient clinics to levels in keeping with national averages
  - Dedicated Urology diagnostic and treatment centre as part of the overall strategy for development of services at CAH
  - Appointment of a fourth Consultant Urologist and support staff
  - Appointment of dedicated urology specialist nurses
  - Instigate regular performance review to ensure expected outcomes from redesign and modernisation.

The author views it as vital that all participants in the review agree to full implementation of the recommendations contained in this report even though this will require some flexibility and compromise by all parties. Failure to do this creates significant risks, not least of which is the potential loss of a viable Urology service at CAH.

TERMS OF REFERENCE OF THE REVIEW GROUP:

The review group (membership below) agreed the following terms of reference

- To provide a factual basis to determine the current and future requirements for Urological Services across the Trust and Southern Area.

- To recommend ways to meet demand over the next five years, maximising the use of available resources and establishing the need for further resources.

- Address current waiting time issues and establish processes to address future demand for outpatient and inpatient interventions

- To review the provision of Urological services examining care pathways starting in Primary Care and looking at other ways of working

- To consider the impact of changes in Urological work on other services e.g. Radiology, Pathology and Oncology.

- To make recommendations on the appropriate capacity and resourcing to deliver targets (e.g. Inpatient, Outpatient, and cancer targets) taking into account the demand for non-cancer work and the impact of training and education.

- To ensure implementation of the recommendations of this review and establish ongoing review and performance management of the clinical urology service

Membership of review group

Dr C Humphrey	Medical Director (CHAIR), CAH
Mr J Mone	Director of Nursing & Quality, CAH
Mr WJI Stirling	Clinical Director, Surgery, CAH
Mr M Young	Lead Consultant Urologist, CAH
Mrs M McAlinden	Director of Planning, SHSSB
Dr D Corrigan	Consultant in Public Health Medicine, SHSSB
Dr G Millar	General Practitioner
Miss A Brennan	Planning Department, CAH
Mr J Marley	Nurse Lecturer /Practitioner (Urology), CAH
Mr H Campbell	Finance Department, CAH
Mr S McClinton	Consultant Urologist, External Advisor
Jean Mansfield	Project coordinator

Introduction

The object of this report is to create the environment in which excellence in Urological care in the SHSSB will flourish, and to ensure that patients have rapid access to a safe, high quality service by fully trained specialists. For this to be achieved the people delivering Urology services require the infrastructure, support and resources necessary to deliver that excellent service.

Many factors impact Urologists and Urological Departments and thus influence the direction of change and the planning of Urological Services. The future direction of the NHS clearly intends that patients should be seen and treated promptly. It has at its core an emphasis on fairness, equity of access, and high quality care. It also highlights the potential for the changing role of allied medical staff other than consultants for the delivery of certain aspects of healthcare. This includes the use of nurses and other health-care professionals with an emphasis on effective team working.

Recent and future changes in Urological training will lead to two types of Consultant Urologist – those who will do mainly diagnostic and day case work and those who will carry out more major surgery. At the core of an excellent Urological service there must be sufficient Consultant Urologists with access to an adequate numbers of beds and operating sessions together with the support of appropriate numbers of properly trained nurses and theatre staff.

This report is presented against the background of a perceived need to improve the quality of Urological Care for all patients in the SHSSB area together with a reduction in waiting times for both outpatient and inpatient services.

THE CURRENT LEVEL OF SERVICE:

The total catchment population covered by CAH numbers 300,000 approximately. To service this population there are two full time Consultant Urological Surgeons providing the service from Craigavon Area Hospital (CAH), and an additional Consultant Surgeon with an interest in Urology in Daisy Hill Hospital, Newry (providing one session per week). The two Consultant Urological Surgeons work a 1:2 rota and often have no middle grade cover, a situation that is currently unacceptable and unsustainable in the long term. All inpatient services are provided at CAH with outpatient services based at Banbridge and Armagh. A total of 1 SpR, 1 SHO and 2 clinical research fellows, who provide a sessional clinical commitment only, provide junior staff support.

The Urology speciality association, BAUS, recommendations (ref 1) are that there should be a minimum of 1 Urological Surgeon per 100,000 population, with a move to 1:80,000 by 2007. It is likely that increasing demands in the future, and changes in urological training, will require an expansion in the number of Consultant Urologists (so called 'Office' urologists) over and above the need for Urological surgeons

Based on the BAUS recommendations CAH should have 3 Urological Surgeons currently, rising to 4 by 2007.

BAUS also recommends that for a population of 500,000 a total of 6 - 8 Consultant Urological Surgeons, each with a specialist interest (e.g. oncology 3-4, endourology 2, female urology 1-2, andrology 1) would provide optimum cover (ref 2). These consultants will spend a substantial part of their time working on their specialist interest but will also have to provide routine core urology and emergency cover to the population.

It is clear that the SHSSB, in conjunction with the other Boards in Northern Ireland, will need to address the provision of Urological Services across the province in the longer term to ensure that sub specialisation develops in a planned and integrated way.

(i) OUTPATIENT ACTIVITY (2000 - 2004):

Adequate time to see patients at Outpatient clinics is vital if a safe, quality service is to provided and complaints from patients avoided.

BAUS guidelines suggest that a consultant sees 7 –10 new outpatients per clinic with similar numbers of review patients (i.e. maximum 20 patients per clinic). This is equivalent to a maximum of 420 new patients per year (based on a 42 week Consultant working year) with a similar number of review patients (total 840). This number could increase by 5 – 10 patients per clinic if middle grade cover is available. Experienced middle grade cover also allows cover for clinics during periods of consultant leave.

Table 1.3 in the information report (appendix 1) shows Outpatient activity at CAH, Banbridge and Armagh. Adding in stone centre patients gives summative totals of

	2000-01	2001-02	2002-03	2003-04
New	620	567	448	568
Review	4073	4110	3860	3789
Total	4693	4677	4308	4357

outpatient attendances across the various sites. The number of new patients seen is low and the new:review ratio is high (1:7 in 2003-2004) in comparison to recommended BAUS practice.

The Stone Treatment Centre provides an excellent regional service for patients with urinary calculi and the facilities offer the potential for further utilisation in dealing with outpatients. There are also a large number of ward attendees (mainly review patients) seen on 2 South.

At Daisy Hill Hospital in Newry,129 new patients were seen at a dedicated Haematuria clinic (2001-2 figures provided by Mr Brown). A number of patients are also referred to centres out side of the SSHB area with figures for 2003-4 showing 255 new patients and 521 review patients being seen at other centres.

Waiting time standards are not being met at CAH with patients waiting over 2 years for routine new outpatient appointments.

The figures demonstrate that the total outpatient numbers being seen in the SHSSB area are too high for two consultants to deal with effectively. Given that the demand for Urological services is high it is not surprising that the current waiting times for routine / specialist clinics is 56 weeks with over 1000 patients currently waiting for a first appointment. However the current number of new patients seen seems low while the number of review patients seems high and could be reduced through service redesign (see recommendations). There is also scope for increasing the numbers of new patients seen if the review workload can be reduced to help streamline the clinics. This is addressed in the recommendations and could include measures such as reducing the number and quality of referrals by referral guidelines, utilising specialist nurses and having a more robust discharge policy agreed within the Urology service.

KEY POINTS

1. Total number of outpatients seen is proportionately high by national norms
2. The number of review patients seen should be reduced by service redesign and unit policy changes
3. Clinic templates should be changed to reflect national norms
4. Partial booking for outpatients would help reduce DNA rates

(ii) INPATIENT ACTIVITY:

All inpatient services are delivered at CAH from 21 beds (19 in 2 South and 2 in 2 West), together with very limited access to a Surgical day case unit of 14 beds (providing up to 4 beds per list). BAUS recommends a minimum of 8 beds per 100,000 population (i.e. 24 beds at CAH) with access to short stay or overnight beds that could close at weekends.

The current bed capacity is inadequate for the current level of activity and will not support any increased activity. This is demonstrated by the bed occupancy rates of over 90%, which indicate that the unit is working at full capacity. The average length of stay, at 3.9 days, is similar to national figures and indicates efficient use of the resources available.

The knock-on effect of an inadequate bed capacity has been a steadily increasing emergency workload (now 60% of activity) with the consequent effect of cancellation of elective cases leading to a rising elective waiting time. Many patients now wait over 12 months for inpatient treatment (209 patients in March 2004) with 117 patients waiting over 2 years.

Inpatient activity figures (CAH)

	2000-01	2001-02	2002-03	2003-04
Elective	765	740	663	645
Emergency	594	649	914	952
Day case	1103	1068	1196	1047
Total FCE's	2462	2459	2778	2647

A further 192 patients were treated at centres outside the SSHB area (2003-4) giving a total of 2839 patients in 2003-4.

Utilising activity figures from Scotland (appendix 2) it is possible to model the potential activity at CAH using both national (Scotland) and regional (Grampian) activity figures from 2001-2 and 2002-3. Based on these figures a reasonable estimate of expected FCE's for CAH is approximately 3000 per annum, which matches well with the current activity levels.

KEY POINTS

1. Projected inpatient activity figures are in line with current activity figures
2. Emergency work load is increasing and impacting adversely on elective activity – additional beds are required
3. BAUS would expect a Consultant to perform a minimum of 750 FCE's per annum depending on case mix. To deal with the expected 3000 FCE's would require an establishment of 4 Consultant Urologists and the current 2-man unit is clearly working extremely hard and well beyond expected levels.

5 all day LISTS
10 sessions INPTS

(iii) THEATRE ACTIVITY:

drop to 7 if DayCase LIST ↑ even more if access to 5 can be

Utilising activity figures from Scotland it is possible to model the expected number of procedures for the population served by CAH (appendix 3). This equates to approximately 3000 procedures per year. If 40% of these are done as day cases then there is a need for over 270 all day main theatre lists per year, or 5 lists per week. Current access to theatre is 2 all day main theatre lists per week and it is clear that this is insufficient to meet current requirements.

If the amount of day case activity rose to 60%, the requirement for theatre time would drop to 3.5 theatre lists per week. Current access to day case lists is very limited and this would need to be addressed if the Urology department is to meet the capacity demand. Based on a 40% day case rate there is a need for 3 day case lists per week, and with a 60% day case rate this would increase to 4 per week. A small, but significant amount of operating is currently done at Daisy Hill with approximately 400 procedures per annum (the majority, 356 patients, having cystoscopy only). A number of more complex endoscopic procedures are performed (40 patients/yr) but the surgeon performing these has expressed his concerns at continuing to provide this service.

~8 DC/ WK not Flexible. CYSTOSCOPY

KEY POINTS:

1. Assuming activity remains similar there is a need for additional operating time. This needs to be incorporated into any future plans for development at CAH.
2. Additional day surgery lists could increase the overall conversion from inpatient to day case patients. CAH has a 40% Day Case activity rate and reviewing the activity data there is the potential to increase this further. This should be incorporated into the Trusts strategic plans for increasing day surgery capacity at CAH. There is also capacity available at South Tyrone hospital and potentially at Daisy Hill.
3. In the future more operating lists will be needed to meet demand and the cancer waiting time targets.

URO-ONCOLOGY ISSUES:

The Southern Area Urological Cancer Implementation Group produced a report in 2002 on re-organising Urology Cancer Services. Much of this is still to be implemented and it is clear that local General Practitioners feel that the Urology service is providing a poor or very poor service in respect to oncology patients.

Urological cancer forms a large proportion of the workload of a Urology department, and this is likely to rise in the face of the rising incidence of prostate cancer and an ageing population. Based on comparative analysis there are likely to be over 200 new cases per annum of urological cancer across the Southern Area and 600 cases of suspected cancer requiring investigation.

Provision of services for urological cancer

CAH is a designated Cancer Unit for the SH&SSB area and does have agreed clinical guidelines for urology cancers as laid out in the Urological Cancer Implementation Group report (2002). However, implementation of these guidelines has been incomplete due in part to the fact that levels of medical staffing in the urology department are generally lower than recommended by BAUS. In addition there has been limited development of the role of specialist nurses across the area as a whole, with a single part-time specialist nurse in post at CAH. Ward nurses have taken on special interest areas but find it difficult to get released from ward work due to lack of staff to back fill during their absence.

A new Macmillan cancer unit is not currently utilised by the Urology department although a waiting list initiative for TRUS biopsies would seem to suggest that this facility would be ideal for use by Urological patients. It is extremely concerning that over 50 patients are currently awaiting TRUS biopsy at CAH.

The estimated impact of the cancer workload can be derived from Scottish registrations of all new urological cancers. For the two commonest urological cancers, prostate and bladder cancer, the expected incidence rates are:
Prostate = 50/100,000 population
Bladder = 20/100,00 population

TRUS BIOPSIES ~~Radiology~~ Urology. who should do it? Could be either Radiology in CAH do it.

This equates to150 new cases of prostate cancer and 60 new cases of bladder cancer expected per year at CAH.

This will generate annual numbers of radical prostatectomy and cystectomy operations of approximately 16 patients (approx 7.5% all new cases). Each of these complex procedures has a consequential impact on inpatient activity, as these cases are likely to require up to 1 session per case.

These figures may be considered to be a conservative estimate as for example some that are currently sent for radiotherapy may be more optimally treated surgically.

Associated Specialty Issues

The Multidisciplinary team

Uro-Oncology involves close collaboration between radiation and clinical oncologists together with pathology and radiology services. Increasing the demand for Uro-Oncology will potentially impact further on the ability of related specialties to deliver the service within expected delivery targets. BAUS currently recommends that for a population of 500,000 there should be a minimum of 2-3 radiologists, 2 Clinical (Radiation) Oncologists, 1 Medical Oncologist, 1 Palliative Care Specialist and 2 Histopathologists to support multidisciplinary team work (ref 2). It should also be recognised that a whole time Oncology Nurse Specialist is an essential member of the Cancer MDT.

Specialist Nurses

The role of Specialist Urological Nurses has developed and expanded in recent years and they are now seen as being essential to the running of any Urological unit. Currently there is a single Lecturer-Practitioner in post with ward-based nurses providing support to a haematuria service, a pre-operative assessment service, urodynamics, the Stone treatment centre and ward based chemotherapy. Models of nursing support for development in the urology service have been put forward in a discussion paper (appendix 4). Adopting one of these models will be an essential part of the redesign of Urological services at CAH.

Cystoscopy who wd to do them? Can Specialist nurses be used? Yes! Model + training in place

KEY POINTS

1. There is a clear need for the implementation of referral guidelines for each of the urological cancers, from primary to secondary care and from local to specialist team.
2. Improved definition of the role and function of nurse specialists would enhance the service patients receive.
3. Serious consideration should be given to sharing of exampies of good practice in achieving rapid diagnosis for patient with suspected urological cancer (examples from other urology services are available on the website www.modern.nhs.uk/cancer).
4. Further work analysing delays in investigation and treatment and patient pathways is essential.
5. Establishment of a minimum dataset for urological cancer to improve quality of information is required.

Urology Service Configuration Models

There are several models for service configuration. Increasingly the demand from Primary Care and the Department of Health is for patients to be seen, investigated and diagnosed within a reasonable timescale. If this is to be achieved then a major change in Urological practice has to be envisaged to accommodate all these proposals and meet the increasing demands on Consultant practice from Clinical Governance and Audit.

Urology is a high technology specialty with expensive requirements for new equipment and imaging techniques. There is also the need to provide emergency cover in the face of a reduction in Junior doctors' hours and further pressures anticipated as a result of European Working Time Directive. BAUS guidelines on workload recommend that consultant urologists should be on call for emergencies no more frequently than 1:5. Also there must be

sufficient number of consultants to allow the development of subspecialty teams and there needs to be a critical mass of work for trainees to get sufficient practical operating experience.

In order to provide the most efficient service possible a dedicated Urology area would be the most desirable goal. This which would allow for in-house referrals, outpatient facilities, day-case activity and a receiving room facility for mobile casualty referrals. A useful model for this is the unit established at Ayr Hospital which has made a major impact on the way the Urology service runs and the service it offers patients.

This arrangement would have the following benefits:

- Best quality care for patients and better management of resources
- Reduction of waiting times for investigation and treatment
- Meets SAC requirements for Training with improved clinical exposure for trainees
- Provides a regional focus for Urological Care.
- The introduction of clinical protocols for patient management would ensure patient and GP satisfaction with the service

Recommendations

1.1 Staffing

Recommendation	Expected outcome	Action by	Time scale
Immediate appointment of a locum Consultant to address waiting list issues, in particular the elimination of those waiting over 18 months.	Reduction of waiting times for operations and reduction of outpatient waiting times.	Chief executive, CAH	Year 1
Appointment of a third substantive Consultant Urological Surgeon.	Stabilisation of Urology Service	Chief Executive, CAH and SHSSB	Year 1
Appoint appropriate support staff (Secretarial, nursing and other medical staff e.g. radiology, pathology) to support expanded Urology service.	Allows redesigned Urology service to deliver to its full potential	Chief Executive, CAH and SHSSB	Year 2
Application for increases in middle grade staff (at SpR and SHO level).	Improved support of Consultant staff	Urology Service in conjunction with SAC / SHO training committee	Year 2

Recommendation	Expected outcome	Action by	Time scale
Appointment of a fourth substantive Consultant Urological Surgeon.	Allow Urology service to meet known and expected demand levels	Chief Executive, CAH and SHSSB	Year 3
Appointment of Specialist Urology Nurses.	To support redesign projects	Director of Nursing	Year 3

1.2 Infrastructure

Recommendation	Expected outcome	Action by	Time scale
Implement advance booking of investigations for outpatients.	Most patients will have a 'one stop' visit with a management plan formulated	Urology service	Year 1
Increase bed capacity to 24 beds. This should be part of the strategic plan at CAH for increases in bed capacity.	Ensure reduction in cancellation of elective surgery	Chief Executive and Medical Director, CAH	Year 1
Increase number of operating lists available to Urology.	Allow Urology service to meet current and expected capacity needs	Medical Director and Clinical Director for Surgery, CAH	Year 1

Recommendation	Expected outcome	Action by	Time scale
Utilise South Tyrone Hospital for day case activity	Improve day case waiting times and better utilise existing resources	Urology Service	Year 1
Instigate nurse led, Consultant supported direct access clinics	Improve OP waiting times and service for cancer patients	Urology Service and Director of Nursing	Year 1
Instigate telephone follow-up by specialist nurses	Reduce numbers of patients seen for review at outpatients	Urology Service	Year 1
Ensure Urology day case needs are included in strategic plans for increase in day surgery capacity at CAH	Allow further increases in day case rate and ambulatory surgery	Medical Director and Clinical Director for Surgery, CAH	Year 2-4
Initiate project to establish a dedicated Urology diagnostic and treatment centre (possibly using the Ayr model)	Redesign and modernise the Urology service for all SHSSB patients	Chief Executive and Medical Director, CAH SHSSB	Year 2-4

1.3 Service redesign

Recommendation	Expected outcome	Action by	Time scale
Develop, implement and monitor area-wide clinical guidelines with standard referral proforma	Ensure referrals are required and allow management of conditions in General Practice where appropriate	Urology Service and General Practice representatives	Year 1
Establish a system to regularly update GPs on the management of urological problems and provide feedback on referrals that do not match referral guidelines	Ensure referral pattern reflects current evidence based practice	Urology Service and General Practice representatives	Year 1
Implement full and /or partial booking systems for outpatients	Reduce DNA rate and enhance patient satisfaction	Urology Service and Outpatient administration	Year 1
Implement advance booking of investigations for outpatients	Most patients will have a 'one stop' visit with a management plan formulated	Urology service	Year 1

Recommendation	Expected outcome	Action by	Time scale
Ensure multidisciplinary discussion of urological cancer patients in line with regional / national guidelines	Improved patient journey and outcomes	Oncology multidisciplinary team	Year 1
Establish project to map oncology patient pathways	Improve waiting times and patient journey	Oncology multidisciplinary team	Year 2-5

FINANCIAL IMPLICATIONS

Cost Description	WTEs	Cost (£)	Capacity (Y/N)	Signed
Direct Costs				
Consultant				
Other Medical Staff				
Secretary				
Out-Patient Clinics				
Ward Costs				
Main Theatres Cost				
Day Theatres Cost (inc. anaesthetics cover)				
Total Direct Costs (A)				
Support Costs				
Radiology				
Pathology				
Sterile Services				
Pharmacy				
Medical Physics				
Medical Records				
Ambulance Services				
Physiotherapy				
Occupational Therapy				
Speech Therapy				
Dietetics				
Medical Study Leave				
Other Support Costs				
Total Support Costs (B)				
Total All Recurrent Costs (A+B)				
Non-Recurrent Costs				
Office Accommodation				
Computer Equipment				
Day Surgery Instrumentation				
Day Surgery Equipment				
Clinic Equipment				
Relocation Expenditure				
Total NR Costs				
Overall Cost				

References

1. A Quality Urological Service for Patients in the New Millennium. BAUS October 2000

2. The Provision of Urological Services in the UK. BAUS February 2002

3. Guidelines on the development of the Nurse Led Clinic for the assessment of men with Lower Urinary tract Symptoms. BAUN Working Party 2003

4. Service improvement guide – prostate cancer. Cancer Services Collaborative 200 (http://www.modernnhs.nhs.uk/cancer).

Daycase	Haematuria		14.3	13.3	273	3419		163.8	205.14			
	Check cystoscopy		10.9	13.8	207	3595		124.2	215.7			
	Urethral stricture		5.4	3.7	102	1017		61.2	61.02			
		Total	30.6	30.8	582	8031	Total	349.2	481.86	**Total DC**	**1126**	**1554**
										Total FCE's	**2838**	**3213**

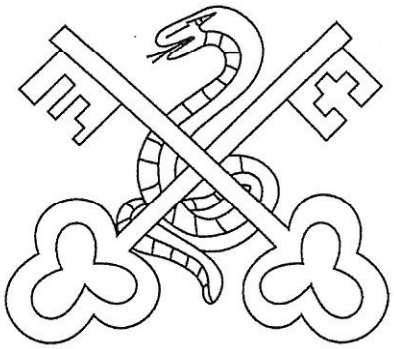
	2002-2003											
Inpatients	Diagnosis group		% of total		Numbers			Expected in Craigavon based on 300,000 pop				
			Grampian	Scotland	Grampian	Scotland					Extrapolated totals	
	Bladder cancer		10	9.5	265	2798		159	167.88			
	BPH		4.7	6.3	130	1860		78	111.6			
	Retention of urine		4.5	7.3	126	2158		75.6	129.48			
	Calculus of kidney		5	2.9	138	855		82.8	51.3			
	Calculus of ureter		5.3	4.5	146	1322		87.6	79.32			
	Prostate cancer		3.7	4.3	102	1274		61.2	76.44			
		Total	33	35	907	10267	Total	544.2	616.02	**Total IP**	**1601**	**1812**
Daycase	Haematuria			12		3135		0	188.1			
	Check cystoscopy			12		3128		0	187.68			
	Urethral stricture			3.8		997		0	59.82			
							Total	0	435.6	**Total DC**	**0**	**1245**
										Total FCE's		**3056**

For inpatients approx 10-13% of work is related to BPH, 10% to bladder cancer, 8-10% to stone disease and 5% to prostate cancer.
25% of daycase work is related to investigation or treatment of bladder cancer.
A reasonable estimate of total FCE's expected for CAH would be approx 3000 / annum. Current total is 2647.
The minimum number of Consultants required to deliver this is 4, based on 750 FCE's per yr

APPENDIX 2

Approx 65% of procedures are cystoscopy with a further 10% for TURBT.
TURP accounts for 6-8%, with major open surgery 2-3%
Cystoscopy numbers apparently decreased in 2002-3 due to a change in coding.
Average expected procedures in CAH approx 3000 per annum with approx 50% being daycase
Assuming 6.5 procedures per IP list there is a need for 230 lists per year, equivalent to 4.5 IP lists per week
Assuming 8 procedures per Day case list there is a need for 190 lists per year, equivalent to 4 day case lists per week

APPENDIX 3



THE BRITISH ASSOCIATION
OF UROLOGICAL SURGEONS

A Quality Urological Service for Patients in the New Millennium

Guidelines on workload, manpower and standards of care

Produced by the Council of
the British Association of Urological Surgeons
October 2000

A Quality Urological Service for Patients in the New Millennium

Guidelines on workload, manpower and standards of care.

I commend this document to you. It has been produced by the Council of the British Association of Urological Surgeons (BAUS) to assist Health Authorities, Trust Chief Executives, Clinical Directors and Consultant Urologists in planning a safe, high quality Urological Service for their community.

BAUS has consulted widely in the preparation of these guidelines which are broadly consistent with advice issued by other Surgical Specialty Associations and the Royal College of Surgeons of England.

We also believe that these guidelines fully reflect the government's current initiatives on improvements in the availability and quality of health care.

The guidelines should be included in the Professional Development Portfolio of all consultant urologists. They should be used as a yardstick to inform the process of annual consultant appraisal, the annual review of the consultant work programme and the drafting of job descriptions for new consultant appointments.

We live in a rapidly changing world. BAUS Council will review these guidelines at frequent intervals to take account of any changes in the consultant contract or changes in working patterns which may evolve in the future.

Our thanks are due to the following urologists for their work in the production of this document:

Mr Patrick H O'Boyle
Professor A R Mundy
Mr Adrian Joyce
Mr F James Bramble
Mr R Fletcher Deane

J M FITZPATRICK, MCh FRCSI FRCSGlas FRCS
President
British Association of Urological Surgeons

October 2000