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 new outpatient attendances at the Stone Treatment Centre were erroneously recorded as review attendances. The new outpatient attendances are therefore understated by approximately 240.

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

		Core Activity	IHA	IS	Totals
2009/10	Cons Led New OP	610	474	0	**1084**
	ICATS/Nurse Led New OP	1233	30		**1263**
	Total New OP	1843	504	0	**2347**
	Cons Led Review OP	2391	70	0	**2461**
	ICATS/Nurse Led Rev OP	1594	0	0	**1594**
	Total Review	3985	70	0	**4055**
	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[2]	Mr O'Brien	Mr Akhtar[3]	All Core Activity
2009/10	New OP	242	174	193	**609**
	Review OP	964	903	327	**2194**
	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 Young's new outpatients are understated by an estimated 240, as Stone Treatment new attendances were recorded as reviews.
[3] 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 total number of patients is 4,037. The Trust's plan to deal with this backlog has been included as Appendix 2.

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 only outstanding issue is that of oncology input to the meeting. Confirmation of when this will be available is awaited from Belfast Trust and it is expected that a date for commencement will be available in the near future.

The Southern Trust provides chemotherapy only for prostate cancer patients (at Craigavon Hospital). Chemotherapy for all other cancers and radiotherapy for all cancers is provided by Belfast Trust. When oncology support is

available for the MDM then referral will take place during the meetings. An interim arrangement is in place with referral taking place outside the meetings.

The Trust accepts that all radical pelvic operations will be undertaken at Belfast City Hospital. The Trust asks for clarification with regard to:

- At what point in the pathway patients should be referred;
- Arrangements for review of the patients.

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 with further detail being provided in Appendix 3.

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. The Trust's length of spell compares very favourably with the peer group average.

Check if these were just elective procedures.

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 has compared its performance to the BADS targets for 2008/09 (clinical coding is complete) and 2009/10 (clinical coding is incomplete). The analysis is provided as Appendix 4. The Trust will use the BADS recommendations to determine appropriate day case rates for the new service model for urology.

4. Demand for Team South Urology Service

The Trust has utilised the methodology recommended by the Board to calculate the demand for the service. It has been assumed that the population of Fermanagh will be similar to the Southern area. As inclusion of Fermanagh will increase the population catchment area for urology by 18%, an uplift of 18% has been applied. Table 6 overleaf shows the calculation of the estimated demand for the service. It should be noted that this does not factor in any future growth in demand.

Table 6: Projected Activity for Team South

		2009/10 Actual Activity					
		Core Activity	**IHA**	**IS**	**Growth in WL**	**SHSCT Activity to be Provided**	**Tean Sout Capa Requ**
2009/10	Cons Led New OP	610	474	0	87	1171	1
	ICATS/Nurse Led New OP	1233	30		100	1363	1
	Total New OP	1843	504	0	187	2534	**2**
	Cons Led Review OP	2391	70	0		2461	2
	ICATS/Nurse Led Rev OP	1594	0	0		1594	1
	Total Review	3985	70	0		4055	**4**
	Day Case	1502	3	383	47	1935	**2**
	Elective FCE	1199	29	140	28	1396	**1**
	Non Elective FCE	629	0	0		629	

1) Source is Business Objects
2) Activity has been counted on specialty of clinic
3) Review activity is actual activity and N:R ratio will be skewed because of the significant review backlog . As shown 1:2
4) OP WL between end Mar 09 & end Mar 10 had increased by 187 (Information Dept).
5) 2009/10 breaches have been used to estimate growth in waiting list for day cases and FCEs
6) 18% added for Fermanagh, based on population size relative to SHSCT population

The projected demand from Table 6 was used to calculate the numbers of session which will be required to provide the service. These are summarised in Table 7 below with the detail of the calculations provided as Appendix 5.

Table 7: Weekly Sessions for New Service Model

	Weekly Sessions
Consultant Led OPs	
General	5
Stone Treatment	1
ICATS	
Prostate Assessment	1.5
Prostate Biopsy [1]	1
Prostate Histology [2]	1
LUTS	3
Haematuria	1
Andrology/General Urology	5
Urodynamics	1.5
	14
Main Theatres	9
Day Surgery	
GA	3
Flexible Cystoscopy	3
Lithotripsy	1/2

1) Prostate Assessment and Biopsy will run side by side
2) Consultants will see their own patients, so whilst this has been noted as a single session, it is unlikely to be a single session in practice.
3) All sessions with the exception of ICATS andrology & general urology, will run over 48 weeks. ICATS andrology & general urology will run over 42 weeks.
4) Lithotripsy day case sessions have been calculated over 42 and 48 weeks. A second consultant with special interest in stone treatment will be required if sessions are to run over 48 weeks.

5. Proposed Service Model

The proposed service model will be an integrated consultant led and ICATS model. The ICATS service is currently being reviewed. Some changes which will improve the service provided to patients have already been agreed by clinical staff. These include:

- The prostate pathway has been reviewed (a draft revised pathway is included in Appendix 6). Patients requiring a biopsy will be given the opportunity to have this done on the same day as their initial assessment (where this is clinically appropriate).
- Patients triaged to the haematuria service will have flexible cystoscopy carried out on the same day as their initial assessment. In the current service model these patients have to come back to the hospital to have this done in the Day Surgery Unit.
- Urodynamics will move from the inpatient ward to the Thorndale Unit and sufficient staff will be trained to avoid backlogs of patients awaiting investigation.

The Andrology and General Urology elements of the ICATS service will be reviewed over the coming months.

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. 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. The frequency of sessions is to be agreed with the Western Trust.

Outpatient clinics will be held at Craigavon, South Tyrone, the Erne and Armagh Community 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.

Consultant and Nurse led sessions will be provided over 48 weeks. The detail of job plans is to be agreed with clinical staff but they will be based around the sessions identified in the previous section. Due to available theatre capacity, particularly in main theatres, a 3 session operating day is currently being discussed.

Work is ongoing to develop patient flow and clinical pathways for the service. Draft pathways are included as Appendix 6. The on call urologist at Craigavon Area Hospital will be available to provide advice at any time to medical staff at the Erne or Daisy Hill Hospitals on the management or transfer of emergency cases.

6. Timetable for Implementation

Task	**Timescale**
Submission of Team South Implementation Plan	22 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

APPENDICES

UROLOGY NEW MODEL REQUIREMENTS

	Clinics Actual	Capacity	Dr	Act. to Capacity	odd ratio actual clinic to capacity
				212/249	0.85
cah	126	146	233		
sth	40	51	40	371 dr sessions	1.75 Dr per actual clinic with 7 dr in system
b/a	46	52	98		
Total	212	249	371		

These figure indicate that 85% of outpatient capacity in terms of clinics actually took place (as opposes to full capacity)
It took 371 doctors to perform the activity
Interestingly 1.75 doctors attended on average for each of these clinics (out of 7 doctors available in the system)
////////

TRUST FIGURES total need for yr

new + r/v	1440+4307	5747	pt / yr		
		638	Dr session/yr	9 pt /Dr	**0.85 factor**
		12.3	Drs/wk		12.3x1.176 14.5 Dr/wk
	12.3/2	6.2	clinic/wk	4 cons with 2 Drs/clinic	6.2x1.176 7.3 clinic/wk
	6.2/4	1.5	clinics/ cons/wk	4 cons present per wk	

MY FIGURES for All

new+r/v	1440+4697	6171	pt/yr		**0.85 factor**	1.176
	6171/9	682	Dr session/yr	9 pts/Dr		
	682/52	**13.1**	**Dr /wk**		13.1x1.176	**15.4 dr/wk**
	13.1/2	**6.5**	**clinics/wk**		6.5x1.176	**7.6 clinic/wk**
	6.5/4	1.6	clinics/ cons/wk	4 cons present per wk		

MY FIGURES excl. STC

new+r/v	1440+3520	4960	pt/yr			
	4960/9	551	Dr session/yr	9 pts/Dr		
	551/52	**10.6**	**Dr /wk**		10.6x1.176	**12.5 Dr/wk**
	10.6/2	**5.1**	**clinics/wk**		5.1x1.176	**6 clinic/wk**
	5.1/4	1.3	clinics/ cons/wk	4 cons present per wk		

The figure trust supplied are not far away from my supply but the subsequent calculates are different.
The STC stone clinic may skew the figures as this is a large r/v clinic, hence working it out separately

Of the total to be seen , I have divide by 9 pt per doctor per clinic to get the nos of dr sessions per year
Dividing again by 52 to get the weekly figures (you should reconsider this as divided by 50 effective weeks instead)
This figure equals the nos of dr required to attend a clinic per week
If there is CONSISTENTLY two dr at a clinic, then dividng this by two gives the nos of clinics per week
However as defined by clinical practice last year there is a drop out rate of actual to expected clinics of 0.85
If this continues into the new model then this has to be factored

Therefore the number of clinic required per week is between 6.2 to 7.6 taking all into account
Even excluding the STC this figure is 5 - 6 clinics per week
//////////
Daycases

739 dsu ga
1204 flex
272 eswl
2215 total

Our figure of 1200 flex cystoscopies , I feel is a conservative number - with addition consultants there will be more

1200 flex at 9pt average per list = 133 sessions per year = 2.7 lists per week (on a 50 week year)
1500 flex at 9 pt av per list = 166.7 session/yr = **3.3 lis tper week** (on a 50 wk year)

Are you content there were 740 general anaesthetic day cases done at that this met the target ??
Work out session at an improved rate of 5 per list (otherwise still count this as 4 per list)
ie 740/5 = 148 session per yr
148 / 50 wks = **2.96 lists/wk** DSU

740/4/4 = 185 session per year
185/50 = **3.7 lists per wk** DSU
Inpatients
9 sessions per week sound correct per previous exercise and backed by AOB figures
COVER FOR THE UNIT

presumption	sessions	consultants	sp.drs	total
TH sessions	9	9	9	18
clinics	6.5	6.5	6.5	13.1
DSU ga	2.6	2.5	2.5	
DSU flex	2.5	0	2.5	2.5
wd + a/e referal	10	5	10	
haematuria DR	1	0	1	
urodyn	3.4	3.5	0	
STC	2	1	1	
luts	2	0	2	
med st	1	0	1	
histo	1.5	0	1.5	
trus histo	1	0	1	

factor up

	potiental	cons	sp. Drs
		9	9
if (.85)	7.6 clinics	7.5	7.5
2.6 x 5/3	4.3	4	4
1500/8pt/52x(	3.9	0	4
	ward/day	5	10
? X 3 clinics		0	3
>3.4 for 5 cons	1	4	0
3 session		1	1
?x 4 cinics			4
	1	0	1
	2	1	2
	2	1	2

flex
74/80
0.925

how many haem refered /wk
170/yr 3.4 /wk

trus biopsy	1	0	1			2		2	2
MDT	1	3	1			1	3 con involv	3	1
SPA	10	6	5	if 5	15		con+spdr x2	10	5
admin	7	3	5	if 5	10			5	5
off	6		10	if5		10			10
TOTAL	67.5	39.5	60					52.5	70.5

Sp.Dr 6 to 7/10 sessions available	35.5	short	46	short
(2 off +2spa/admin)	39	short	**49.5**	short
current 3.5 sp.dr = 21 to 24.5 session				

potiential shortfall in specialty doctor sessions /wk

for five urologist and five sp doctor team **35 to 50 sessions sp.dr short/wk**

This sessional shortfall is based on 5 middle grade doctors. As defined above there were 1.75 dr per clinic even when there were 7 drs arround
With the increase in consultants and sessions then 5 middle grades will not cover this to the expected level
These figure are a conservative estimate taking into account working practice changes

ie: 3-5 jobs at 10 pa activity would be required to maintain the service

REQUIREMENTS FOR UROLOGY OUTPATIENTS AND ICATS ACTIVITY Jan11

ACTIVITY	**current** nos sessions per week	nos sessions per week **needed**	Nos Person MIN	Nos Person MAX	Rooms MIN	Rooms MAX	Fixed Nos MIN Rooms	Fixed Nos MAX Room Sessions	**likely required**	**in unit required office rooms**	double up	min multi function clinic	Max multi Function clinic room	**Likely required**	**in unit Specific purpose rooms**	**Toilet change room**	MIN fixed Function proced	MAX fixed function proced	comment	extreme
Consultant office	10	10	3	5			30	50	**30**										two cons have office	
Secretaries Office	10	10	3	5			30	50	**20**										two sec in one offices	sec1:2 cons
Urology Nurse SpecialistS Office 1	10	10			0.5	1	5	10		**10**									two nurse sharing rotational	
UrologyNurse SpecialistS Office 2	0	10			0.5	1	5	10		**10**									but increase need for virtual clinic	
Reg /Junior office	0	10			1	1	10	10		**10**									nimdta requirement	
GPWSI office	0	2	1	1	0	1	0	2		**0**	x								where admin done ? With spr	uses spr room
consultant room 1st wkly clinic	3	5	4	5								4	5	**5**					? room large enough (exam)	all cons have cah clinic
consultant clinic (reg room)	1.5	5	3	5								3	5	**4**					probable will have someone	? leave per wk on av.
exam room	3	5			0	2						0	5	**1**					? Exam room needed	
consultant room 2nd wkly clinic	0	?	2	5								0	5	**2**					pending decision 2nd clinic	
consultant clinic (reg room)	0	?	0	2								0	2	**0**					likely no spr 2nd clinic	
exan room	0	?	2	5								0	5						if clinic ? Still need	
Histology clinic	1	2	1	2								1	2	**2**					currently 1 need for 2	
Consultant Specialist clinic 1st	2	5	3	5								3	5	**5**					likely	
Consultant Specialist clinic 2nd	1	2	1	2								1	2	**2**					unlikely	
LUTS New	2	4			1	1						2	4	**4**					currently two sessions	
LUTS Review	1	2			1	1						1	2	**2**					currently 1 + gp follow-up	
GPWSI clinic	1	1			1	1						1	1	**1**					unlikely to change	
Prostate Diagnostic D1	1.5	3			1	1						1.5	3	**3**					double of now (1.5)	
Prostate TRUS biopsy D2	1.5	3			1	1											1.5	3	up 0.5	
Prostate biopsy recovery room																	1.5	3		
Prostate Diagnostic Histo clinic D3	1	2			1	1						1	2	**2**					one now needs to be one more	
Consultant Treatment planniing D4	2.5	3	3	4								3	4	**3**					how many cons. Doing D4?	
ICATS oncology stable Review clinic	1	2			1	1						1	2	**2**					expand by 0.5 or even 1	
Urodynamic session	4	6			1	1											4	6	4 at present ? Need 6	
Urodynamic Clinic room	2	6	2	3	1	1						2	3	**3**					2 to 4 cons. doing urodyn ??spec clinic	
Female Urology service new	0	4			1	1						0	4	**4**					uncertain clinic	
Female Urology service R/V	0	2			0	0						0	2	**2**						
Ultrasound room	6	9			1	1											6	10	define actual floor space	
Andrology clinic	2.5	2.5			1	1						2.5	2.5	**2.5**						
Haematuria clinic consult	1	2			1	1						1	2	**2**						
Haem Flexible C/U room	0	2			1	1											1	2		
Intravesical Treatment Room	1	4			0.5	1											2	3	3 chemo unit	
Intravenous A/B room	1	10			0.5	1													? Double up cons. room	
TROC Room + change catheters / ISC	2	4			0.5	1											2	4		
STC clinic	1	2			1	1														
DSU flexible C/U list	1.5	2			1	1														
Reception area															1					
urology Waiting Room	10	10			1	1	10	10		**10**										
visitor tiolet																1				
Toilets female	10	10			1	2										2				
Tiolet male	10	10			1	2										2				
changing room for all activity female	10	10			1	1										2			? Tiolet double up	
changing room for all activity male	10	10			1	1										2			? Tiolet double up	
Blood / urine Room + pharmacy	10	10			1	1	10	10							1					
staff changing and toilet															1					
Tiolet attached Flex / urodyn																1				
Tiolet 2nd procedure room																1				
Sluice															1					
Decontamination room															1					
Dispersal room															1					
Linen room, Dry store , disposables															1					
Kitchen															1					
TOTAL sessions per week							100	152	50	40		28	67.5	51.5			18	31		
sessions per day ie /5							20	30.4	10	8	0	5.6	13.5	10.3			3.6	6.2		
rooms / session ie /2							**10**	**15.2**	**5**	**4**		**2.8**	**6.75**	**5.15**	8	**11**	**1.8**	**3.1**		
							Nos MIN Rooms	Nos MAX Room	**likely required**	**required office**	double up	multi function	**max** multi Function	**Likely required**	**Specific purpose**	**Toilet change**	min fixed Function	**new fixed function**		

ACTIVITY							sessions	Sessions	con/sec	rooms		clinic	clinic room	clinic	rooms	room	proced	proced	comment	extreme
rounded to likely total							**10**	**15**	**5**	**4**		**3**	**7**	**5.2**	**8**	**11**	**1.65**	**3**		
	Room requirement																			
	ROOM TYPES																			
				max	**likely**															
	Consultant / secretarial Office type				5			0		0		0								
	in unit offices / Waiting room				4			4		4		4								
	in unit specific purpose rooms				8			8		8		0								
	consulting room			7	5			5		5		5								
	urology functional room				3			3		3		3								
	tiolets / changing				11			11		0		0								
		TOTAL		38	36			31		20		12	1+ ? 2							
			Therefore everything = 36 rooms																	
			No consultants = 31 rooms																	
			minus the toilets = 20 rooms																	
			Pure clinic input rooms = av. of 15 rooms																	
		remember 3 current consultants to move to 5 consultant team and more nurse practioners																		
			max	**min**		**unit (max**	**unit (min)**													
			5	**5**		**0**	**0**													
			6	**6**		**5**	**5**													
						7	**7**													
			7	**5**		**7**	**5**													
			3	**3**		**3**	**3**													
						11	**11**													
			21	**19**		**33**	**31**													
			without toilets																	
		in unit office /waing rooms/ staff			6	6		5	5											
		in unit specific purpose rooms						7	7											
		consulting room			7	5		7	5											
		urology functional room			3	3		3	3											
			TOTAL		16	14		22	20											

REQUIREMENTS FOR UROLOGY OUTPATIENTS AND ICATS ACTIVITY Jan11
TAKING OUT SOME ACTIVITY AND COMPROMISE ON VOLUME OF FACILITIES

ACTIVITY	current nos sessions per week	session per week needed	Nos Person MIN	Nos Person MAX	Rooms MIN	Rooms MAX	Fixed Nos MIN Rooms sessions	Fixed Nos MAX Room sessions	**likely required**	**in unit equired office rooms**	double up	min multi function clinic	Max multi Function clinic room	**Likely required**	**in unit Specific purpose rooms**	**Toilet change room**	MIN fixed Function proced	MAX fixed function proced	comment	xtreme
Consultant office	10	10	3	5			30	50	**30**										two cons have office	
Secretaries Office	10	10	3	5			30	50	**20**										two sec in one offic	2 cons
Urology Nurse SpecialistS Office 1	10	10			0.5	1	5	10		**10**									two nurse sharing rotationa	
UrologyNurse SpecialistS Office 2	0	10			0.5	1	5	10		**10**									but increase need for virtua	
Reg /Junior office	0	10			1	1	10	10		**10**									nimdta requirement	
GPWSI office	0	2	1	1	0	1	0	2		**0**	x								where admin done r room	
consultant room 1st wkly clinic	3	5	4	5								4	5	**5**					? room large enough clinic	
consultant clinic (reg room)	1.5	5	3	5								3	5	**4**					probable will have s on av.	
exam room	3	5			0	2						0	5	**0**					? Exam room needed	
consultant room 2nd wkly clinic	0	?	2	5								0	5	**0**					pending decision 2nd clinic	
consultant clinic (reg room)	0	?	0	2								0	2	**0**					likely no spr 2nd clinic	
exan room	0	?	2	5								0	5						if clinic ? Still need	
Histology clinic	1	2	1	2								1	2	**2**					currently 1 need for 2	
Consultant Specialist clinic 1st	2	5	3	5								3	5	**5**					likely	
Consultant Specialist clinic 2nd	1	2	1	2								1	2	**0**					unlikely	
LUTS New	2	4			1	1						2	4	**4**					currently two sessions	
LUTS Review	1	2			1	1						1	2	**2**					currently 1 + gp follow-up	
GPWSI clinic	1	1			1	1						1	1	**1**					unlikely to change	
Prostate Diagnostic D1	1.5	3			1	1						1.5	3	**3**					double of now (1.5)	
Prostate TRUS biopsy D2	1.5	3			1	1											1.5	3	up 0.5	
Prostate biopsy recovery room																	1.5	3		
Prostate Diagnostic Histo clinic D3	1	2			1	1						1	2	**2**					one now needs to be one r	
Consultant Treatment planniing D4	2.5	3	3	4								3	4	**3**					how many cons. Doing D4	
ICATS oncology stable Review clinic	1	2			1	1						1	2	**2**					expand by 0.5 or even 1	
Urodynamic session	4	6			1	1											4	6	4 at present ? Need 6	
Urodynamic Clinic room	2	6	2	3	1	1						2	3	**3**					2 to 4 cons. doing urodyn '	
Female Urology service new	0	4			1	1						0	4	**2**					uncertain clinic	
Female Urology service R/V	0	2			0	0						0	2	**1**						
Ultrasound room	6	9			1	1											6	10	define actual floor space	
Andrology clinic	2.5	2.5			1	1						2.5	2.5	**2.5**						
Haematuria clinic consult	1	2			1	1						1	2	**2**						
Haem Flexible C/U room	0	2			1	1											1	2		
Intravesical Treatment Room	1	4			0.5	1											2	3	3 chemo unit	
Intravenous A/B room	1	10			0.5	1													? Double up cons. room	
TROC Room + change catheters / ISC	2	4			0.5	1											2	4		
STC clinic	1	2			1	1														
DSU flexible C/U list	1.5	2			1	1														
Reception area															0					
Waiting Room	10	10			1	1	10	10		**10**										
visitor tiolet																0				
Toilets female	10	10			1	2										1				
Tiolet male	10	10			1	2										1				

changing room for all activity female	10	10		1	1								1		? Tiolet double up
changing room for all activity male	10	10		1	1								1		? Tiolet double up
Blood / urine Room + pharmacy	10	10		1	1	10	10					1			
staff changing and toilet								10							
Tiolet attached Flex / urodyn													1		
Tiolet 2nd procedure room													1		
Sluice												1			
Decontamination room												1			
Dispersal room												1			
Linen room, Dry store , disposables												1			
Kitchen												1			
TOTAL sessions per week						100	152	50	50		28	67.5	43.5			18	31	
sessions per day ie /5						20	30.4	10	10	0	5.6	13.5	8.7			3.6	6.2	
rooms / session ie /2						**10**	**15.2**	**5**	**5**		**2.8**	**6.75**	**4.35**	6	**6**	**1.8**	**3.1**	
ACTIVITY						Nos MIN Rooms session	Nos MAX Room session	**likely required** con/sec	**equired office rooms**	double up	multi function clinic	**max** multi Function clinic room	**Likely required** multi room	**Specific purpose rooms**	**Toilet change room**	min fixed Function proced	**new fixed function proced**	comment	xtreme
rounded to likely total						**10**	**15**	**5**	**5**		**3**	**7**	**4.5**	**6**	**6**	**1.65**	**3**		

Room requirement

ROOM TYPES

		max	likely			
Consultant / secretarial Office type		5	0	0	0	
in unit office /waing rooms/ staff		5	5	5	5	
in unit specific purpose rooms		6	6	6	0	
consulting room	7	4.5	4.5	4.5	4.5	
urology functional room		3	3	3	3	
tiolets / changing		6	6	0	0	
TOTAL	38	30	25	19	12.5	1+ ? 2

Therefore everything = 30 rooms
No consultants = 25 rooms
minus the toilets = 19 rooms
Pure clinic input rooms = av. of 14 rooms

REQUIREMENTS FOR UROLOGY OUTPATIENTS AND ICATS ACTIVITY Jan11

Big compromise on activities and facilities

ACTIVITY	current nos sessions per week	nos sessions per week **needed**	Nos Person MIN	Nos Person MAX	Rooms MIN	Rooms MAX	Fixed Nos MIN Rooms sessions	Fixed Nos MAX Room Sessions	**likely required**	**in unit equired office rooms**	double up	min multi function clinic	Max multi Function linic room	**Likely required**	**in unit Specifi urpos rooms**	**Toilet change room**	MIN fixed Function proced	MAX fixed unction proced	ommerxtreme
	10	10	3	5			30	50	**30**										two cons have office
	10	10	3	5			30	50	**20**										two se2 cons
	10	10			0.5	1	5	10		**10**									two nurse sharing rotational
	0	10			0.5	1	5	10		**10**									but increase need for virtual clinic
	0	10			1	1	10	10		**10**									nimdta requirement
	0	2	1	1	0	1	0	2		**0**	x								where r room
	3	5	4	5								4	5	**0**					? room clinic
	1.5	5	3	5								3	5	**0**					probat on av.
	3	5			0	2						0	5	**0**					? Exam room needed
	0	?	2	5								0	5	**0**					pending decision 2nd clinic
consultant clinic (reg room)	0	?	0	2								0	2	**0**					likely no spr 2nd clinic
exan room	0	?	2	5								0	5						if clinic ? Still need
	1	2	1	2								1	2						currently 1 need for 2
	2	5	3	5								3	5						likely
	1	2	1	2								1	2						unlikely
	2	4			1	1						2	4						currently two sessions
	1	2			1	1						1	2						currently 1 + gp follow-up
	1	1			1	1						1	1						unlikely to change
	1.5	3			1	1						1.5	3				1.5	3	up 0.5
	1	2			1	1						1	2	**2**			1.5	3	one now needs to be one more
	2.5	3	3	4								3	4	**3**					how many cons. Doing D4?
	1	2			1	1						1	2	**2**					expand by 0.5 or even 1
	4	6			1	1											4	6	4 at present ? Need 6
	2	6	2	3	1	1						2	3	**2**					2 to 4 cons. doing urodyn ??spec c
	0	4			1	1						0	4	**2**					uncertain clinic
	0	2			0	0						0	2	**1**					
	6	9			1	1											6	10	define actual floor space
	2.5	2.5			1	1						2.5	2.5	**2.5**					
	1	2			1	1						1	2	**2**					
	0	2			1	1											1	2	
	1	4			0.5	1											2	3	3 chemo unit
	1	10			0.5	1													? Double up cons. room
	2	4			0.5	1											2	4	
STC clinic	1	2			1	1													
DSU flexible C/U list	1.5	2			1	1													
Reception area															0				
Waiting Room	10	10			1	1	10	10		**10**									
visitor tiolet																0			
Toilets female	10	10			1	2										1			
Tiolet male	10	10			1	2										1			
changing room for all activity female	10	10			1	1										1			? Tiolet double up
changing room for all activity male	10	10			1	1										1			? Tiolet double up
Blood / urine Room + pharmacy	10	10			1	1	10	10							1				
staff changing and toilet										**10**									
Tiolet attached Flex / urodyn																1			
Tiolet 2nd procedure room																1			

Sluice										1			
Decontamination room										1			
Dispersal room										1			
Linen room, Dry store , disposables										1			
Kitchen										1			
TOTAL sessions per week	100	152	50	50		28	67.5	33.5			18	31	
sessions per day ie /5	20	30.4	10	10	0	5.6	13.5	6.7			3.6	6.2	
rooms / session ie /2	**10**	**15.2**	**5**	**5**		**2.8**	**6.75**	**3.35**	6	**6**	**1.8**	**3.1**	
ACTIVITY	Nos MIN Rooms sessions	Nos MAX Room Sessions	**likely** **requirec** con/sec	**equire** **office** **rooms**	double up	multi function clinic	**max** multi Function linic room	**Likely required**	**Specifi** **urpos** **rooms**	**Toilet change room**	min fixed Function proced	**new fixed unction proced**	ommerxtreme
rounded to likely total	**10**	**15**	**5**	**5**		**3**	**7**	**3.5**	**6**	**6**	**1.65**	**3**	

Room requirement
ROOM TYPES

		max	**likely**					
Consultant / secretarial Office type		5		0		0	0	
in unit office /waing rooms/ staff		5		5		5	5	
in unit specific purpose rooms		6		6		6	0	
consulting room	7	3.5		3.5		3.5	3.5	
urology functional room		3		3		3	3	
tiolets / changing		6		6		0	0	
TOTAL	38	29		23.5		18	11.5	1+ ? 2

Therefore everything = 29 rooms
No consultants = 24 rooms
minus the toilets = 18 rooms
Pure clinic input rooms = av. of 13 rooms

Separate consultant clinic and office space etc from icats

ACTIVITY	**current** nos sessions per week	nos sessions per week **needed**	Nos Person MIN	Nos Person MAX	Rooms MIN	Rooms MAX	Nos MIN Rooms sessions	Nos MAX Room Sessions	**likely required**	double up	multi function clinic	multi Function clinic room	**Likely required**	Toilet room	changing room	min fixed Function proced	max fixed function proced	comment extreme
																		two cons have office
																		two sec i:1:2 cons
Urology Nurse SpecialistS Office 1	10	10			0.5	1	5	10	10									two nurse sharing rotational
UrologyNurse SpecialistS Office 2	0	10			0.5	1	5	10	10									but increase need for virtual clinic
																		nimdta requirement
																		where acspr room
																		? room l⊂ah clinic
																		probable⊬k on av.
																		? Exam room needed
																		pending decision 2nd clinic
																		likely no spr 2nd clinic
																		if clinic ? Still need
																		currently 1 need for 2
																		likely
																		unlikely second clinic
LUTS New	2	4			1	1					2	4	4					currently two sessions
LUTS Review	1	2			1	1					1	2	2					currently 1 + gp follow-up
																		unlikely to change
Prostate Diagnostic D1	1.5	3			1	1					1.5	3	3					double of now (1.5)
Prostate TRUS biopsy D2	1.5	3			1	1										1.5	3	up 0.5
Prostate Diagnostic Histo clinic D3	1	2			1	1					1	2	2					one now needs to be one more
																		how many cons. Doing D4?
ICATS oncology stable Review clinic	1	2			1	1					1	2	2					expand by 0.5 or even 1
Urodynamic session	4	6			1	1										4	6	4 at present ? Need 6
Urodynamic Clinic room	2	6	2	3	1	1					2	3	3					2 to 4 cons. doing urodyn
changing room for all activity female	10	10			1	1									2			? Tiolet double up
changing room for all activity male	10	10			1	1									2			? Tiolet double up
Female Urology service new	0	4			1	1					0	2	2					uncertain clinic ?only one full day
Female Urology service R/V	0	2			0	0					0	1	1					not two days as per first sheet
Ultrasound room	6	9			1	1										6	10	define actual floor space
Andrology clinic	2.5	2.5			1	1					2.5	2.5	2.5					
Haematuria clinic consult	1	2			1	1					1	2	2					
Haem Flexible C/U room	0	2			1	1										1	2	
Intravesical Treatment Room	1	4			0.5	1										2	4	3 chemo unit
Intravenous A/B room	1	10			0.5	1												? Double up cons. room
TROC Room + change catheters / ISC	2	4			0.5	1										2	4	
Blood and urine Room	10	10			1	1	10	10	10									
STC clinic	1	2			1	1												
DSU flexible C/U list	1.5	2			1	1												
Waiting Room	10	10			1	1	10	10	10									
Toilets female	10	10			1	2								2				
Tiolet male	10	10			1	2								2				
Reception area																		
visitor tiolet														1				
staff changing									10									
TOTAL sessions per week							30	40	50		12	23.5	23.5			16.5	29	
sessions per day ie /5							6	8	10		2.4	4.7	4.7			3.3	5.8	
room sessions ie /2							**3**	**4**	**5**		**1.2**	**2.35**	**2.35**			**1.65**	**2.9**	
Rounded nos rooms / session							**1.5**	**2**	**2.5**		0.6	**1.175**	**1.175**			**0.825**	**1.45**	

each session	take out consulant clinic	
	office rooms	2.5
	clinics	1
	procedure	1.5

CONSULTANT OFFICE space

ACTIVITY	**current** nos sessions per week	nos sessions per week **needed**	Nos Person MIN	Nos Person MAX	Rooms MIN	Rooms MAX	Nos MIN Rooms sessions	Nos MAX Room Sessions	**likely required**	double up	multi function clinic	multi Function clinic room	**Likely required**	Toilet room	changing room	fixed Function proced	fixed function proced
Consultant office	10	10	3	5			30	50	30								
Secretaries Office	10	10	3	5			30	50	20								
Reg /Junior office	0	10			1	1	10	10	10								
GPWSI office	0	2	1	1	0	1	0	2	0	x							
consultant room 1st wkly clinic	3	5	4	5							4	5	4				
consultant clinic (reg room)	1.5	5	3	5							3	5	4				
exam room	3	5			0	2					0	5					
consultant room 2nd wkly clinic	0	?	2	5							0	0	0				
consultant clinic (reg room)	0	?	0	2							0	0	0				
exan room	0	?	2	5							0	0	0				
Histology clinic	1	2	1	2							1	2	2				
Consultant Specialist clinic 1st	2	5	3	5							3	5	5				
Consultant Specialist clinic 2nd	1	2	1	2							1	2	0				
GPWSI clinic	1	1			1	1					1	1	1				
Consultant Treatment planniing D4	2.5	3	3	4							3	4	3				
Blood and urine Room	10	10			1	1	10	10	10								
Total sessions	45	70	26	46	3	6	80	122	70	0	16	29	19				
sessions / day	9	14	5.2	9.2	0.6	1.2	16	24.4	14	0	3.2	5.8	3.8				
rooms / sessions	4.5	7	2.6	4.6	0.3	0.6	8	**12.2**	**7**	0	1.6	**2.9**	**1.9**				

for each session

offices 7
clinic rooms **between 2 to 3**
more if second clinic

Alternative clinic session = ie no second clinic just a specialist clinic

ACTIVITY	**current** nos sessions per week	nos sessions per week **needed**	Nos Person MIN	Nos Person MAX	Rooms MIN	Rooms MAX	Nos MIN Rooms sessions	Nos MAX Room Sessions	**likely required**	double up	multi function clinic	multi Function clinic room	**Likely required**	Toilet room	changing room	min fixed Function proced	max fixed function proced	comment extreme
Consultant office	10	10	3	5			30	50	30									two cons have office
Secretaries Office	10	10	3	5			30	50	20									two sec i:1:2 cons
Urology Nurse SpecialistS Office 1	10	10			0.5	1	5	10	10									two nurse sharing rotational
UrologyNurse SpecialistS Office 2	0	10			0.5	1	5	10	10									but increase need for virtual clinic
Reg /Junior office	0	10			1	1	10	10	10									nimdta requirement
GPWSI office	0	2	1	1	0	1	0	2	0	x								where acspr room
consultant room 1st wkly clinic	3	5	4	5							4	5	4					? room lɛah clinic
consultant clinic (reg room)	1.5	5	3	5							3	5	4					probablɛwk on av.
exam room	3	5			0	2					0	5						? Exam room needed
consultant room 2nd wkly clinic	0	?	2	5							0	0	0					pending decision 2nd clinic
consultant clinic (reg room)	0	?	0	2							0	0	0					likely no spr 2nd clinic
exan room	0	?	2	5							0	0	0					if clinic ? Still need
Histology clinic	1	2	1	2							1	2	2					currently 1 need for 2
Consultant Specialist clinic 1st	2	5	3	5							3	5	5					likely
Consultant Specialist clinic 2nd	1	2	1	2							1	2	0					unlikely second clinic
LUTS New	2	4			1	1					2	4	4					currently two sessions
LUTS Review	1	2			1	1					1	2	2					currently 1 + gp follow-up
GPWSI clinic	1	1			1	1					1	1	1					unlikely to change
Prostate Diagnostic D1	1.5	3			1	1					1.5	3	3					double of now (1.5)
Prostate TRUS biopsy D2	1.5	3			1	1										1.5	3	up 0.5
Prostate Diagnostic Histo clinic D3	1	2			1	1					1	2	2					one now needs to be one more
Consultant Treatment planniing D4	2.5	3	3	4							3	4	3					how many cons. Doing D4?
ICATS oncology stable Review clinic	1	2			1	1					1	2	2					expand by 0.5 or even 1
Urodynamic session	4	6			1	1										4	6	4 at present ? Need 6
Urodynamic Clinic room	2	6	2	3	1	1					2	3	3					2 to 4 cons. doing urodyn
changing room for all activity female	10	10			1	1									2			? Tiolet double up
changing room for all activity male	10	10			1	1									2			? Tiolet double up
Female Urology service new	0	4			1	1					0	2	2					uncertain clinic ?only one full day
Female Urology service R/V	0	2			0	0					0	1	1					not two days as per first sheet
Ultrasound room	6	9			1	1										6	10	define actual floor space
Andrology clinic	2.5	2.5			1	1					2.5	2.5	2.5					
Haematuria clinic consult	1	2			1	1					1	2	2					
Haem Flexible C/U room	0	2			1	1										1	2	
Intravesical Treatment Room	1	4			0.5	1										2	4	3 chemo unit

Intravenous A/B room	1	10		0.5	1									? Double up cons. room
TROC Room + change catheters / ISC	2	4		0.5	1								2	4
Blood and urine Room	10	10		1	1	10	10	10						
STC clinic	1	2		1	1									
DSU flexible C/U list	1.5	2		1	1									
Waiting Room	10	10		1	1	10	10	10						
Toilets female	10	10		1	2							2		
Tiolet male	10	10		1	2							2		
Reception area														
visitor tiolet												1		
staff changing								10						
TOTAL sessions per week						100	152	110	28	52.5	42.5		16.5	29
sessions per day ie /5						20	30.4	22	5.6	10.5	8.5		3.3	5.8
room sessions ie /2						**10**	**15.2**	**11**	**2.8**	**5.25**	**4.25**		**1.65**	**2.9**
Rounded nos rooms / session						**10**	**15**	**11**	**3**	**6**	**4.5**		**2**	**3**

Room requirement		
Office type	11	
consulting room	6	? 4.5
functional room	3	

REQUIREMENTS FOR UROLOGY OUTPATIENTS AND ICATS ACTIVITY June 11

SEE SHEET 3

ACTIVITY	likely required	in unit required office rooms	Max multi Function clinic room	Likely required	in unit Specific purpose rooms	Toilet change room	MIN fixed Function proced	MAX fixed function proced	comment
Consultant office	30								two cons have office
Secretaries Office	20								two sec in one offices
Urology Nurse SpecialistS Office 1		10							two nurse sharing rotational
UrologyNurse SpecialistS Office 2		10							but increase need for virtual clinic
Reg /Junior office		10							nimdta requirement
GPWSI office		0							where admin done ? With spr
consultant room 1st wkly clinic			5	5					? room large enough (exam)
consultant clinic (reg room)			5	4					probable will have someone
exam room			5	1					? Exam room needed
consultant room 2nd wkly clinic			5	2					pending decision 2nd clinic
consultant clinic (reg room)			2	0					likely no spr 2nd clinic
exan room			5						if clinic ? Still need
Histology clinic			2	2					currently 1 need for 2
Consultant Specialist clinic 1st			5	5					likely
Consultant Specialist clinic 2nd			2	2					unlikely
LUTS New			4	4					currently two sessions
LUTS Review			2	2					currently 1 + gp follow-up
GPWSI clinic			1	1					unlikely to change
Prostate Diagnostic D1			3	3					double of now (1.5)
Prostate TRUS biopsy D2							1.5	3	up 0.5
Prostate biopsy recovery room							1.5	3	
Prostate Diagnostic Histo clinic D3			2	2					one now needs to be one more
Consultant Treatment planniing D4			4	3					how many cons. Doing D4?
ICATS oncology stable Review clinic			2	2					expand by 0.5 or even 1
							4	6	4 at present ? Need 6
Urodynamic Clinic room			3	3					2 to 4 cons. doing urodyn ??spec clinic
Female Urology service new			4	4					uncertain clinic
Female Urology service R/V			2	2					
Ultrasound room							6	10	define actual floor space
Andrology clinic			2.5	2.5					
Haematuria clinic consult			2	2					
Haem Flexible C/U room							1	2	
Intravesical Treatment Room							2	3	3 chemo unit
Intravenous A/B room									? Double up cons. room
TROC Room + change catheters / ISC							2	4	
STC clinic									
DSU flexible C/U list									
Reception area					1				
urology Waiting Room		10							
visitor tiolet						1			
Toilets female						2			
Tiolet male						2			
changing room for all activity female						2			? Tiolet double up
changing room for all activity male						2			? Tiolet double up
Blood / urine Room + pharmacy					1				
staff changing and toilet		10							
Tiolet attached Flex / urodyn						1			
Tiolet 2nd procedure room						1			
Sluice					1				
Decontamination room					1				
Dispersal room					1				
Linen room, Dry store , disposables					1				
Kitchen					1				
TOTAL sessions per week	50	50	67.5	51.5			18	31	
sessions per day ie /5	10	10	13.5	10.3			3.6	6.2	
rooms per each session ie /2	**5**	**5**	**6.75**	**5.15**	7	**11**	**1.8**	**3.1**	

ACTIVITY	likely required con/sec	required office / Uro- rooms	max multi Function clinic room	Likely required clinic	Specific purpose rooms	Toilet change room	min fixed Function proced	new fixed function proced	comment
rounded to likely total	5	5	7	5.2	7	11	1.65	3	

Room requirement

ROOM TYPES

	max	likely					
Consultant / secretarial Office type		5		0	0		0
in unit offices / Waiting room		5		5	5		5
in unit specific purpose rooms		7		7	7		0
consulting room	7	5		5	5		5
urology functional room		3		3	3		3
tiolets / changing		11		11	0		0
TOTAL	38	36		31	20		13

1+

add one clinic

Therefore everything = 36 rooms

No consultants = 31 rooms

minus the toilets = 20 rooms

Pure clinic input rooms = av. of 14 rooms

Received from Michael Young on 01/09/22. Annotated by Urology Services Inquiry

REQUIREMENTS FOR UROLOGY OUTPATIENTS AND ICATS ACTIVITY Jan11
TAKING OUT SOME ACTIVITY AND COMPROMISE ON VOLUME OF FACILITIES

ACTIVITY	**likely required** Sessions	**in unit required office rooms**	**Likely required**	**in unit Specific purpose rooms**	**Toilet change room**	MAX fixed function proced	comment
Consultant office	**30**						two cons already have office
Secretaries Office	**20**						
Urology Nurse SpecialistS Office 1		**10**					
UrologyNurse SpecialistS Office 2		**10**					
Reg /Junior office		**10**					
GPWSI office		**0**					where admin done ? With spr
							? room large enough (exam)
							probable will have someone
			1				? Exam room needed
consultant room 2nd wkly clinic			**0**				pending decision 2nd clinic
consultant clinic (reg room)			**0**				likely no spr 2nd clinic
exan room							if clinic ? Still need
Histology clinic			**2**				currently 1 need for 2
Consultant Specialist clinic 1st			**5**				likely
Consultant Specialist clinic 2nd			**0**				unlikely
LUTS New			**4**				currently two sessions
LUTS Review			**2**				currently 1 + gp follow-up
GPWSI clinic			**1**				unlikely to change
Prostate Diagnostic D1			**3**				double of now (1.5)
Prostate TRUS biopsy D2						3	up 0.5
Prostate biopsy recovery room						3	
Prostate Diagnostic Histo clinic D3			**2**				one now needs to be one more
Consultant Treatment planniing D4			**3**				how many cons. Doing D4?
ICATS oncology stable Review clinic			**2**				expand by 0.5 or even 1
Urodynamic session						6	4 at present ? Need 6
Urodynamic Clinic room			**3**				2 to 4 cons. doing urodyn ??spec clinic
Female Urology service new			**2**				uncertain clinic
Female Urology service R/V			**1**				
Ultrasound room						10	define actual floor space
Andrology clinic			**2.5**				
Haematuria clinic consult			**2**				
Haem Flexible C/U room						2	
Intravesical Treatment Room						3	3 chemo unit
Intravenous A/B room							? Double up cons. room
TROC Room + change catheters / ISC						4	
STC clinic							
DSU flexible C/U list							
Reception area				0			
Waiting Room		**10**					
visitor tiolet					0		
Toilets female					1		
Tiolet male					1		
changing room for all activity female					1		? Tiolet double up
changing room for all activity male					1		? Tiolet double up
Blood / urine Room + pharmacy				1			
staff changing and toilet		**10**					
Tiolet attached Flex / urodyn					1		
Tiolet 2nd procedure room					1		
Sluice				1			
Decontamination room				1			
Dispersal room				1			
Linen room, Dry store , disposables				1			
Kitchen				1			
TOTAL sessions per week	50	50	44.5			31	
sessions per day ie /5	10	10	8.9			6.2	
rooms per each session ie /2	**5**	**5**	**4.45**	6	**6**	**3.1**	

ACTIVITY	**likely required** con/sec	**required office / Uro- rooms**	**Likely required Clinic**	**Specific purpose rooms**	**Toilet change room**	**new fixed function proced**
rounded to likely total	**5**	**5**	**4.5**	**6**	**6**	**3**

Room requirement ROOM TYPES	**likely**				
Consultant / secretarial Office type	5	0		0	0
in unit office /wating rooms/ staff	5	5		5	5
in unit specific purpose rooms	6	6		6	0
consulting room	4.5	4.5		4.5	4.5
urology functional room	3	3		3	3
tiolets / changing	6	6		0	0
TOTAL	29.5	24.5		18.5	12.5

1+

Therefore everything = 30 rooms
No consultants = 25 rooms
minus the toilets = 19 rooms
Pure clinic input rooms = av. of 13.5 rooms

REQUIREMENTS FOR UROLOGY OUTPATIENTS AND ICATS ACTIVITY
UPDATE FOR OCT 12

		in unit	Max			in unit		MIN	MAX				
	likely	required	multi	Likely	Likely	Specific	Toilet	fixed	fixed	fixed			
	required	office	Function	required	required	purpose	change	Function	function	function			
ACTIVITY		rooms	clinic room	Jun-11	Oct-12	rooms	room	proced	proced	likely	comment		
Consultant office											two cons have office		
Secretaries Office											two sec in one offices		
Urology Nurse SpecialistS Office 1		10									two nurse sharing rotational		
UrologyNurse SpecialistS Office 2		10									but increase need for virtual clinic		
Reg /Junior office		10									nimdta requirement		
GPWSI office		0									where admin done ? With spr		
consultant room 1st wkly clinic			5	5	5						? room large enough (exam)		
consultant clinic (reg room)			5	4	4						probable will have someone		
exam room			5	1	0						? Exam room needed		
consultant room 2nd wkly clinic			5	2	2						pending decision 2nd clinic		
consultant clinic (reg room)			2	0	0						likely no spr 2nd clinic		
exan room			5								if clinic ? Still need		
Histology clinic			2	2	1						currently 1 need for 2		
Consultant Specialist clinic 1st			5	5	5						likely		
Consultant Specialist clinic 2nd			2	2	2						unlikely		
LUTS New			4	4	4						currently two sessions		
LUTS Review			2	2	2						currently 1 + gp follow-up		
GPWSI clinic			1	1	1						unlikely to change		
Prostate Diagnostic D1			3	3	2						double of now (1.5)		
Prostate TRUS biopsy D2								1.5	3	2	up 0.5		
Prostate biopsy recovery room								1.5	3	1			
Prostate Diagnostic Histo clinic D3			2	2	1						one now needs to be one more		
Consultant Treatment planniing D4			4	3	3						how many cons. Doing D4?		
ICATS oncology stable Review clinic			2	2	2						expand by 0.5 or even 1		
Urodynamic session								4	6	4	4 at present ? Need 6		
Urodynamic Clinic room			3	3	3						2 to 4 cons. doing urodyn ??spec		
Female Urology service new			4	4	2						uncertain clinic		
Female Urology service R/V			2	2	1								
Ultrasound room								6	10	8	define actual floor space		
Andrology clinic			2.5	2.5	2								
Haematuria clinic consult			2	2	1								
Haem Flexible C/U room								1	2	2			
Intravesical Treatment Room								2	3	3	3 chemo unit		
Intravenous A/B room											? Double up cons. room		
TROC Room + change catheters / ISC								2	4	2			
STC clinic													
DSU flexible C/U list													
Reception area						0							
urology Waiting Room		0											
visitor tiolet							0						
Toilets female							2						
Tiolet male							2						
changing room for all activity female							2				? Tiolet double up		
changing room for all activity male							2				? Tiolet double up		
Blood / urine Room + pharmacy						1							
staff changing and toilet		10											
Tiolet attached Flex / urodyn							1						
Tiolet 2nd procedure room							1						
Sluice						1							
Decontamination room						1							
Dispersal room						1							
Linen room, Dry store , disposables						1							
Kitchen						1							
TOTAL sessions per week	0	40	67.5	51.5	43			18	31	22			
sessions per day ie /5	0	8	13.5	10.3	8.6			3.6	6.2	4.4			
rooms per each session ie /2	**0**	**4**	**6.75**	**5.15**	**4.3**	6	**10**	**1.8**	**3.1**	**2.2**			
			max					min	**new**				
	likely	**required**	multi	**Likely**	**Likely**	**Specific**	**Toilet**	fixed	**fixed**				
	required	**office /**	Function	**required**	**required**	**purpose**	**change**	Function	**function**				
ACTIVITY	con/sec	**Uro- rooms**	clinic room	**clinic**	**clinic**	**rooms**	**room**	proced	**proced**		comment		
rounded to likely total	**0**	**4**	**6.75**	**5.15**	**4.3**	6	**10**	**1.8**	**3.1**	**2.2**			

CONSIDERATIONS FOR UROLOGY CONSULTANT JOB PLANS

Points to consider

Table 1 sessional allocation

MDT	1	1
Oncall	1	1
SPA	1.5	1.5
Ward	1	1
Admin	1	1
Theatre	2	2.5
Dsu	0.5	0.5
outpatient	2.5	2.5
Specialty session	0.5	1
TOTAL sessions	11	12

Outpatient + sp session per consultant / week = 2.5 + 0.5 or 2 +1 = 3

Table 2 outpatient sessions

Out patient location			
option	Option one	Option Two	
Consultant clinic cah	5	5	
Stc	1	1.5	Needed for service
oncology	2	3	Needed for service
D4	1.5	1	
D1	1	1	
Erne	.5	.5	
Sth	.5	.5	
Dhh	.5	.5	
Ban			
arm	.5	.5	frequency
trus			
urod			
Total session	**12.5**	**13.5**	

Table 3 SUMMARY WEEKLY / FORTNIGHTLY / MONTHLY = CLINIC NUMBERS

Out patient location			
option		Clinic per 2 week / per month	Summary
Consultant clinic cah	3 + 0.5 + 0.5	8 / 16	3 per month
Stc	1.5	3 / 6	
oncology	3	6 / 12	
D4	0.5 + 0.5	2 / 4	
D1	0.5 + 0.5	2 / 4	
Erne	0.5	1 / 2	
Sth	0.5	1 / 2	8 Outreach / month
Dhh	0.5	1 / 2	
Ban			
arm	0.5	1 / 2	
trus			
urod			
Total session	**12.5**	25 / 50	

Table 4 PROPOSAL OUTPATIENT SESSIONS

Team member	Week 1	Week 2	Week 3	Week 4	Week 5 **oncall**	Comment
1	Oncol Consult Out reach 1	Oncol Consult =	Oncol Consult Outreach 2	Oncol Consult =	Oncol Consult	One extra consultant clinic
2	Oncol Outreach 3 D1	Oncol Consult =	Oncol Consult D1	Oncol Consult =	Oncol Consult	
3	Oncol Consult =	Oncol Consult D 1	Oncol Outreach 4 =	Oncol Consult D 1	Oncol Consult	
4	STC = D 4	STC Consult Outreach 5	STC Consult D 4	= Consult Outreach 6	STC Consult	
5	= Consult Outreach 7	STC Consult D 4	STC = Outreach 8	STC Consult D4	Consult Consult	
Total	13	12	13	12		50 out pt sessions/ month

- 12.5 clinics per week and therefore 50 clinics per 4 week month is a convenient equalization across the five posts
- If 11.5 clinic/week <> 46 clinics/month means each consultant (-1) drops a clinic per month
- Oncol = all oncology work by 'oncology' team.
- D4 = oncology work by 'stone' team *(consider other additional patient types to complete sessions)*

Table 5 **outpt with specialty sessions and dsu**

Team member	Week 1	Week 2	Week 3	Week 4	Week 5 **oncall**	Comment
1	Oncol Consult Out reach 1	Oncol Consult =	Oncol Consult Outreach 2	Oncol Consult =	Oncol Consult	One extra consultant clinic
Spec/dsu	Sp Session Eg urodyn	DSU	Sp Session Eg ?	DSU	DSU Th x1	Allocation of admin of practice or other activity
2	Oncol Outreach 3 D1	Oncol Consult =	Oncol Consult D1	Oncol Consult =	Oncol Consult	
Spec/dsu	D2 Biopsy	DSU	D2 Biopsy	DSU	DSU Th x1	Prostate service
3	Oncol Consult =	Oncol Consult D 1	Oncol Outreach 4 =	Oncol Consult D 1	Oncol Consult	
Spec/dsu	DSU	D 2 Biopsy	DSU	D 2 Biopsy	DSU Th x1	Prostate service
4	STC = D 4 \ other	STC Consult Outreach 5	STC Consult D 4 \ other	= Consult Outreach 6	STC Consult	
Spec/dsu	DSU	Sp Session :eswl/uro	Sp Session Eg: eswl	DSU	DSU Th x1	Co-ordination stone service
5	= Consult Outreach 7	STC Consult D 4 \ else	STC = Outreach 8	STC Consult D4 \ else	Consult Consult	
Spec/dsu	DSU	Sp Session Eg : urodyn	DSU	Sp Session Uro/eswl	DSU Th x1	Co-ordination of urodynamic service
Total						69 out pt sessions/ month

Speciality Session = TRUS biopsy, Urodynamics, ESWL and others ? Andrology

DSU and Speciality session are logged at 0.5 sessions per week – (*Discussion is this enough)*

Table 6 **theatre session (see theatre document)**

Surgery session	Days committed	Comment on availability	
A	Tues pm / one weds	Least effect on weds ; most effect tues pm (?oncol)	DHH Erne
B	50/50 tues /weds slant		DHH though Erne possible
C	Always friday	Always Friday (oncology)	Erne STH
D	50/50 tues slant / weds	? oncol	DHH best (too close to Erne re tues am list)
E	Weds pm / one fri	Least effect on tuesday	Erne STH

FIVE MAN UROLOGY TEAM THEATRE SESSIONS

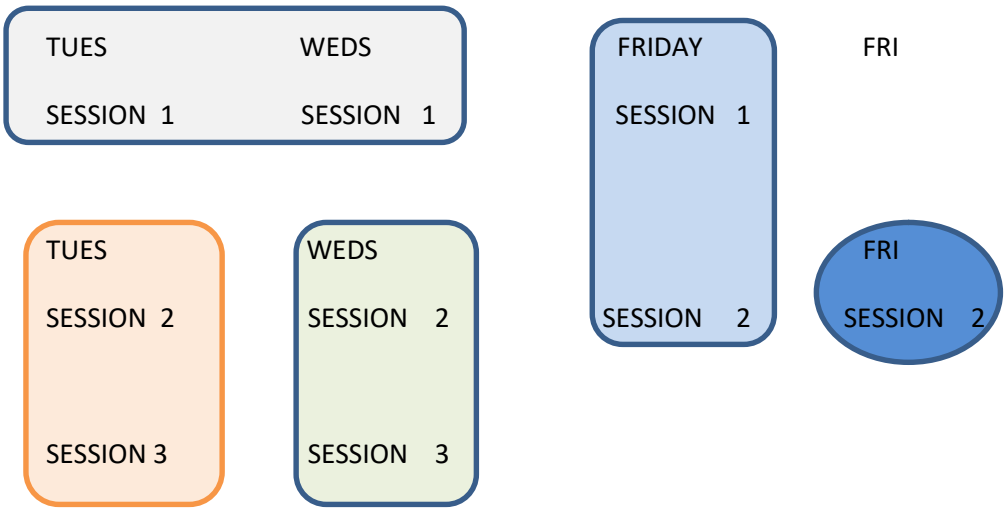

Table **7**

team member – where not good /good for outreach sessions based on day in theatre

Team member	TH SESSION	TYPE	PERSON	NOT GOOD	BEST ranking	NOS clinics	OPTION 1	OPTION 2
A	TUES weds	STONE	Young	Sth tues. Erne tues	Dhh Ban Sth mon Erne mon arm	2	DHH BAN	ERNE BAN
B	TUES WEDS	ONCOL	Glackin	Sth tues. Erne mon Erne tues.	Dhh Sth mon A B	1	STH MON	DHH
C	FRIDAY	STONE	Pahuja	dhh	All except dhh	2	ERNE & STH Either day	STH STH
D	TUES. WEDS	ONCOL	Connolly	Sth tues. Erne mon Erne tues.	Dhh Sth mon B A	1	DHH	STH
E	WEDS fri	ONCOL	O'Brien	Erne tues dhh	Erne mon Sth mon A B Dhh Sth tues	2	ERNE MON ARM	DHH ARM

(B AND D CAN SWITCH) (C AND E CAN SWITCH)

TABLE 8 A THEATRE sessions that COULD impinge on other activities pending which week in

Week	surgeon	Mon am	Mon pm	Tues am	Tues pm	Weds am	Weds pm	Thurs am	Thurs pm	Fri am	Fri pm
1	A										
2	A										
3	A										
4	A										
1	B										
2	B										
3	B										
4	B										
1	C										
2	C										
3	C										
4	C										
1	D										
2	D										
3	D										
4	D										
1	E										
2	E										
3	E										
4	E										

TABLE 8 B THEATRE + **OUTREACH**

Week	surgeon	Mon am	Mon pm	Tues am	Tues pm	Weds am	Weds pm	Thurs am	Thurs pm	Fri am	Fri pm
1	A										DHH
2	A										
3	A	BAN									
4	A										
1	B										
2	B		STH								
3	B										
4	B										
1	C										
2	C				STH						
3	C										
4	C				ERNE						
1	D										
2	D										
3	D										DHH
4	D										
1	E										
2	E	ERNE									
3	E										
4	E	ARM									

TABLE 8 C THEATRE + OUTREACH + **ONCOLOGY/STC CLINIC**

Week	surgeon	Mon am	Mon pm	Tues am	Tues pm	Weds am	Weds pm	Thurs am	Thurs pm	Fri am	Fri pm
1	A		STC						STC		DHH
2	A										
3	A	BAN	STC						STC		
4	A										
1	B									O	
2	B		STH							O	
3	B									O	
4	B									O	
1	C										
2	C		STC		STH						
3	C										
4	C		STC		ERNE						
1	D										
2	D	O	O								
3	D										DHH
4	D	O	O								
1	E										
2	E	ERNE								O	
3	E									O	
4	E	ARM								O	

TABLE 8 D

THEATRE + OUTREACH + ONCOLOGY/STC CLINIC + **SPECIALITY SESSION & THIRD CLINIC**

Week	surgeon	Mon am	Mon pm	Tues am	Tues pm	Weds am	Weds pm	Thurs am	Thurs pm	Fri am	Fri pm
1	A		STC			ESWL			STC	D4	DHH
2	A										
3	A	BAN	STC			ESWL			STC	D4	
4	A										
1	B	D1	D2							O	
2	B		STH							O	
3	B	D1	D2							O	
4	B									O	
1	C		D4	URO							
2	C		STC		STH						
3	C		D4	URO							
4	C		STC		ERNE						
1	D	O	O								
2	D	D1	D2								
3	D	O	O								DHH
4	D	D1	D2								
1	E										
2	E	ERNE				MDT PREP				O	URO
3	E									O	
4	E	ARM				MDT PREP				O	URO

TABLE 8 E

THEATRE + OUTREACH + ONCOLOGY/STC CLINIC + SPECIALITY SESSION & CLINIC

+ **CONSULTANT CLINIC**

Week	surgeon	Mon am	Mon pm	Tues am	Tues pm	Weds am	Weds pm	Thurs am	Thurs pm	Fri am	Fri pm
1	A		STC			ESWL			STC		DHH
2	A									D4	C
3	A	BAN	STC			ESWL			STC	D4	C
4	A										C
1	B	D1	D2							O	C
2	B		STH							O	
3	B	D1	D2							O	
4	B	C	C							O	
1	C		D4	URO			C				
2	C		STC		STH		C				
3	C		D4	URO			C				
4	C		STC		ERNE						
1	D	O	O							C	
2	D	D1	D2							C	
3	D	O	O								DHH
4	D	D1	D2							C	
1	E				C						
2	E	ERNE			C	MDT PREP				O	URO
3	E				C					O	
4	E	ARM			C	MDT PREP				O	URO

TABLE 8 F

THEATRE + OUTREACH + ONCOLOGY/STC CLINIC + SPECIALITY SESSION & CLINIC

+ CONSULTANT CLINIC **+ DSU**

Week	surgeon	Mon am	Mon pm	Tues am	Tues pm	Weds am	Weds pm	Thurs am	Thurs pm	Fri am	Fri pm
1	A		STC			ESWL			STC	DSU	DHH
2	A									D4	C
3	A	BAN	STC	DSU		ESWL			STC	D4	C
4	A										C
1	B	D1	D2							O	C
2	B	DSU	STH							O	
3	B	D1	D2							O	
4	B	C	C	DSU						O	
1	C		D4	URO			C				
2	C		STC	DSU	STH		C				
3	C		D4	URO			C				
4	C		STC	DSU	ERNE						
1	D	O	O				DSU			C	
2	D	D1	D2							C	
3	D	O	O							DSU	DHH
4	D	D1	D2							C	
1	E			DSU	C						
2	E	DSU	ERNE	URO	C	MDT PREP				O	
3	E				C					O	
4	E	ARM		URO	C	MDT PREP				O	

TABLE 8 G THEATRE + OUTREACH + ONCOLOGY/STC CLINIC + SPECIALITY SESSION & CLINIC + CONSULTANT CLINIC + DSU **+ THURSDAY ACTIVITY**

Week	surgeon	Mon am	Mon pm	Tues am	Tues pm	Weds am	Weds pm	Thurs am	Thurs pm	Fri am	Fri pm
1	A		STC			ESWL		Ward/ Goverance	STC	DSU	DHH
2	A							Ward/Gov	MDT	D4	C
3	A	BAN	STC	DSU		ESWL		Ward/Gov	STC	D4	C
4	A							Ward/Gov	Stone MDT		C
1	B	D1	D2					Ward/Gov	MDT	O	C
2	B	DSU	STH					Ward/Gov	MDT	O	
3	B	D1	D2					Ward/Gov	MDT	O	
4	B	C	C	DSU				Ward/Gov	MDT	O	
1	C		D4	URO			C	Ward/Gov			
2	C		STC	DSU	STH		C	Ward/Gov			
3	C		D4	URO			C	Ward/Gov	MDT		
4	C		STC	DSU	ERNE			Ward/Gov	Stone MDT		
1	D	O	O				DSU	Ward/Gov	MDT	C	
2	D	D1	D2					Ward/Gov	MDT	C	
3	D	O	O					Ward/Gov	MDT	DSU	DHH
4	D	D1	D2					Ward/Gov	MDT	C	
1	E			DSU	C			Ward/Gov	MDT		
2	E	DSU	ERNE	URO	C	MDT prep		Ward/Gov	MDT	O	
3	E				C			Ward/Gov	MDT	O	
4	E	ARM		URO	C	MDT prep		Ward/Gov	MDT	O	

Table 9

On call week

	MON	TUES	WEDS	THURS	FRI
AM	Ward / emergency Theatre / Urgent cases / triage	Ward / emergency Theatre / Urgent cases / triage	Ward / emergency Theatre / Urgent cases / triage	Hand over Ward round	Ward / emergency Theatre / Urgent cases / triage
PM	Clinic	(Clinic)	(DSU)	MDT	Theatre

= one or two clinics and DSU + one theatre pending other activity in the month

ie virtually a full weeks fixed sessions

= Arranging one hour theatre availability on emergency list every morning

This is the first draft !!!

Trying to keep some consistency within each day ie outpatient and theatre etc

There is room to alter

Pick your team member letter for theatre session and the rest follows.

This runs on a four week cycle (and there are 5 of us)

On those few occasions there is a week 5 = suggest repeating one of the weeks

The important point is that theatre sessions do not affect other activities.

The theatre allocation in the week for everyone is governed by who is on-call

Comments

TABLE 8 H **CORRECTED THEATRE ALLOCATION** + OUTREACH + ONCOLOGY/STC CLINIC + SPECIALITY SESSION & CLINIC + CONSULTANT CLINIC + DSU + THURSDAY ACTIVITY

Week	surgeon	Mon am	Mon pm	Tues am	Tues pm	Weds am	Weds pm	Thurs am	Thurs pm	Fri am	Fri pm
1	A		STC			ESWL		Ward/ Goverance	STC	DSU	DHH
2	A							Ward/Gov	MDT	D4	C
3	A	BAN	STC	DSU		ESWL		Ward/Gov	STC	D4	C
4	A							Ward/Gov	Stone MDT		C
1	B	D1	D2					Ward/Gov	MDT	O	C
2	B	DSU	STH					Ward/Gov	MDT	O	
3	B	D1	D2					Ward/Gov	MDT	O	
4	B	C	C	DSU				Ward/Gov	MDT	O	
1	C		D4	URO			C	Ward/Gov			
2	C		STC	DSU	STH		C	Ward/Gov			
3	C		D4	URO			C	Ward/Gov	MDT		
4	C		STC	DSU	ERNE			Ward/Gov	Stone MDT		
1	D	O	O				DSU	Ward/Gov	MDT	C	
2	D	D1	D2					Ward/Gov	MDT	C	
3	D	O	O					Ward/Gov	MDT	DSU	DHH
4	D	D1	D2					Ward/Gov	MDT	C	
1	E			DSU	C			Ward/Gov	MDT		
2	E	DSU	ERNE	URO	C	MDT prep		Ward/Gov	MDT	O	
3	E				C			Ward/Gov	MDT	O	
4	E	ARM		URO	C	MDT prep		Ward/Gov	MDT	O	

New urology service model

Annual availability of consultant, accounting for holidays and study leave = 42 weeks

Question

Can activity be undertaken when consultant not on site?

Are certain activities assumed to be performed without a consultant presence anyway?

Assumption -

defined quantum work needs undertaken per week in any case

If consultant presence required then:

42 weeks x 3 consultants = 126 weeks of work per year 3 consultant model

42 weeks x 4 consultants = 168 weeks of work per year 4 consultant model

42 weeks x 5 consultants = 210 weeks of work per year 5 consultant model

Therefore

2.4 consultants present each wk in 3 cons model (126 wks of work/52 weeks = 2.4)

3.2 consultants present each wk in 4 cons model (168 wks of work / 52 weeks = 3.2)

4 consultants present each wk in 5 cons model (210 wks of work / 52 weeks = 4)

Assumption :

one consultant will be OFF at any one time in a five consultant model and this also is nearly the case in the four consultant model also.

Assumption from statistics supplied:

30 New and 100 Review per week

23 inpts and 32 daycases per week

Question

Are these figure just for consultant based work performed alone as well as consultant only clinics or are these figures inclusive of ICATS referrals??

Consultant model

work per week / each consultant so that target meet

Nos Consultants	3 model	4 model	5 model
New Pt 30	(30/2.4) 12.5	(30/3.2) 9.3	(30/4) 7.5
Review 100	(100/2.4) 41.6	(100/3.2) 31.6	(100/4) 25
Inpts 23	(23/2.4) 9.6	(23/3.2) 7.2	(23/4) 5.75
Daycases 32	(32/2.4) 13.3	(32/3.2) 10	(32/4) 8

Increased constraints of outpt - eg taking consent and day4s

Interaction with ICATS -are consultants responsible for the nurses and the junior doctors who run the service - is it going to be integrated into totality of service

Thursday am

Dr Gillian Rankin
Interim Director of Acute Services
Craigavon Area Hospital
Craigavon

Dear Dr Rankin 21/09/10

I am writing in response to your recent communication about the Urology Outpatient template. I had been under the impression that this issue had been sorted out at the meeting a week or two ago with Heather Trouton and Martina Corrigan. We had defined all of my clinic template. It appeared to be suitable to all concerned and complied with start and finish times with the allocation of 20 minute and 10 minute time slots depending on the patient category. Your recent correspondence however appears to be at variance. There are a few points that I would like to make:

1. The recent changes made to the clinic template has noted an increase in the number of slot allocations.

2. My outreach clinic on a Monday morning is still in a state of flux, due to the arrangements of the Stone Treatment Centre. The expectation is that the numbers at the Banbridge Clinic will increase further;.

3. If with time it is defined that addition slots can be created I am fully in agreement that this can be undertaken.

4. My past experience has defined that it is the total number of patients at a clinic that is the rate limiting factor for the clinics duration.

5. I acknowledge the BAUS Guidelines document. However, it is from the year 2000, i.e. a decade ago. It refers to general urology clinics with the recognition

that specialist clinics do occur and that these specialists clinics have the expectation of fewer patients attending.

6. The BAUS guidelines also recognize that there is a difference between units where the rota is 1:2 or 1:3 to those working in bigger units where the rota is 1:5 with the resultant recognition and expectation in terms of a reduction in the overall output.

7. The introduction of the ICAT service has skewed the nature of the consultant clinic, in that a variety of more complex urological consultations are being undertaken. One might regard this as a specialist clinic referred to in the BAUS guideline.

8. The nature of the patients returning for a review consultation at present is such that the backlog has resulted in these patients requiring more time in terms of 'catch-up' to define their needs – it nearly turns into a new patient consultation.

9. Past clinic templates were in the order of 35 patients, this was during the period of general urology outpatients, a heavy reliance on a DNA rate and, of importance, we had more junior doctors working on the team - often with 3 or potentially 4 doctors at a clinic. As you are aware we are very restricted in our current urology staff numbers.

I do however, have a few suggestions:

a. I have welcomed the review of the clinic template as defined with Heather and Martina. Further, refinement I would suspect will occur.

b. This would include looking at the clinic times i.e morning or afternoon. I do however, feel that the DoH has to recognize fully the implication of outreach

clinics and travel time. There are also potential implications for the Working Time Directives of our junior staff when defining these templates.

c. You will observe that the new to review ratio at my clinic is actually better than your proposals. However, there has to be a split between the definition of the total amount of work to be undertaken against any new to review ratio.

d. I do believe if we can sort out the current outstanding review patients that the patients that are coming back for review from the current outpatient sessions will indeed not require as much time to see and sort out - from this an improvement in the time slots would be envisaged;

e. Engagement with the General Practitioners Service with new working arrangements I would regard as an extremely fruitful enterprise. In fact of all the points noted on change I would regard this as probably the most important and productive. Again this does take time in setting up properly.

f. A major enterprise would be the combination of a 72 hr triage with a 'virtual' clinic where the urologist of the week would triage letters and arrange investigation or contact the GP with advice etc. This would have to be well recognized work, as I have performed this in the past when waiting times were excessive (– unfortunately it was unrecognized work time and fell on 'deaf ears')

g. The 72 hr to one week triage is a feature that I currently attempt to obtain

In conclusion we have engaged to relook at our clinic templates. I believe that it falls short of the DoH request by only a few patients. My experience notes that it is the total number of patients attending a clinic combined with the general nature of the complaint to be the rate limiting factors. I do not distinguish between a clinic being

attended to by one or two doctors. The ratio of new to review remains the same, only the clinic numbers double with two doctors. (It is interesting to note that the BAUS Guidelines record that if a second doctor is at a clinic the numbers of patients should be reduced). On consultation with other established units our clinic template is not too far away from the mark. I am very much open to discussion with the General Practitioners Service about changes in clinical pathway. I appreciate we meet with Dr Beckett with regards to this issue. My interpretation of that meeting was as an opening discussion. I found that it had a lot of mileage and therefore would welcome further discussion. At a previous meeting with the department it appeared to me that there was recognition that there were variations between the three regions and that this was acceptable for a variety of reasons. I hope we can use these thoughts when discussing this with the Department of Health and that they can accept our structure, after all we were instrumental in the introduction of urology ICATS in Northern Ireland.

Yours sincerely

Michael Young MD FRCS(Urol)

CRAIGAVON AREA HOSPITAL
68 LURGAN ROAD
PORTADOWN, BT63 5QQ

UROLOGY DEPARTMENT

CONSULTANT: Mr MRA Young, Consultant Urologist
SECRETARY: Miss Paulette Dignam
TELEPHONE: Personal Information redacted by the USI
FAX: Personal Information redacted by the USI
E-MAIL: Personal Information redacted by the USI

27th October 2010

DR GILLIAN RANKIN
DIRECTOR OF ACUTE SERVICES
ADMIN FLOOR
CAH

Dear DR RANKIN

You have written again on the subject of clinic templates for urology outpatients. I have previously corresponded on this subject with you. Unfortunately I do not particularly see that I can change my comments. As pointed out in that correspondence, I think it is a little unfair to fully define the Banbridge and Armagh clinics as these particular clinic times have in the last few months only changed to a Monday morning. There still is a state of flux with this as I have to return to do a stone clinic back here in Craigavon. It would be reasonable to say that this area is currently being re-addressed with regards to the stone clinics timing, but until this is done, it is hard for me to fully participate in a full clinic template at these clinics. I would however state that our intention is for the Registrar to stay on further at the clinic until its completion time, and with this additional numbers will be added to the clinic. So, to fully address the Banbridge and Armagh scenario, a resolution of the other clinic being co-ordinated at the same time has to be resolved before this particular issue can be sorted.

With regards to the Craigavon clinic, I really do not see what the issue is here; the request appears to be virtually what I am doing. This last month or two, I have been keeping clinic times finding that the clinic runs to its full duration and in fact last week, when I added on several additional cases, bringing the clinic template to fourteen patients seen, ended with the clinic finishing time at 5:55pm which is an hour overdue on a Friday afternoon. As noted in my previous letter, clinic template times were set up with Martina and Heather on a ten and twenty minute basis. Also the new to review ratio appears exceptionally good in comparison to previous levels. However it is the total number of patients at the clinic that is 'the bottom line', as patients consultation times do vary and the whole clinic time does allow for these variations to be smoothed out.

I do not feel that the administration has fully taken on board and realised the impact of the change in type of urology patients attending the various clinics. The original BAUS document related to a general urology outpatient attendance i.e. all comers. The BAUS document records that sub-speciality clinics generally have fewer patients attending. Our ICATS service has siphoned away certain categories of patients away, which has resulted in the sub-speciality urology clinic scenario occurring for the Consultants clinic.

I am sure you are aware that BAUS will be updating its advice on the provision of urological services. Although this is not formally published, I have had the opportunity to view this in draft form. It makes interesting reading. It comments on more all-inclusive clinic attendances with investigations on the day of attendance, that a specific urology area is defined (much the same as we have been trying put across to the Trust for a Urology Day Care Area) and with regards to clinic numbers, it records that clinic attendance numbers should be reduced to reflect these added activities. They are recommending that five to ten new patients are seen per clinic, or five new and seven follow ups, pending the sub-speciality interest. They feel that this is a reasonable workload.

At our previous discussions, I have tried to put across the principal of full team work i.e. the right health care provider seeing the patients. With doing this, productivity and economy of time can be used to its best ability. A further interesting comment from this draft BAUS document, comments on a Clinical Nurse Specialist being available for each Consultant. It also observed that General Practitioners are reluctant to follow up urology patients, but do welcome that follow of patients can be delivered in a variety of ways from telephone consults through to follow up in person either at large GP surgeries or in defined urological clinical areas within hospitals.

In conclusion, I would like to refer you back to my original letter and its content. There has been additional requirements expected of us at outpatients with such activities as pre-assessment etc. These activities and the noted comments do hinder the ability to meet the old (outdated) BAUS expectation. This, as noted above, is now recognised by BAUS. Your comments on the new to review ratio are noted and I will endeavour to try and attain an improved new to review ratio as an overall aim but if I deem a patient requires a review appointment (which would distort the new to review ratio) I will still be giving that patient a review appointment. I still feel that instead of defining individuals output, it is the Team output that should be the quantitative assessment. I believe that we need to move on from this outpatient commentary to defining our urology service in total i.e. wards, inpatients, theatre lists, day lists on the various sites, are much more important issues to be addressed.

A second issue I would like to raise is the apparent, unusual engagement with the Urology Department when discussing its future. We have indeed been discussing issues, yet a proposed job plan is distributed on a Friday evening which is apparently for discussion the following Monday and then supposedly presented to

the Department of Health by the end of that week. I am sure you are aware that a proposed five man job plan had been produced by our Department several years ago yet this has not been considered. Discussion on Job Plans are not defined in this fashion. It is also interesting that only certain aspect of the BAUS recommendations are taken into account. A further perturbing point of this engagement which I feel is rather irregular is the fact that there was no urology member present when the Department of Health came down to the Trust this week. It appears that I found out about this by default. Aspects of the urology reconfiguration would appear to have been discussed with them prior to any engagement with our Department. This has certainly compromised the whole situation.

I am sure you realise that we as a unit are passionate and concerned about how Urology Services in the area will be performed as we will be the ones carrying it out. Recent events are affecting our ability to proceed effectively, especially at this most important time of Urology transition in Northern Ireland and I feel that the current terms of engagement need to be improved.

Yours sincerely,

Mr M RA Young, MD FRCS (Urol)
Consultant Urologist
/pd

cc. A.F `

20th November 2009

Heather Trouton
Assistant director of Acute Services

Dear Heather

We were grateful that you facilitated a meeting to discuss the ward changes instigated four months ago. It certainly gave the opportunity to voice concerns and put forward our thoughts. I did find it rather unusual and frankly perturbing that an individual from the floor was able to score out one of the proposals. We have had the opportunity to further reflect on the discussions and therefore wish to put forward our thoughts and requirements.

The Urology Service requires a singular completely autonomous nineteen bedded Urology Unit with its own Ward Manager and Sister. This is not unprecedented as it existed before and in fact there are examples of this currently being available in the new configuration. We also have to be mindful of the expected expansion in the Urology Service. The recent external urology review for Northern Ireland clearly documents a requirement and in fact a stipulation that there is a Urology Unit.

This is our opportunity to now get it right, so to speak, and it is unlikely that we will be able to avail of yet further changes. There will indeed be the expectation that staff changes between the wards will be occurring in any case and therefore the principal of wanting as little movement as possible is not a particularly strong argument.

It is not entirely clear that admitting emergencies to all wards is going to solve the current issues. Options to increase emergency bed numbers would undoubtedly be advantageous. Since we have lost surgical bed numbers, full utilisation of existing beds should be a prime goal.

An autonomous Urology Unit can indeed be attained by several plans, however our proposal for the ward configuration is indeed very valid. This proposal is that: we have a nineteen bedded Urology unit, defined ENT and the other surgical sub-specialties having their clinical areas also staffed by the appropriate nurses, and an admissions ward to ensure the patients are admitted on time. The area of short stay is less understood. A clear definition of twenty three hour and short stay needs to be embraced.

We appeal to you to consider and reflect again on this proposal. This configuration would be:

- 3 South having the Urology Unit on one side,
the other side of 3 South being ENT with breast surgery and short stay.
- 4 North housing gastrointestinal and emergency
- 4 South having vascular, general and emergency surgery. On the other side of the ward would be the Admissions Unit with twenty three hour stay.

This enables the vast majority of General Surgery to be on the one floor. This would provide the advantage of keeping the admissions and twenty three hour stay unit open continuously and catering for a full week to include the planned weekend work considerations. The ENT and breast admissions would be directly to their own specialised unit. This would ease the load on the admissions ward, where there would be a focus on the principal of twenty three hour surgical patients. Also the principal of a 'clean' surgical floor combined with potential future quality issues may well be an attractive proposition for the breast surgeons. The top floor would therefore concentrate the emergency surgical patients which will aid the medical and nursing staff. This principle also would cater more for the potential weekend workload.

We do believe that this proposal for a configuration is as valid as any other. The primacy of a urology unit in a defined area, staffed by urologically trained nurses with a ward sister and a urology manager is absolutely essential.

Yours sincerely

MRA Young MD FRCS(Urol)

To Chief Executive Office

7th June 2012

Dear Mairead

As you are aware I have expressed concern with the Chair about the constitution of the panel for the upcoming urology consultant interviews. My understanding is that the Chair had also enquired on the same subject. I do fully understand and appreciate the need for Trust policies and comply with this principle.

I regard the appointment of three consultants on one day to a unit currently made up of two consultants, as an uncharted area and certainly unusual in UK terms. From our conversation of last night, I would formally request, due to the unique nature of this situation, that it is only right and proper that both Urologists in the unit be on the appointment panel. I am not asking for anyone to be replace but this will be a Trust issue. I do believe candidates will be more at ease with this approach.

I note the college extern is locally based. I had thought the Trust policy was for the extern to be from outside of the province, but HR appears satisfied with this point. A further point which came to mind after our conversation related to the fact that one of our posts will cover the Western Board's area. Would it be a suitable for Mr Brown to remain on the panel as a representative for all of the outlying units we will be covering in this new arrangement?

Again I would like to take this opportunity in thanking you for your time and consideration on this issue and for whatever decision is taken.

Michael Young

Lead Clinician Urology

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.	

TEAM SOUTH RESPONSE TO UROLOGY REVIEW 2014

DIFFICULTIES WITH REVEW:

- Lack of openness re: agenda for review in first place = really about centralisation of pelvic cancer.
- Fixed reference point, namely year 2000 document i.e. ten years behind – although a good document for its time.
- Not listened to our concerns that things moved on from this document; for instance same time span allocated to patients despite considerable added administration adjoining this for each patient.
- May have increased consultants but little resources or extra facilities.

ISSUES FOR US IN CRAIGAVON:

- Variable employment of middle grade – more often than not don't have – results in stop/start clinic; outcome to affect clinic design and CNS involvement.
- Infrastructure of Day Surgery availability. Mainly stand-alone units therefore patients definitively need to be both fit and procedure very specific dependent.
- Rural Community – treatment closer to home. Travel affecting our numbers at clinics.
- Defining how many theatre lists originally was a challenge due to diversity of procedures and target time.
- SABA was an historical document, uncompromising to changes in need.
- Demand and capacity changes.
- Administration time allocated inadequate – expectation that this runs alongside what already doing in a particular session.
- On-call duties, like administration, runs in tandem.
- Turnover of consultants has been an instability.

- Matching demands of targets with patient slots needs significant fine tuning. Conflict between oncology, urgent and non-oncology plus routine work all have different demands and expectations.

- Revisit the question of bladder removal as part of non-oncology reconstructive urology. Really felt that this was misrepresented by the Department with some people having fixed ideas, which we regard as incorrect. This area is lacking in general in Northern Ireland (as is Andrology, but this was always going to be an issue as the 2009 review was based on oncology)!

- Lack of engagement by GP's.

POSITIVES AND PROGRESS:

- Engaging with reform as much as possible (see answers to urology review summary of recommendations stocktake).

- SWAH up and running, South Tyrone regular attendances, Daisy Hill soon to start with new consultants, new Thorndale Unit – worked out what we needed and Trust provided.

- Urology staff, nurses, CNS, consultants; some stability being obtained.
- "Trying to get on with it":

  Exploring new schedules
  Late finishes in theatre
  Adaptable list allocation – backfill
  Team Approach
  Minimising cancellations via monthly scheduling

- ICATS – did work in principle – good when had staff
  Needs to move on and be redesigned – this is a project in hand

- New to Review ratios have improved; more instructions given to GP's but overall shared care still an issue despite trying.

- Hoping now to have a more stable unit with consultant and CNS delivery (middle grade posts would be an extra and little output despite exceptionally good training for our SPR's).

- More complete unit now to offer the range of services and hoping that consultant's offering a service are not side tracked to help out in other areas.

- Hoping to move to offering hot clinics, improved triage to aid clinic attendances therefore improve on-stop approach and improved access for emergency cases from casualty etc.

- Fifth and sixth consultant will help a lot with the above points.

- Potential for networking with other units e.g. already some ESWL workload coming from South Eastern Trust. Also the potential for functional/reconstructive alliance in Northern Ireland for each unit i.e. not centralised but having an alliance.

WHAT DO WE NEED?

An improved administrative flow of patients; this is not only ICT based but personnel working within unit e.g. a clinic co-ordinator administrative person.

- Theatre capacity in CAH (bulk of work) needs enhancing. Original difficulty precisely defining needs. Should have two theatre lists per consultant.
- Enhanced Day Surgery and twenty three hour facilities within the main hospital would increase our scope.
- Appreciation that new BAUS recommendations will be available soon – understanding that there is a further improvement in consultant to population base and that there has been a shift in the age/expectation/and procedures since last review.
- A recognition that one shoe does not fill all; each department can have its policies to gain as much productivity.
- Stick to targets before moving on to the next one.
- A distinct focus on care pathway aiming for an enhanced triage, hot clinic principal with rapid access.
- Elimination of external factors such as wait limiting features as access to radiology.

TEAM SOUTH RESPONSE TO UROLOGY REVIEW 2014

I think we all recognise that there were issues with the original RV; whose terms going + methods

DIFFICULTIES WITH REVEW:

- Lack of openness re: agenda for review in first place = really about centralisation of pelvic cancer.
- Fixed reference point, namely year 2000 document i.e. ten years behind – although a good document for its time.
- Not listened to our concerns that things moved on from this document; for instance same time span allocated to patients despite considerable added administration adjoining this for each patient.
- May have increased consultants but little resources or extra facilities.

However we very much welcomed this RV as we have had a previous RV with a good outcome & it was what N I need Hence our original expectations escalated it has fallen short so again welcome the standard

ISSUES FOR US IN CRAIGAVON:

- Variable employment of middle grade – more often than not don't have – results in stop/start clinic; outcome to affect clinic design and CNS involvement. → w/L
- Infrastructure of Day Surgery availability. Mainly stand-alone units therefore patients definitively need to be both fit and procedure very specific dependent.
- Rural Community – treatment closer to home. Travel affecting our numbers at clinics.
- Defining how many theatre lists originally was a challenge due to diversity of procedures and target time.
- SABA was based on an historical document, uncompromising to changes in need. – Consultant only here may be different elsewhere
- Demand and capacity changes.
- Administration time allocated inadequate – expectation that this runs alongside what already doing in a particular session. Just too Busy
- On-call duties, like administration, runs in tandem. ~ not good practice
- Turnover of consultants has been an instability.

- Matching demands of targets with patient slots needs significant fine tuning. Conflict between oncology, urgent and non-oncology plus routine work all have different demands and expectations.

- Revisit the question of bladder removal as part of non-oncology reconstructive urology. Really felt that this was misrepresented by the Department with some people having fixed ideas, which we regard as incorrect. This area is lacking in general in Northern Ireland (as is Andrology, but this was always going to be an issue as the 2009 review was based on oncology)!

But already challenged by Volume

- Lack of engagement by GP's.

→ Urology Service provided

POSITIVES AND PROGRESS:

- Engaging with reform as much as possible (see answers to urology review summary of recommendations stocktake).

- SWAH up and running, South Tyrone regular attendances, Daisy Hill soon to start with new consultants, new Thorndale Unit – worked out what we needed and Trust provided.

Self Contained Ambulatory based INUIT

- Urology staff, nurses, CNS, consultants; some stability being obtained.
- "Trying to get on with it":

open to

  - Exploring new schedules
  - Late finishes in theatre
  - Adaptable list allocation – backfill
  - Team Approach
  - Minimising cancellations via monthly scheduling

• Covers all the bases e.g. often taken by Consult. LUTS. despite deficit of Junior Consultants back fill

• extended loc. clinic

- ICATS – did work in principle – good when had staff
  Needs to move on and be redesigned – this is a project in hand

out pt times per pt

Needs redefined all parts

- New to Review ratios have improved; more instructions given to GP's but overall shared care still an issue despite trying.

- Hoping now to have a more stable unit with consultant and CNS delivery (middle grade posts would be an extra and little output despite exceptionally good training for our SPR's).

- More complete unit now to offer the range of services and hoping that consultant's offering a service are not side tracked to help out in other areas.

• ~~Benefit Ambulatory endeavour to have a~~

• ~~Continence Service~~ See

- Hoping to move to offering hot clinics, improved triage to aid clinic attendances therefore improve on-stop approach and improved access for emergency cases from casualty etc.
- Fifth and sixth consultant will help a lot with the above points.
- Potential for networking with other units e.g. already some ESWL workload coming from South Eastern Trust. Also the potential for functional/reconstructive alliance in Northern Ireland for each unit i.e. not centralised but having an alliance.

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Urology Department
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Consultant Urologist
Mr MRA Young, MD FRCS (Urol)

Consultant's Secretary
Mrs Michelle McClelland

---

19 August 2002

Dr L McCaughey
Medical Director
CAHGT

Dear Liam

Between our meeting and letters of July this year, I have expressed grave concerns about the Trust's provision of services to our urology population and urology manpower. These two points are closely interrelated but they are two separate issues. Undoubtedly there are serious pathological conditions, as yet undiscovered, amongst referrals, and on the existing waiting list. The waiting time of these and especially those whom we already strongly suspect to have a serious condition, is at a level which exposes the Trust to potential complaints or legal involvement. Beyond reiterating the content of my letters of 26 and 31 July 2002, the volume of work performed and expectation of work to be carried out is currently far too excessive. This is compounded further by waiting list initiatives and planned developments. I was hoping for an early response both to how to address the early and medium arrangements (letter 26.07.02). Clinically the short-term address relates to outpatient referrals. It is appreciated that the bed space allocation will not be resolved quickly but an adequate provision must be defined for urology. (letters 26 & 31 July 2002) As you are aware, there is a formula to calculate this allocation. As haematology have only 8 of the beds on the other half of 2 South, there is no reason why the remainder cannot be allocated to urology.

The current manpower and on call commitment, as everyone agrees, are not at the correct levels. This is especially so since Consultants regularly are first on call without Registrar cover, unlike any other Department in the Hospital. The prospect of cover arrangements are also at a significant level.

To date we have been trying to develop the service and with this we have been prepared to accept the 'rough with the smooth'. However, this goodwill is running thin, despite the reciprocal outward appreciation, it is not backed by actions.

I also regard it as not advantageous to us as Urologists or to the Trust to take unilateral decisions at short notice to cease certain activities (despite these issues being addressed informally and formally with the Trust over the past twelve-eighteen months). Several surveys have been performed and the new Consultant's contract have stalled any implementation. As you are aware certain dates have been suggested. I personally feel, to be fair to all concerned, that the date of the 1 September 2002 was indeed too soon. Others suggested 1 November 2002 as adequate notice, however, as so many initiatives are planned to start in October (TRUS, Urodynamics and Flexible Cystoscopy), I feel this would be counter productive to start and then stop. I therefore regard that the date of 1 October 2002 be defined as having these issues addressed to our mutual satisfaction.

It is appreciated that Consultant and bed space expansion cannot occur overnight. What is expected however is a defined timetable for such events. The main issues to resolve by 1 October 2002 are the matters of on-call commitment and recognition of our 1:2 rota.

If this issue cannot be resolved, then a unilateral decision to reduce the workload will be taken, compatible with what we regard as in keeping with patient's safety and our time management.

Although the Trust has been aware of our concerns for over one year, I would doubt if the Trust has informed the Board of the same. This may appropriate in view of the eminent plans. Sine there has been little progress, I am re-referring this issue back to the LMC again, despite the Committee being aware of our plight one year ago. I do however feel such concerns are probably best channeled in this direction.

It is sad to see these types of issues work for some and not for others.

Yours sincerely

_____

Mr MRA Young, MD FRCS (Urol)
Lead Clinician in Urology
/mm

cc Mr. I Stirling, Clinical Director of Surgery, CAHGT
Mr. J Templeton, Chief Executive, CAHGT
Mr E Mackle, LNC – Chairman, CAHGT

12 September 2002

Mr. I Stirling
Clinical Director of Surgery
CAHGT

Dear Ivan

As part of my role as Lead Clinician, I have been looking at the various aspects of our urology service. Although the service has not expanded in terms of manpower etc as yet, the Department has taken on quite a considerable amount of extra duties when looked at as an overview. These “extras” may appear individually small but cumulatively are quite significant, often having hidden additional ill-definable workloads and are prone to expansion.

Despite the fact that Secretarial/Audio Typist/Clerical staff are in short supply and there are financial constraints I wish to discuss the current provision of secretarial support to the urology service.

- During the last year, on the occasions when any of the Secretarial staff members have been on leave, the work literally piles up immediately. There is no extra capacity in our system to cope with this at all and help is only gained on occasions with a significant struggle. This should not be the way a major organization works.

- Audio Typist support is of an excellent quality thankfully, but again I feel that there is an understaffing in view of the increased volume of work. This may not be fully budgeted for as such.

- Surely a Surgical Consultant in this hospital should have a full time secretary, especially when for many years this has been the case! How can the finance department in this hospital downgrade such a post to part-time, just because the previously incumbent secretary did so for one month before leaving? The finance department are fully aware of this situation yet are extremely slow to rectify the situation. The shows a lack of responsibility.

- The other main issue I would urge you to consider relates to my Secretary. I note that there has been a considerable increase in various aspects of both workload and administration, over and above what was initially designed for this particular secretarial post. Firstly there is a volume issue

The management and co-ordination of extra lists in Urodynamics, Flexible Cystoscopies, Haematuria Clinics, a 25-30% increase in outpatient clinics of Banbridge, Armagh and Craigavon, considerable increase on the planned activity of the Stone Treatment Centre (40 patients per year – 350 patients plus associated clinic) and the existing ad hoc TRUS prostate biopsies of one-two per week. This is the definable.

Administrative work attached to my role as Lead Clinician, Director of the Stone Treatment Centre, diary management and especially following up the forty-fifty telephone enquiries a day, goes unrecognized. This administration and co-ordination of letters, notes and enquires is of an exceptionally high quality. Other quality issues include teaching and supervising junior audio typists, which I believe are not supposed to be part of the job.

In view of her management co-ordination, ability to prioritize, excellent liaison characteristics, ability to cope - combined with IT administrative skills and teaching (from external studies) I request that this post be re-graded in line with administrative management levels, especially when our plans to expand the service will include IT/ coordinator administrative staff.

All this I hope will reward hard work, encourage retention of trained staff in the unit and enable the Urology Department to develop a post compatible with administrative capability.

These issues I would be grateful if you could redress with the appropriate bodies.

Yours sincerely

_____

Mr MRA Young, MD FRCS (Urol)
Lead Clinician in Urology
/my

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Consultant Urologist
Mr MRA Young, MD FRCS (Urol)

Consultant's Secretary
Mrs Michelle McClelland

1 October 2002

Dr L McCaughey
Medical Director
CAHGT

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on call without Registrar cover, unlike any other Department in the Hospital. The prospective cover arrangements are also at a significant level.

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Yours sincerely

_____
Mr MRA Young, MD FRCS (Urol)
Lead Clinician in Urology
/mm

cc Mr. I Stirling, Clinical Director of Surgery, CAHGT
Mr. J Templeton, Chief Executive, CAHGT
Mr E Mackle, LNC – Chairman, CAHGT

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Consultant Urologist
Mr MRA Young, MD FRCS (Urol)

Consultant's Secretary
Mrs Michelle McClelland

---

28 June 2004

Mr Calvin Spence
BMA House
16 Cormac Place
Cormac Wood
Ormeau Road
Belfast
BT7 2JB

Dear Calvin

We have spoken informally on this issue some months ago but I am now requesting formal representation from the BMA on the issue of our plight regarding Consultants working on the Registrar rota in Urology at Craigavon Area Hospital.

The background to this originates from the Registrars having to be on a one in five rota. Since we have only three Registrars (one SPR and two Research Registrars) available to us, this therefore results in a shortfall for cover. This is compounded a lack of prospective cover. This results in Consultants filling in the gaps on a routine basis during the standard rota and for the Registrars holiday periods. This is in addition to their one in two Consultant rota.

We have written to our Local Negotiating Committee within Craigavon Area Hospital some years ago now with regards to this issue. It was meant to be at the top of the list to discuss with the Trust, however the meetings between the LNC and the Trust appear to have been cancelled on a frequent basis and when the opportunity arose for discussion our issue was not raised. At a recent meeting with the Medical Director, Dr Humphries I raised this point. She commented that at a recent meeting it was indeed raised, but noted that it was unlikely to be resolved locally and she backed my statement that I had the intention of writing and involving the regional BMA. It is therefore apparent that not only do I wish the regional BMA to be involved but that the Trust feels the same way.

It is interesting to note that the Trust has been fully aware of this issue but has not attempted to either resolve this issue nor have they instigated or attempted to employ Locum cover.

I submitted a bill based on a formula suggested by the Consultant and Specialist Association, some years ago which was specifically designed to cover such eventualities. This has not been honoured never mind acknowledged.

It should be noted that to date we have only asked for such payments for Consultants covering Registrar duties.
However it should also be noted that the Trust at no time has offered extra payment for our arduous one in two surgical/urological on-call nor have they suggested or provided locum cover for holiday periods i.e 1:2 rota with prospective cover.

Last summer, our Chief Executive called for an external service review for urology in Craigavon. This however has only just commenced this month, virtually a year later. I would anticipate that from this extra staff will be employed on a permanent basis. In the interim the employment of a Locum Consultant has been suggested. If such a person is employed this would certainly improve the situation considerably.

My request from the BMA is that:-

1. The outstanding issue of Consultants performing Registrar on-call duties be
retrospectively compensated.
2. That Consultants performing Registrar on-call duties in the future be defined and formally compensated
3. That the BMA define why the Trust in their full knowledge did not of their own volition attempt to provide adequate cover for prospective leave
4. Define why the Trust did not compensate, in any manner, the staff or the Urology Department during such periods
5. That the BMA define a precise date when these arrangements apply – noting for some months now that a suggested date of 1st July to be used. Previous communication from the Chief Executive has already defined a precise date for retrospective claims some years ago.
6. That at such a date, if no cover is arranged that compensation is immediately defined and implemented.

I have written to our local Chair of the LNC to inform him of our request to transfer negotiations to yourselves.

Yours sincerely

Mr MRA Young, MD FRCS (Urol)
Lead Clinician in Urology

Private and Confidential
Dr C Humphrey
Medical Director
Craigavon Area Hospital Group HSS Trust
Craigavon Area Hospital
68 Lurgan Road
Portadown
CRAIGAVON
BT63 5QQ

Our Ref: 6951438 23 July 2004

Dear Dr Humphrey

Consultants Working in Urology

I am writing on behalf of the above having received a letter from Mr Young. I understand that there have been problems for a number of years with the heavy consultant workload, problems which appear not to have been addressed by the trust.

The main element seems to be the Registrars and their one in five rota. With only three Registrars (one SpR and two Research Registrars) available, this results in a shortfall for cover. Because of the numbers this results in consultants filling in the gaps on a routine basis during the standard rota and for holiday periods. All this is in addition to their own one in two rota.

I know that the medical staff Local Negotiating Committee within Craigavon Area Hospital were briefed about this. However meetings between the LNC and the Trust appear to have been cancelled on a frequent basis and the issue has not been able to be raised, although I am aware that the matter has been raised with you personally.

Further, the consultants doing SpR locums should have been paid for same. Such work is outside their contractual duties. Also, as you may know, under the new consultant contract a supplement is payable in respect of availability to work during on-call periods. The two consultants concerned are entitled 8% supplements each. Moreover, their Job Plans must incorporate the average amount of time they usually spend on unpredictable emergency work each week. Given their rota, this will probably add the maximum of one Programmed Activity per week to the Job Plan.

In addition to the payments that the consultants are entitled to, there is the question of locums required for holiday periods. I have advised the consultants that this is the trust's responsibility to organise.

I gather that an external service review for urology in Craigavon is currently being undertaken. This is clearly overdue but I would urge the trust to address both retrospectively and prospectively the issues noted below.

To summarise, I feel that the following should now be addressed.

The retrospective compensation of the Consultants performing Registrar on-call duties should be resolved.
Arrangements should be put in place for formal compensation for consultants performing Registrar on-call duties in the future.
The prospective pay and time for on-call work should be written in to the Job Plans.
A firm date concerning when these arrangements apply should be established. I understand that for some months now the suggested date of 1 July has been referred to and that the Chief Executive had defined a precise date for retrospective claims some years ago.

I have to say that if there are no positive signs from the trust on these issues, I will have to advise the consultants to withdraw the SpR cover, because this is outside the requirements of their contract. Having said that, I would hope that this matter can be resolved amicably on both sides. Please let me have your comments as a matter of urgency.

Yours sincerely

Jim Milligan
Assistant Secretary

cc Mr RAM Young
Dr P Murphy, LNC

Department of Urology

20 June 05

Dear Caroline

Yet again a further summer is virtually upon us. As there has been no change in the urology status, I am writing to enquiry about the arrangements the Trust proposes to put in place to cover the holiday period when the Consultant Urologists are on leave during this summer.

Yours sincerely

MRA Young MD FRCS(Urol)

PLANNING AND CONTRACTS DIRECTORATE

MEMORANDUM

CRAIGAVON AREA HOSPITAL GROUP TRUST
Caring Through Commitment

To:	Urology Review Group Urology Project Team	From:	Anne Brennan Planning Manager *email:* [redacted] Personal Information redacted by the USI
cc.	Mr. D. Herron		
Date:	Wednesday, 22 December 2004	Ref:	Urology Consultant Post – SHSSB Feedback Requested

Dear all,

Please find attached information relating to the Urology Consultant post as forwarded for discussion to the SHSSB for discussion. Any comment/feedback would be welcomed.

Merry Christmas and a Happy New Year to all!

Regards,

_____
Anne Brennan
Planning Manager

PLANNING AND CONTRACTS DIRECTORATE

MEMORANDUM

CRAIGAVON AREA HOSPITAL GROUP TRUST
Caring Through Commitment

To:	Dr. D. Corrigan Mrs. M. McAlinden	From:	Anne Brennan *email:* Personal Information redacted by the USI
cc.	Urology Project Group Urology Review Group		
Date:	Wednesday, 22 December 2004	Ref:	Urology Consultant Post – SHSSB Feedback

Dear Dr. Corrigan & Mrs. McAlinden

Further to recent discussions in relation to the Urology Consultant job plan please find attached outline 10 sessions plan for submission for speciality approval and further details on our plans relating to this post.

Table I: 10 session Job Plan for specialty approval

Day	Description
Monday AM	Main Theatre [0.75 session]
Monday PM	Main Theatre [0.75 session] *Emergency [0.25 session]*
Tuesday AM	Day Surgery [0.25 session]/Ward Round [0.25 session]/SPA [0.50 session]/*Emergency 0.50 session*
Tuesday PM	Ward Round [0.50 session]/SPA [0.50 session]
Wednesday AM	Patient Administration [0.5 session] *Emergency [0.50 session]*
Wednesday PM	SPA [1.0 session]
Thursday AM	SPA/MDT [0.5 session]/*Emergency [0.50 session]*
Thursday PM	Outpatients [0.37 session]/Patient Administration [0.5 session]
Friday AM	Ward Round [0.75] *Emergency 0.25 session*
Friday PM	Patient Administration[0.5 session] /Outpatients [0.37 session]

Equating to the following:

Table II: Summary of 10 sessional post

Main Theatre	3 all Day Theatre lists per month	1.5 sessions
Day Surgery	1 per month	0.25 session
Outpatients	3 clinics per month	0.75 session
Ward Rounds	1.5 sessions per week	1.5 session
Emergency	2 sessions per week	2.0 sessions
Patient Admin	1.5 sessions per week	1.5 sessions
SPA	2.5 per week	2.5 sessions
		10 sessions

The recent Consultant diary exercise has demonstrated that the existing consultants have a 16 – 18 PA plan plan, this work combined with an analysis of current workload and planned future developments for the service have lead us to calculate that a 13 session job plan per consultant is required to deal with the current demands on the service. [39 sessions per week among the speciality]
The Trust would anticipate approaching the successful candidate to undertake the additional 3 sessions in order to reach this level.

The appointment of an additional consultant post at 13 PA's, combined with the current service redesign would allow for existing consultants to work towards a 13 PA job plan with no nett loss in capacity.

The 13 PA job plan would deliver the following*:[see Table III]*

- Inpatient Ward Rounds
- Administration
- Supporting Professional Activities
- Emergency Cover

In addition it will provide:

- Main Theatre
- Day Case
- Outpatients
- Specialist Clinics

The Trust feels that the introduction of a 10 PA job plan would not be practical given current demands on the service and the statutory requirements of the new consultant contract.

We would welcome your feedback/comments on this proposal and await this in order to complete a full outline of Urology capacity as discussed.

I look forward to hearing from you.

Regards,

Anne Brennan
Planning Manager

Table III: Urology Specialty Proposed Sessional Workload

Week No:	Activity											
	Main Theatre	*Day Surgery*	*Outpatients*	*Specialist Clinics*			*Emergency*	*Ward Rounds*	*SPA*	*Patient Admin*	*MDT*	*Total Sessions*
				Urodynamics	*Prostate/LUTS*	*Stone Treatment ESWL/Other Special Interest*						
Monthly sessions Urology include. additional consultant post	18 sessions	6 sessions	12 sessions	4 ses	4 sess	4 sess	24 sessions	24 sessions	30 sessions	24 sessions	6 sessions	
Current Sessions	*currently 16 sessions*	*currently 4 GA/6 LA lists*	*currently 11 sessions*	*8 sess*	*0 sess*	*8 sess*						
Monthly Sessions per consultant	6 sessions	2 sessions	4 sessions	1.33 sess	1.33 sess	1.33 sess	8 sessions	8 sessions	10 sessions	8 sessions	2 sessions	
Weekly Sessions per consultant	1.5 sessions	0.50 sessions	1.0 session	0.32 session	0.32 session	0.32 session	2.0 sessions	2.0 sessions	2.5 sessions	2.0 sessions	0.5 session	13 sessions per consultant per week

UROLOGY TRENDS

1. Enclosed are several graphs showing the activity trends of the Craigavon Urology Department over the past few years.
2. The first graph shows Finished Consultant Episodes.

3. Activity as defined by change from March 1997

	Emerg.	Elective	Daycase	Outpt.
To 99	-6.8%	+49%	+44%	-6.7%
To 2001	-8%	42%	+55.4%	-0.7%

The Year on year changes during these time are:

	96/97	97/98	98/99	99/00	00/01
Emerg.	+1.9%	-9.6%	+3.2%	+3.9%	-5%
Elective	+0.9%	+33%	+12.1%	-5.9%	+0.9%
Daycase	-2.9%	+29%	+11.7%	+14.1%	-5.4%
Outpt.	+44%	-4.1%	-2.7%	+10.7%	+3.8%

SUMMARY

1. Day case numbers substantially increased by about 50% since 1997, with a plateau trend now.

2. Emergency admissions less by 7-8% but averaging 600 patients per year +/- 17.

3. Elective surgery defined as initial substantial increase between 1997-1999 but now plateaued at this upper limit.

4. Outpatients – again initial increase of 44% but now relatively static

5. Static levels appear to have been reached for current activity.

QUARTERLY DECISIONS TO ADMIT FOR JUNE 1997- SEPTEMBER 2001
(as defined in graph)
The trend to admit is shown in graph 2.

These average :-
269/quarter – June 1997/98
348/quarter – June 1998/99
409/quarter - June 1999/00
431 /quarter - June 2000/01

This defines a year on year increase of +29%, +17.5% and +5.4%.

The overall change from 1997 – 2000 is of a 60% increase in the trend to admit.

SUMMARY

Despite a substantial increase in planned workload the trend appears to be slowing up.

UROLOGY WAITING LIST

The resultant urology waiting lists between March 1996 – 2001 are shown in graph 3.

The outpatient number awaiting first appointments were 126 in 1996 and have grown to 1144 in 2001 (808% increase).
The inpatients were 244 in 1996, now being 824 (238% increase).
The day-patients were 252 have increasing to 427 (69% increase).

SUMMARY

- All waiting numbers have escalated, with the day cases to a lesser degree.

UROLOGY AS DEFINED BY RECOVERY PLAN 2001 or CURRENT STATUS AS DEFINED.

1. Contract Performance 2000-2001

	Emerg.	Elective	Daycase	New outpt	R/V outpt	Total outpt
Planned	609	751	1133	1257	3608	4865
Actual	580	757	1212	852	4622	5474
%	-5%	+1%	+7%	-32%	+28%	+13%

2. The medical staff allocation in 2002 is 1.8 Consultant, one SpR, 2 Research Clinical Registrars and one SHO. The SpR and SHO are centrally allocated. The Research Registrars are appointment by Craigavon Area Hospital.

3. There has been an issue with reference to the funding of one Research Registrar and an apparent half-funding of a Consultant.

4. Excluding Orthodontics (2.4 WTE) and Dermatology (5.25 WTE), Urology has the lowest medical staff allocation (5.8 WTE's).

5. It is not the general policy of the Urology Department to employ Locums "to fill the gap" or cover leave.

6. Excluding outpatient activity, we were nearly able to perform our contractual activity despite the bed crisis and not being fully consulted on the setting of such figures.

7. From personal communication and documented figures, outpatient activity has appeared to be a problem area. The new – review ratio (0.23) in Craigavon exceeds that of other Units. However as defined by available figures for this period, there were 497 new patients per Consultant in Craigavon (2136 per Consultant reviews) compared to 311 new patients per Consultant, Belfast City Hospital (702 review patients per Consultant), 310 new patients, Royal Victoria Hospital (630 reviews per Consultant) and 549 new patients per Consultant in Altnagelvin (1080 reviews per Consultant).

8. Cancelled clinics in Craigavon were only 1.7% compared to 21.4% in Belfast City Hospital and 7.5% in Altnagelvin.

9. Assessment of bed utilization was favourable in Craigavon Area Hospital against the combined peer group showing that Craigavon Area Hospital was more efficient. Bed occupancy was nearly 80%.

10. Despite not having a GA day list, our day case rates were similar to the gold standard peer, though we did under perform in comparison to DGH peer groups.

UROLOGY AS DEFINED BY BAUS GUIDELINES

1. See enclosed : "The Quality Urological Services for patients in the new millennium" guidelines of workload, manpower and standards of care
   Produced by the Council of the British Association of Urological Surgeons – October 2000

2. This document states that clinical governance is the framework through which the NHS is accountable for continuously improving the quality of the service and safe guarding high standards of care.

3. In recent years much more emphasis has been placed on clinical effectiveness and audit, clinical governance, professional development, service targets and training of young surgeons. This document considered three specific headings – the Consultant Programme, the Provision of Outpatient Services and Inpatient Activity.

CONSULTANT PROGRAMME

4. BAUS Council believe a 5 +1 fixed session contract is more appropriate for the future with an on call commitment of 1 in 5.

5. Were it is not possible to arrange a 1 in 5 rota a sessional allowance must be allocated appropriately in the job plan. Consultants in smaller Units with onerous on call commitment with the need to cover colleagues on leave, often with limited Junior and inexperienced staff and scenarios like continuous on call for two – three weeks in addition to fulfilling a standard job in to be deplored. It is crucial that the on call component of a job is fully recognized. BAUS recommend for Consultant's with SpR, were senior SHO cover, that a 1 in 2 rota should be allocated three NHD's, a 1 in 3, 2.5 NHD's and 1 in 4, 2 NHD's.

6. It is also recognized that the working year is forty-two weeks (6 weeks leave, 2 weeks study, one-week bank holiday and one week Christmas)

OUTPATIENT SERVICE

7. There is a general agreement that overloading of outpatients leads to dissatisfaction for all concerned. A more in-depth appraisal, forward planning and review of referral letters with adequate consultation times are recommended.

8. The Royal College of Surgeons recommends seven new and seven follow up patients per clinic per Doctor. BAUS wish to follow this principle and certainly there should only be a maximum of twenty patients per Urologist per clinic. Therefore one Consultant and a middle grade SpR should be seeing between twenty and thirty

patients (total figures for the year are quoted in this documented but I am unsure how they are derived).

9. It is recognized that streamline service delivery is possible with haematuria, prostate assessment, andrology and nurse led clinics.

INPATIENT ACTIVITY

10. The average Consultant and his team should perform between 1,000 and 1,250 inpatients and day case FCE's per annum – depending on sub specialty, case mix operating sessions and commitment to teaching SpR.

11. The average DGH Urologist with appropriate facilities should achieve a day case target of at least 60% for total FCE's.

MANPOWER ISSUES

12. The present ratio of Consultant Urologists to the population is 1 in 119,000 – fewer Urologists than any other European partner except for Eire. The next highest ratio to the UK is Norway with 1 in 67,140.

13. At present the waiting times for 90% of urgent urology cancer referrals to receive definitive treatment in England is longer than all other common tumours. It is hoped that a reasonable timetable to work to is 1 in 100,000 by 2003 and 1 in 80,000 by 2007.

SUMMARY

14. To summarize these findings the Trust should be aiming for a Consultant Urologist per 80,000. That twenty – thirty patients should be seen in an outpatient clinic and that between 1,000 and 1,200 Finished Consultant episodes with 60% being Daycases. Incorporation of on-call commitment with allocated time for audit and professional development has to be recognized in this arrangement.

DEFINED WORKING PATTERN AND SHORTCOMINGS IN UROLOGY – CAH

1. Overall during the recovery plan year the FCE's were 1,275 per Consultant Urologist of which 56% were day cases. Outpatients numbers were 2, 737 per Consultant (476 new and 2311 reviews per Consultant) based on a fifty week year [55pt/consultant/wk].

2. The working pattern of daily activity has remained relatively static for some years now.

3. On taking over as Lead Clinician, it was thought that a critical review of our daily activity be performed. Our current ward meetings, involving senior staff, are addressing the issues of improving the quality of care and efficiency. This is primarily an internal event of patient management as opposed to increasing contract activities.

4. The range of services, in terms of sub-specialty urology, is reasonably provided for in Craigavon Area Hospital. The sub-specialties as defined by BAUS Council are oncology, endo-urology, female urology and andrology in addition to general urology.

5. Although general and subspecialities are provided, none offer a prompt or even a standard interval waiting time. This is of grave significance. Waiting times for both outpatient consultation and therapy is in anyone's estimation unacceptable. It is also suspected that waiting times are significantly longer in urology than in any other surgical specialty. In terms of clinical governance and risk management, the Trusts exposure at present is immense for those as yet unseen or untreated.

6. A common theme throughout the individual daily services, (ESWL, Urodynamics, Day Case theatre, teaching) is that they are very dependent on manpower. Although cover is possible, even one person down puts significant strain on the system. There is therefore "little slack in the system"

7. Previous reference was made to an unfunded Research Registrar. This was initially agreed by the Medical Director plus Surgical Directorate and has resulted from the expansion of the Day Surgery list income.

8. It is also unclear, when the second Urologist post became vacant, whether the Board had supplied the additional finance or whether this has indeed been incorporated again with the new financial recovery plan.

9. At a recent Royal College visit it was noted that the SHO post had an excess commitment to clinics.

10. The Research Registrar post is defined with on call commitment and daytime clinical duties. This has helped with the recent changes required in the junior hospital doctor's hours.

11. The Research Registrar's clinical duties include Mr O'Brien's outpatient clinic, Banbridge Outpatients, Armagh Community Hospital outpatients, under graduate teaching, Flexible Cystoscopy list plus cover when the SpR and SHO are on leave. "Their value for money" is immense in terms of productivity.

12. Further cover may be required to fulfill the stipulated Junior Hospital Doctors Hour.

13. The Consultant rota is 1 in 2 with prospective cover.

14. Consultant work on Registrar rota regularly.

15. When any manpower levels falls below critical levels, clinical risk becomes an issue, as seen recently with two audiotypists on maternity leave, resulting in significant delays in urgent oncology referal.

16. Waiting lists in term of outpatients and therapy for cancer patients are unacceptable. I believe no other department would accept this standard. It has become so chronic that its importance has been lost.

FUTURE ASPIRATIONS

1. Consolidations of existing services are important to maintain quality of service. This can be incorporated into future service development. The areas needing immediate attention are related to reducing waiting times for both outpatients and inpatients.

2. Expansion of the Urology Service will be required to provide this, as efficiency is probably at it peak.

3. Expansion of service requires manpower, further allocation of service space provision, additional bed allocation and specialty provision.

4. The main themes are therefore a third Consultant Urologist with all the associated extra provisions this post requires – namely bed allocation, nursing staff, secretarial staff, outpatient facilities, theatre staff and day list sessions.

5. Recognition that existing workload per consultant is too high.

6. Development of subspecialty services to improve quality of care and throughput. These services are :

    - A Prostate Assessment Clinic for both symptomatic patients and those requiring a prostate biopsy

    -Incontinence Service which has a hospital base

    -Oncology Service

    -Andrology Service (possibly as part of a G-U Clinic)

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Consultant Urologist
Mr MRA Young, MD FRCS (Urol)

Consultant's Secretary
Mrs Michelle McClelland

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17 September 2003

Mr. John Templeton
Chief Executive
CAHGT

Dear John

I write to acknowledge receipt of your letter dated 21 August 2003, which I received, in early September, relating to the status of the urology outreach clinics. Recent communications appear to have been like 'ships passing in the night'. I do however regret you have heard commentary relating to the outreach clinics from external agencies, this certainly was not my intent. As far as I am aware the only communication on this issue was via myself at recent surgical directorate meetings and a more formal letter to the Surgical Director and the Medical Director a week or two ago. I was under the impression, following comments at the recent surgical directorate meeting, that communication to your office was to be via the Medical Director. I apologize if I have misinterpreted this.

Your letter appears to insist on the reinstatement of the clinics. This will be acted upon, as you comment that the Trust has an obligation to the Health Board. These clinics will conform to the usual terms and give adequate consultation time to patients.

Our concerns, excluding the outstanding issue of a job plan, has for sometime related to a lack of urological cover on the Craigavon site on a Thursday afternoon. This has led to some difficulties from an emergency perspective. Recent examples for both Consultants show that there was an intention to attend the clinics but due to emergencies and lack of junior cover (working time directive) a Consultant has had to remain on site. These issues, where large clinics are on occasions run solely by juniors, combined with the clinics being booked so far in advance does led to administrative difficulties – for instance having to return from annual leave to do a clinic rather than our secretaries spending time cancelling patients. We therefore take it that the Trust accepts that it is not always possible to have a Urologist on site and the implications thereof. Furthermore, the Trust and Board proposes to open facilities in South Tyrone Hospital and the Board also will be requesting a Urologist's presence in Daisy Hill Hospital. This will result in a urological presence on five sites. I, and the Surgical Director, do not see this as an appropriate safe option.

Our other concern of this issue relates to a satisfactory job plan, which take into account the various facets of the service we provide. This has not been forthcoming. This recent step has been taken, out of frustration, as a temporary measure to both reduce and improve our contribution.

To return to the main issue, I fully accept and welcome a review of urological services. I am however more than disappointed that you would give serious consideration to the continued viability of the urology services. The urology service has indeed been viable and vibrant for some ten years. Our figures from the recent recovery plan were exceptionally favorable and we have made many suggestions to improve the situation and the service but unfortunately they have not been acted upon.

My concerns with regards to a review of the urology services are several fold. Although welcoming an external review, which I suspect might suggest more than we are requesting, my regret would be that since someone to fill the planned post is now available (but not prepared to wait around endlessly) will only slow the proceedings up significantly longer. I have also not observed a review of any other services when making a case for employing additional Consultants – why is this the case for us? I feel that an external review of the urology services, at this stage, will only delay the steps forward we are endeavouring to achieve. These steps, as you are aware, have been discussed previously in detail and were based on national guidelines.

Since taking on the Lead Clinician role several years ago, we all acknowledge that there were difficulties and shortfalls in the ability to cope with the volume of urological workload. I feel that I have put a considerable amount of time and effort into trying to address the urological issues with a fair and logical approach. Firstly we defined the problems using data supplied by the Trust. Secondly, formats to supply urological provision and national guidelines were presented as a model for Craigavon Area Hospital. Both these presentations were fully accepted by yourself and the Medical Director earlier this year. At that stage you stated that you would give a written indemnity to cover the urological service status. This would appear to give full support, despite the known difficulties. On this premise I have been working towards defining an adequate and acceptable way forward.

However recently the 'goal posts' appear to have been moved on this front, but despite this I had proceeded to speak to and then formally write to the individual departments involved in the provision for the requirements of a 3rd Consultant. To date most have not replied and those that did suggested leaving this until after the summer months. In mid August an attempt to get all concerned around the table was not possible until the end of September or even early October being suggested. This is a frustratingly slow process. I appreciate some of the administration is up to myself, but as a busy Clinician, I do not see my role as having to chase after everything and everyone.

We have raised the plight of urology with the Trust management over the past few years, seemingly drawing to a head this time last year at which stage we had suggested a course of action with you. We were at that stage under the impression that an improvement was imminent hence no changes on our behalf were taken.

It will be interesting to note if this review

- takes into account national guidelines,
- elicits why the four extra urology beds promised did not materialize,

- why the requests for replacement instruments has not been acted upon (and is contributing to the 'long waiters' list),
- asks why there is a lack of provision of such facilities such as a prostate clinic,
- why staff retention for urodynamics has not been possible,
- why has the urology cancer implementation group appeared to have ceased,
- why has this unit, with such an oncology and emergency urology workload, not been supplied with the facilities and instruments to provide a more efficient and safe approach
- why has there been no movement on a satisfactory job plan, as defined by the appraisal scheme
- why has the only major advance in the urology service in the last few years been the introduction of a Day Surgery list, which has been taken on by the consultants as an extra unrecognized session but done so because of its significant impact factor despite the restriction in the numbers able to be treated,
- why is there a lack of recognition for the urology consultants full sessional allocation with no account being made for the 1:2 rota, significant periods of prospective on-call to cover for both consultant and registrar leave and all this combined with a high theatre presence which is predominantly performed or led by the consultant (eg- the theatre log for elective and emergency work defines urological activity during 45 of the last 70 days), and the direct patient contact activities (excluding clinics and theatre) and the associated administration.
- why there are extra sessional allowances given, for example, to regular out of hours evening work, decompression chamber on-call and weekend ward rounds in medicine and surgery (these being completely justifiable) yet this shows complete disparity with the urology plight.
- gains acknowledgment from the Board that a unit of this size can only have a defined output, that it is not our responsibility to provide care for every referral and a cap on this is required. This is compounded by the constant adding to the consultant responsibility from changes in junior doctors hours.
- and ask the wider question of why the Department of Health has not attempted to implement its findings for the requirement of sixteen Urologists for the province by 2007 (9 current full-time trained Urologists)

I ask why this issue of the outreach clinics, as defined by the only communication (as opposed to hearsay), can not be deemed a temporary measure until the definition of the urology sites and personnel is complete and thus easing the current burden.

Previous communication with yourself and the L.N.C. has defined the area of consultant cover for the registrars is still outstanding. BMA guidelines would also tend to suggest that there are many other areas that should be addressed, yet we have not opted to do so to date.
For consultants, who have taken on extra lists (day-list, ESWL) on their own volition, without any form of recompense but did so for the enhancement of the service - this is not the best way forward when the service relies on a significant amount of goodwill.

Unfortunately, this has all been very negative and extremely disillusioning for the personnel in a unit, who have a fabulous capacity and willingness to stride forward despite the enormous challenges to do so.

This issue can indeed be easily resolved. Recognition that the combination of a full standard sessional working week and the intensity of on-call is not compatible with personal, family or

working arrangements. Either a standard week is worked and other arrangements for on-call are made or vice versa. Ultimately the decision to invest in the service has to be made, as it is running at full capacity presently. I had intended supplying the Surgical Director with a list of personnel, facilities and equipment requirements. This would have covered the needs of a third consultant, an action plan to improve throughput and increase the efficiency in patient management pathways. However since you plan a review of the service, I would prefer to wait for its findings. I would finally like to note that a third consultant would improve our plight considerably with regards to on-call, the entitlement for further SpRs and improve our waiting times. The allocation of a Planning Officer, full time for a short period of a month or two, to the urology service would undoubtedly speed this whole process up considerably.

I do however leave all this in your hands. I and the rest urology department will continue to endeavour to improve the urology services.

Yours sincerely

_____

Mr MRA Young, MD FRCS (Urol)
Lead Clinician in Urology
/mm

CAH ACTIVITY ON GENERAL WARDS

(excludes activity in Day Unit)

Urology

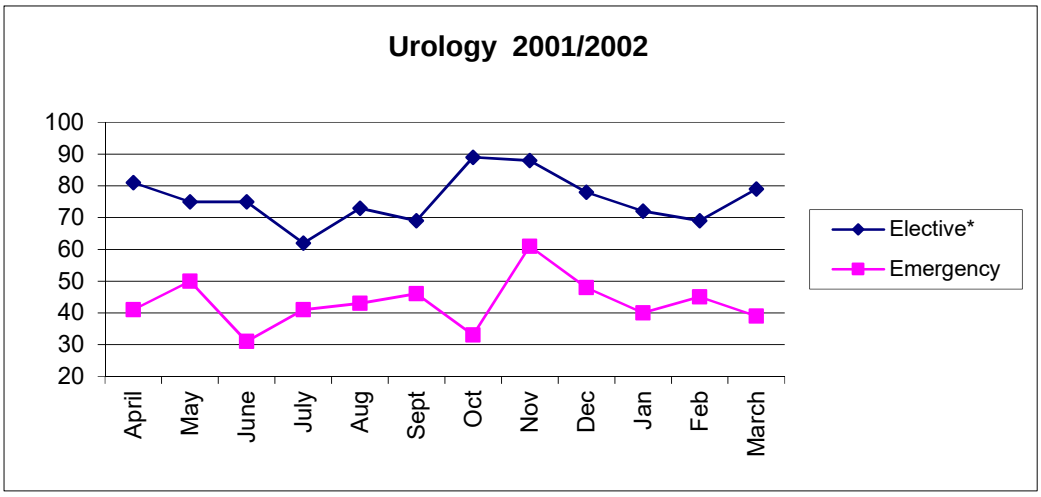
2001/2002	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	Total
Elective*	81	75	75	62	73	69	89	88	78	72	69	79	**910**
Emergency	41	50	31	41	43	46	33	61	48	40	45	39	**518**
Total	**122**	**125**	**106**	**103**	**116**	**115**	**122**	**149**	**126**	**112**	**114**	**118**	**1428**

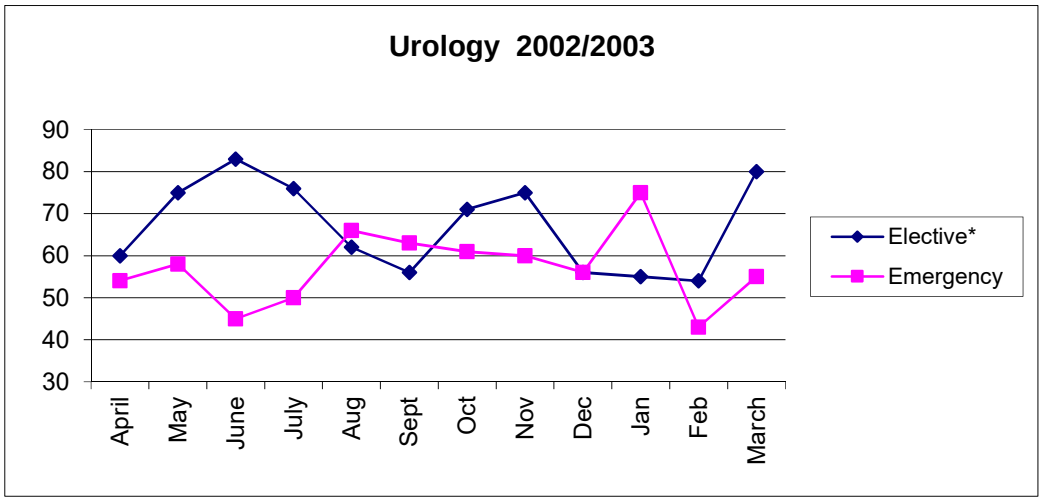
2002/2003	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	Total
Elective*	60	75	83	76	62	56	71	75	56	55	54	80	**803**
Emergency	54	58	45	50	66	63	61	60	56	75	43	55	**686**
Total	**114**	**133**	**128**	**126**	**128**	**119**	**132**	**135**	**112**	**130**	**97**	**135**	**1489**

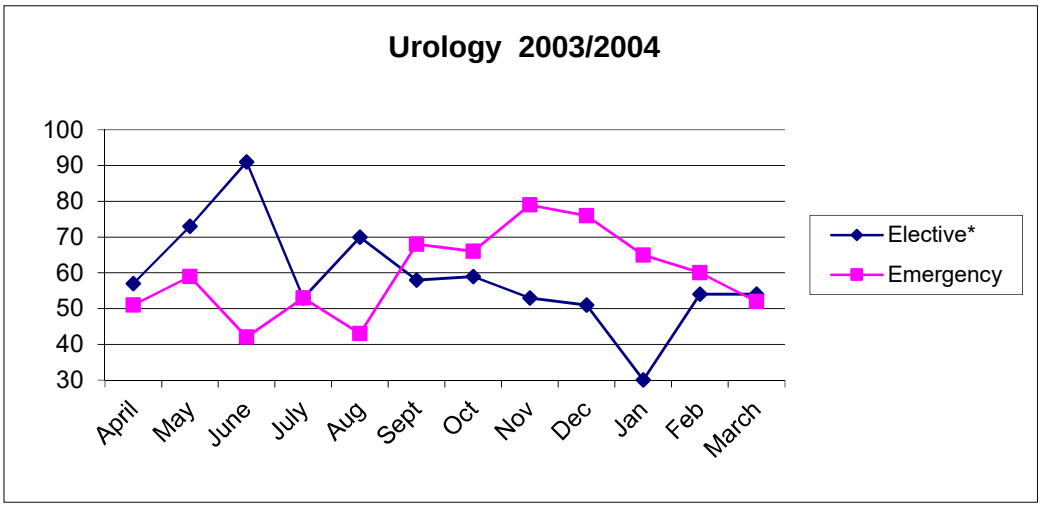
2003/2004	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	Total
Elective*	57	73	91	53	70	58	59	53	51	30	54	54	**703**
Emergency	51	59	42	53	43	68	66	79	76	65	60	52	**714**
Total	**108**	**132**	**133**	**106**	**113**	**126**	**125**	**132**	**127**	**95**	**114**	**106**	**1417**

*** Includes day case activity on general ward**

Information taken from Business Objects
6 April 2004
Sharon Glenny Directorate Administrator



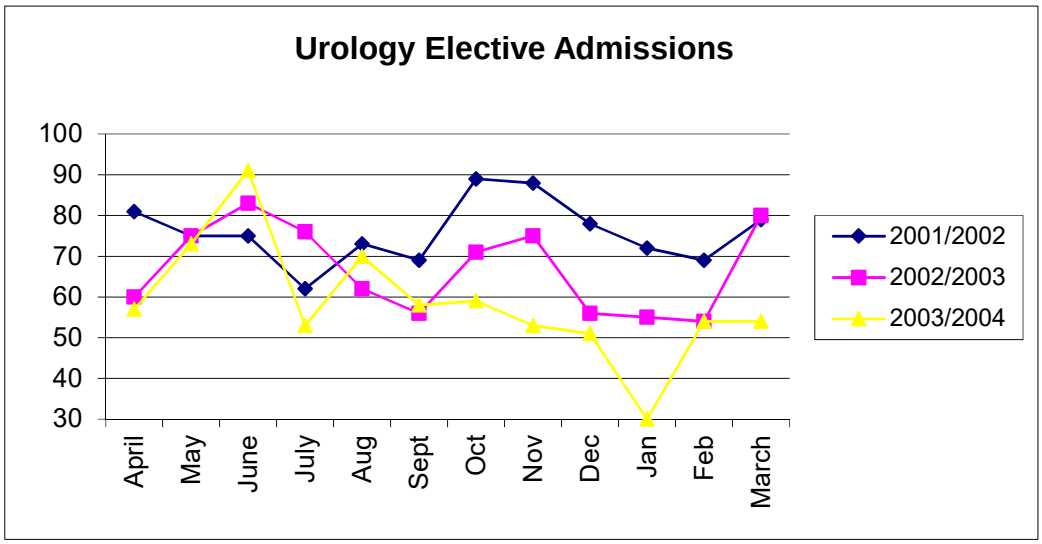




Information taken from Business Objects
6 April 2004
Sharon Glenny Directorate Administrator

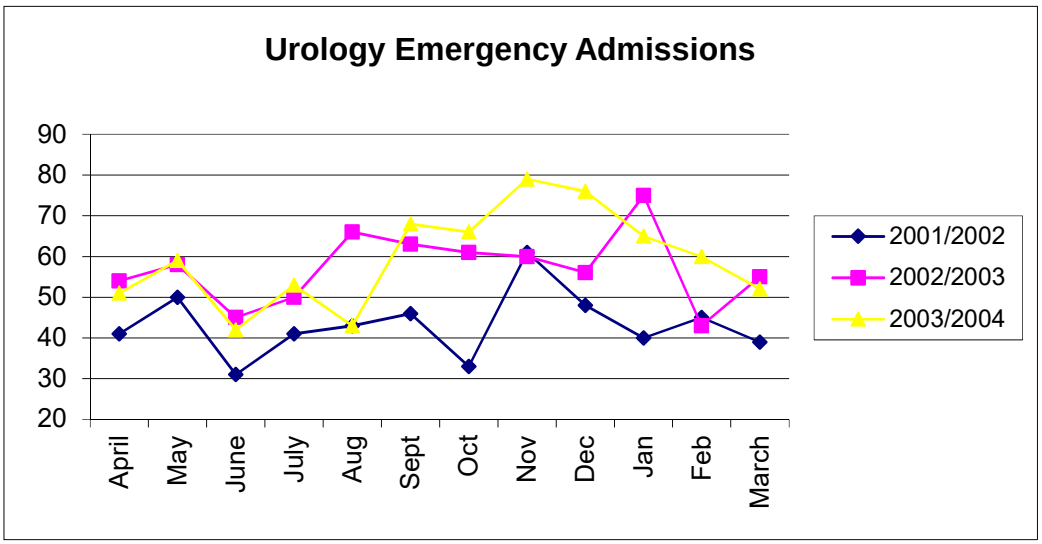
Urology Elective Admissions

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	Total
2001/2002	81	75	75	62	73	69	89	88	78	72	69	79	**910**
2002/2003	60	75	83	76	62	56	71	75	56	55	54	80	**803**
2003/2004	57	73	91	53	70	58	59	53	51	30	54	54	**703**



Urology Emergency Admissions

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	Total
2001/2002	41	50	31	41	43	46	33	61	48	40	45	39	**518**
2002/2003	54	58	45	50	66	63	61	60	56	75	43	55	**686**
2003/2004	51	59	42	53	43	68	66	79	76	65	60	52	**714**



Information taken from Business Objects
6 April 2004
Sharon Glenny Directorate Administrator

Craigavon Area Hospital Group Trust

Trust Delivery Plan 2004 - 2005

Clinical Services Analysis, Priorities for Action and Planning Template

For Urology Cancer Services

Introduction

This template has been designed to make contributing to the development of the Trust Delivery Plan quick and easy.

It provides you with an opportunity to share your initiatives and achievements over the past 12 months, your thoughts on key challenges facing your directorate as well as your feelings on the things occurring in the community and in health service that will change the way you work in the coming year. It also provides an opportunity to highlight your responses to the relevant Priorities for Action for your directorate where appropriate Finally, the template contains a section for you to outline your service goals for the next 12 months and to highlight your key requirements in terms of capital and resources for your directorate

This complete picture will ensure that the Trust Delivery Plan is developed utilising an accurate reflection of our current aspirations and potential.

It will also provide you with a reference document that will enable you to track your progress over the coming year.

How to use this template

Section 1 – This section aims to identify the key achievements and challenges facing your directorate in CAGHT. This section also asks you to think about the things happening in your operating environment that will drive changes in the way you deliver services. What are the trends and how will they impact you? A few bullet points under each heading should cover your key thoughts.

Section 2 – Outlines the relevant Priorities for Action for your speciality as set out by the Department of Health, Social Services and Public Safety. This section asks you to outline progress to date where applicable, some key initiatives and performance indicators for each priority.

Section 3 - This section provides an opportunity to highlight your service goals over the coming period. You may already have substantial plans in place – in which case you can note them – or it may be timely to facilitate a session with your colleagues to do some fresh planning - some of these may be as a direct result of the Priorities for Action. Either way, it is important that you're as collaborative as possible in completing this section. This section also provides an opportunity to be clear about your support needs and resources.

Paragraph here about the process….

Thanks!

Anne Brennan
Planning Manager

Craigavon Area Hospital Group Trust
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Fax: Personal Information redacted by the USI
Personal Information redacted by the USI

Section 1

The environment you work in - Anticipated trends for the future …

Q1: What do you regard as the key challenges facing your speciality within the CAGHT at this time?

Prompts: What are the key issues facing your department at this time, these could be increasing workload, manpower or equipment requirements, capacity constraints.

Key Challenges/ Issues	▪ Lack of facilities from beginning of patient episode to end ▪ Excess referrals ▪ Limited personnel and lack of dedicated staff for oncology ▪ Lack of adequate bed spaces ▪ No dedicated clinics for urology oncology except 2 slots Haematuria clinic ▪ Restricted outpatient and day case facilities ▪ Difficulty in accessing and persuading administration of needs
	▪

Q 2: What have been your major achievements in terms of service developments/new initiatives over the past 12 months?

Key Achievements	▪ Did have a TRUS prostate biopsy waiting list initiative over a year ago, which came about as part of the urology Oncology forum. However as I predicated no sustained clinic emerged from this having asked specifically that there would be ▪ However there has been no further urology oncology forum meeting called by the Chairman ▪ Service development has ground to a halt since the last requests when the Chief Executive called a service review. Nothing has happened since.

Q2 What do you think the biggest developments or changes in the way we deliver services will be over the coming year.?

Prompts: These could be driven by rising public expectations, demographic changes, increased diagnostic capability, increased use of emerging technologies, international service innovations, increased scope for involvement in more multi-disciplinary care or shared outpatient clinics.

Anticipated Changes in Workload/Service Developments:	▪ Seamless investigative process ▪ Multi-disciplinary approach ▪ Demand via GPs and patients for faster access to services ▪ Patient information services such as informed counselling

Q2 Do you think we'll change our patterns of delivery? If so, how?

Prompts: Examples here include shifts between inpatient care and day-case care or between day-case care and outpatient care. The development of peripheral clinics in referring Hospitals may also have an impact.

Shifts in the patterns of delivery of care:	▪ Urology services are currently at full stretch, unless there is an increase in manpower beds, outpatient facilities, investment and equipment are supplied I see no real change ▪ Unless the Trust listens to the those working directly for the services at how best to deliver urology oncology for out area and circumstances as development plan does exist the administration has to listen and deliver

Section 2:

Priorities for Action

Ref:	Section	Responsibility	Progress to Date	Key Initatives	Performance Indicators	Achievable / Doubtful or Not Achievable during 2004/2005

Section 3

Where we're going – Service Focus

	Our Goals	What we'll be doing to achieve:
What do we need to do over the next year to ensure we maintain our existing levels of service? *Prompts: considering the changes to service that we covered in section 1, what will we need to do to accommodate them and not decrease our service levels?*	▪ Emergency admissions are taking over elective patient bed space at a rate that is reducing elective contract. It is necessary to have protective bed space for elective work [as defined in other hospitals have got shorter waiting lists. ▪ Provide improved urology oncology facilities as there is a waiting list for this work	
Do you envisage we'll *develop* our services over the next year and, if so, what will the key developments be? *Prompts: we might already have plans or e might need to make them … what will the key ones be*	▪ Unless we have our service review and it implementation we will be going backwards Access to Macmillan unit for day case and outpatient procedures Development of prostrate clinic	

What *new* services do you envisage coming on board in the next year? *Prompts: these may be planned or require planning*	Prostate clinic Intravesical chemotherapy [on demand not on waiting list]	
What cross-speciality work will we be establishing or developing over the coming year? *Prompts: key activities, pilots, new collaboration – relationships inside the Hospital*	Histopathology and x-ray Multidisciplinary team meeting in conjunction. Training of nurse practitioner to help run service developments	
What are the key vertical relationships we'll be establishing or maturing over the coming year and how will we do that? *Prompts: GPs, community, step-down facilities etc*	Better information service delivery by GP;s to us re prostrate clinic and reciprocal information from out prostate clinic back to community Macmillian service good when installed Faster social services delivery to free up bed capacity	

	Our Needs	What we'll be doing to achieve:
What will our Clinical Support needs be to achieve these things? *Prompts: this question covers plan for all new/planned service developments. Clinical support is considered to include Physiotherapy, Occupational Therapy, Clinical Nutrition, Speech & Language Therapy. Pharmacy services, Diagnostic Imaging services and Laboratory services*	Manpower, facilities, investment and planning for prostrate clinic Space in Macmillan unit for our dedicated staff to run m define and clinics and therapies	
What will our general support needs be? *Prompts: these will be things like catering, house-keeping, portering, laundry, environmental services, security, and pastoral care*	Prostate clinic – IV Chemotherapy Nurse Led Secretarial Support Catering Aequate space and consultative rooms and toilet facilities Pharmacy Counselling service [Nurse Led]	
What will our staffing requirements be? *Prompts: this should include consideration of consultant, nursing & clerical numbers and of the priority skill sets that need developing.*		

What will our key IT requirements be? *Prompts: these could be clinical, corporate or integration/development of existing systems*	Computer for data collection ideally developed and incorporate into out INCAS system Already have plans to develop questionnaire and data collecting systems with the company supplying Urodynamics system	
What will our likely capital or infrastructure requirements be? *Prompts: buildings/space requirements*	Service requires more beds and increased nursing staff Ideally if an area could be allocated to urology that all out actives could be run as an integrated unit	
What will our likely capital equipment infrastructure requirements be? *Prompts: major equipment purchases*	For prostate clinics has already predominantly been purchases unless radiology have any changes Uroflow machine already supplies Also company has provided money to pay for a nurse for 1 year.	

INTRODUCTORY PAPER

'DEFINING THE UROLOGICAL PROBLEM'

- This is an introductory paper to the development of the urological service in Craigavon Area Hospital (CAH).
- As the title quotes, it is to define the current issues, with the production of documents later that address the solution.
- This paper points out the most major areas of concern.
- The first half of this paper defines the trends in urological practice in CAH over the past few years.
- It defines CAH urology in terms of the Recovery Plan 2001 and has comparisons to other units.
- College / British Assoc. of Urological Surgeons Guidelines for Urological Practice are summarized.
- Specific areas of concern and an introduction to future aspirations.

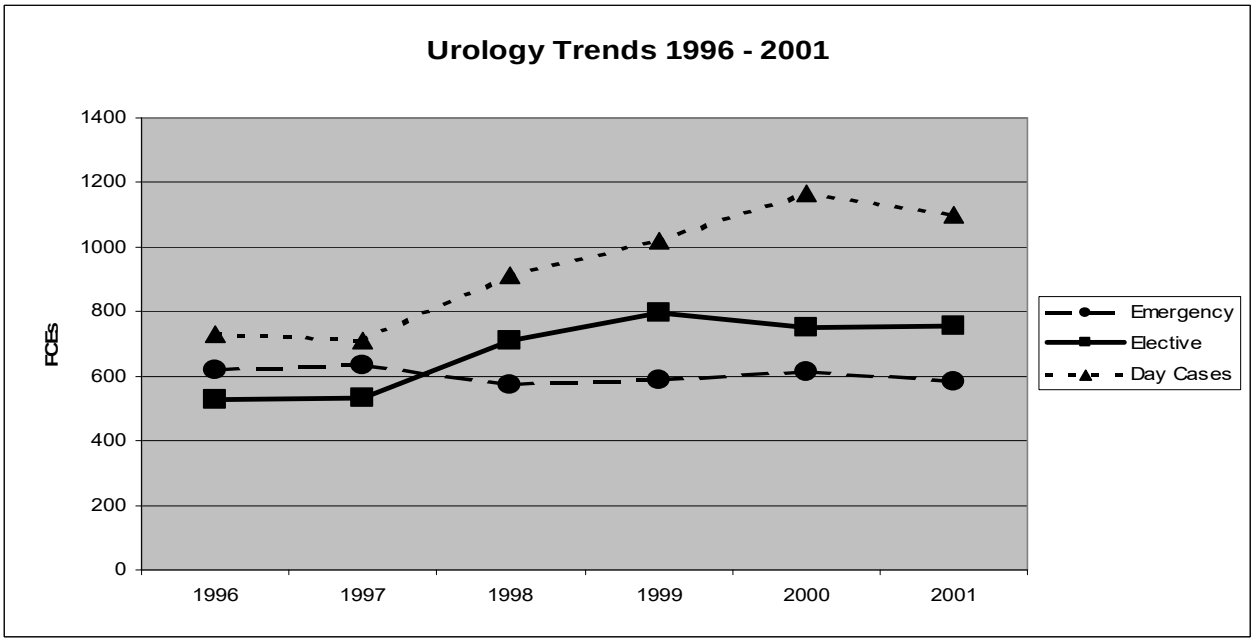
It is anticipated that the factual information supplied will be enough to ensure that the Trust and the Southern Health Board are left in no doubt that there is inadequate urological provision for the population they serve, despite the current Units good efficiency.

M.R.A.YOUNG M.D. F.R.C.S.(Urol).
Consultant Urologist and Lead Clinician in Urology

'DEFINING THE UROLOGICAL PROBLEM'

UROLOGY TRENDS

1. Enclosed are several graphs showing the activity trends of the Craigavon Urology Department over the past few years.
2. The first graph shows Finished Consultant Episodes.



3. Activity as defined by change from March 1997

	Emerg.	Elective	Daycase	Outpt.
To 99	-6.8%	+49%	+44%	-6.7%
To 2001	-8%	+42%	+55.4%	-0.7%

The Year on year changes during this time are:

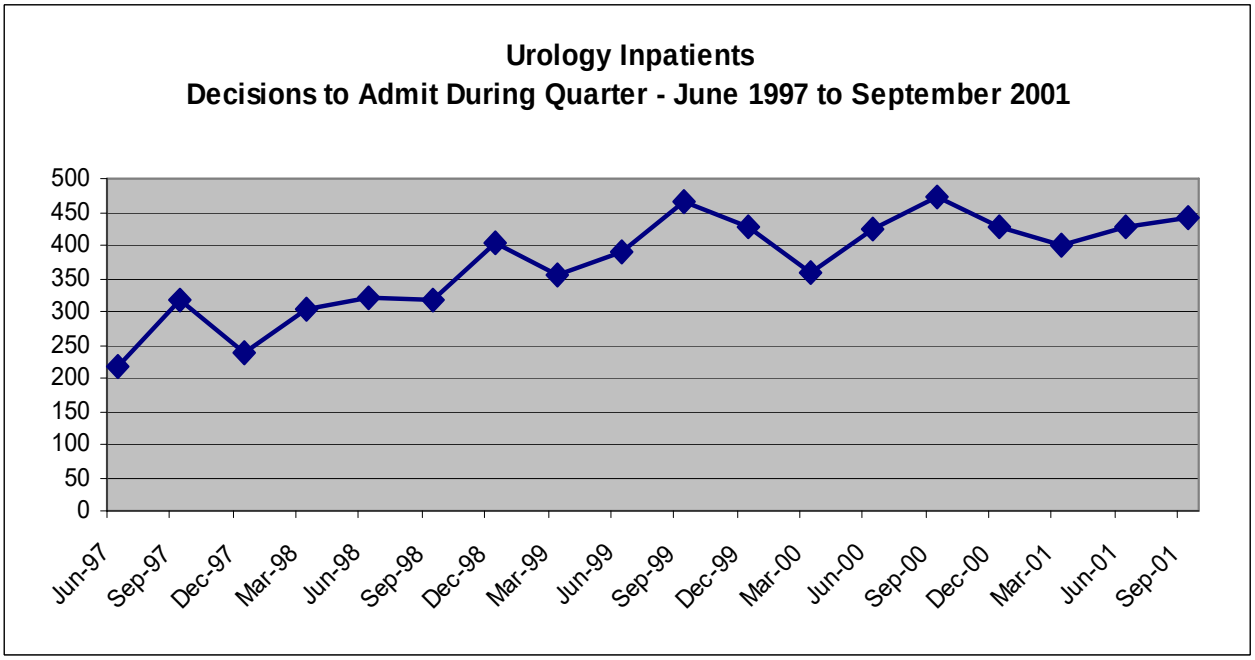
	96/97	97/98	98/99	99/00	00/01
Emerg.	+1.9%	-9.6%	+3.2%	+3.9%	-5%
Elective	+0.9%	+33%	+12.1%	-5.9%	+0.9%
Daycase	-2.9%	+29%	+11.7%	+14.1%	-5.4%
Outpt.	+44%	-4.1%	-2.7%	+10.7%	+3.8%

SUMMARY

1. Day case numbers substantially increased by about 50% since 1997, with a plateau trend now.
2. Emergency admissions less by 7-8% but averaging 600 patients per year +/- 17.
3. Elective surgery defined as initial substantial increase between 1997-1999 but now plateaued at this upper limit.
4. Outpatients – again initial increase of 44% but now relatively static
5. Static levels appear to have been reached for current activity.

QUARTERLY DECISIONS TO ADMIT FOR JUNE 1997- SEPTEMBER 2001

The trend to admit is shown in graph 2.



These average:-

269/quarter - June 1997/98
348/quarter - June 1998/99
409/quarter - June 1999/00
431 /quarter - June 2000/01

This defines a year on year increase of +29%, +17.5% and +5.4%.

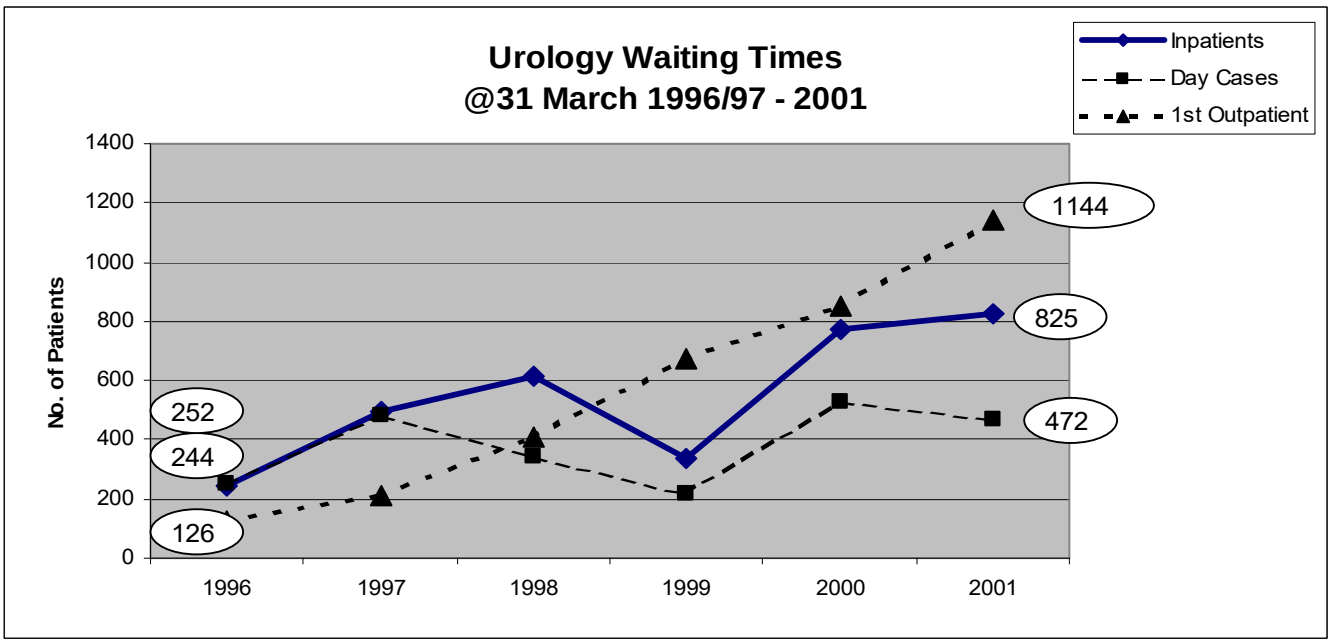
The overall change from 1997 – 2000 is of a 60% increase in the trend to admit.

SUMMARY

Despite a substantial increase in planned workload the trend appears to be slowing up.

UROLOGY WAITING LIST

The resultant urology waiting lists between March 1996 – 2001 are shown in graph 3.



The outpatient number awaiting first appointments were 126 in 1996 and have grown to 1144 in 2001 (808% increase).

The inpatients were 244 in 1996, now being 824 (238% increase).

The day-patients were 252 have increasing to 427 (69% increase).

SUMMARY

- All waiting numbers have escalated, with the day cases to a lesser degree.

UROLOGY AS DEFINED BY RECOVERY PLAN 2001 or CURRENT STATUS AS DEFINED.

1. Contract Performance 2000-2001

	Emerg.	Elective	Daycase	New outpt	R/V outpt	Total outpt
Planned	609	751	1133	1257	3608	4865
Actual	580	757	1212	852	4622	5474
%	-5%	+1%	+7%	-32%	+28%	+13%

2. The medical staff allocation in 2002 is 1.8 Consultant, one SpR, 2 Research Clinical Registrars and one SHO. The SpR and SHO are centrally allocated. The Research Registrars are appointment by Craigavon Area Hospital.

3. There has been an issue with reference to the funding of one Research Registrar and an apparent half-funding of a Consultant.

4. Excluding Orthodontics (2.4 WTE) and Dermatology (5.25 WTE), Urology has the lowest medical staff allocation (5.8 WTE's).

5. It is not the general policy of the Urology Department to employ Locums "to fill the gap" or cover leave.

6. Excluding outpatient activity, we were nearly able to perform our contractual activity despite the bed crisis and not being fully consulted on the setting of such figures.

7. From personal communication and documented figures, outpatient activity has appeared to be a problem area. The new – review ratio (0.23) in Craigavon exceeds that of other Units. However as defined by available figures for this period, there were 497 new patients per Consultant in Craigavon (2136 per Consultant reviews) compared to 311 new patients per Consultant, Belfast City Hospital (702 review patients per Consultant), 310 new patients, Royal Victoria Hospital (630 reviews per Consultant) and 549 new patients per Consultant in Altnagelvin (1080 reviews per Consultant).

8. Cancelled clinics in Craigavon were only 1.7% compared to 21.4% in Belfast City Hospital and 7.5% in Altnagelvin.

9. Assessment of bed utilization was favourable in Craigavon Area Hospital against the combined peer group showing that Craigavon Area Hospital was more efficient. Bed occupancy was nearly 80%.

10. Despite not having a GA day list, our day case rates were similar to the gold standard peer, though we did under perform in comparison to DGH peer groups.

UROLOGY AS DEFINED BY BAUS GUIDELINES

1. See enclosed: "The Quality Urological Services for patients in the new millennium" guidelines of workload, manpower and standards of care
   Produced by the Council of the British Association of Urological Surgeons – October 2000

2. This document states that clinical governance is the framework through which the NHS is accountable for continuously improving the quality of the service and safe guarding high standards of care.

3. In recent years much more emphasis has been placed on clinical effectiveness and audit, clinical governance, professional development, service targets and training of young surgeons. This document considered three specific headings – the Consultant Programme, the Provision of Outpatient Services and Inpatient Activity.

CONSULTANT PROGRAMME

4. BAUS Council consider a 5 +1 fixed session contract is more appropriate for the future with an on-call commitment of 1 in 5.

5. Were it is not possible to arrange a 1 in 5 rota a sessional allowance must be allocated appropriately in the job plan. Consultants in smaller Units with onerous on call commitment with the need to cover colleagues on leave, often with limited Junior and inexperienced staff and scenarios like continuous on call for two – three weeks in addition to fulfilling a standard job in to be deplored. It is crucial that the on call component of a job is fully recognized. BAUS recommend for Consultant's with SpR, were senior SHO cover, that a 1 in 2 rota should be allocated three NHD's, a 1 in 3, 2.5 NHD's and 1 in 4, 2 NHD's.

6. It is also recognized that the working year is forty-two weeks (6 weeks leave, 2 weeks study, one-week bank holiday and one week Christmas)

OUTPATIENT SERVICE

7. There is a general agreement that overloading of outpatients leads to dissatisfaction for all concerned. A more in-depth appraisal, forward planning and review of referral letters with adequate consultation times are recommended.

8. The Royal College of Surgeons recommends seven new and seven follow up patients per clinic per Doctor. BAUS wish to follow this principle and certainly there should only be a maximum of twenty patients per Urologist per clinic. Therefore one Consultant and a middle grade SpR should be seeing between twenty and thirty

patients (total figures for the year are quoted in this documented but I am unsure how they are derived).

9. It is recognized that streamline service delivery is possible with haematuria, prostate assessment, andrology and nurse led clinics.

INPATIENT ACTIVITY

10. The average Consultant and his team should perform between 1,000 and 1,250 inpatients and day case FCE's per annum – depending on sub specialty, case mix operating sessions and commitment to teaching SpR.

11. The average DGH Urologist with appropriate facilities should achieve a day case target of at least 60% for total FCE's.

MANPOWER ISSUES

12. The present ratio of Consultant Urologists to the population is 1 in 119,000 – fewer Urologists than any other European partner except for Eire. The next highest ratio to the UK is Norway with 1 in 67,140.

13. At present the waiting times for 90% of urgent urology cancer referrals to receive definitive treatment in England is longer than all other common tumours. It is hoped that a reasonable timetable to work to is 1 in 100,000 by 2003 and 1 in 80,000 by 2007.

SUMMARY

14. To summarize these findings the Trust should be aiming for a Consultant Urologist per 80,000. That twenty – thirty patients should be seen in an outpatient clinic and that between 1,000 and 1,200 Finished Consultant episodes with 60% being Daycases. Incorporation of on-call commitment with allocated time for audit and professional development has to be recognized in this arrangement.

WORKING PATTERN AND SHORTCOMINGS IN UROLOGY – CAH

1. Overall during the recovery plan year the FCE's were 1,275 per Consultant Urologist of which 56% were day cases. Outpatients numbers were 2, 737 per Consultant (476 new and 2311 reviews per Consultant) based on a fifty week year [55pt/consultant/wk].

2. The working pattern of daily activity has remained relatively static for some years now.

3. On taking over as Lead Clinician, it was thought that a critical review of our daily activity be performed. Our current ward meetings, involving senior staff, are addressing the issues of improving the quality of care and efficiency. This is primarily an internal event of patient management as opposed to increasing contract activities.

4. The range of services, in terms of sub-specialty urology, is reasonably provided for in Craigavon Area Hospital. The sub-specialties as defined by BAUS Council are oncology, endo-urology, female urology and andrology in addition to general urology.

5. Although general and sub-specialities are provided, none offer a prompt or even a standard interval waiting time. This is of grave significance. Waiting times for both outpatient consultation and therapy is in anyone's estimation unacceptable. It is also suspected that waiting times are significantly longer in urology than in any other surgical specialty. In terms of clinical governance and risk management, the Trusts exposure at present is immense for those as yet unseen or untreated.

6. A common theme throughout the individual daily services, (ESWL, Urodynamics, Day Case theatre, teaching) is that they are very dependent on manpower. Although cover is possible, even one person down puts significant strain on the system. There is therefore "little slack in the system".

7. Previous reference was made to an unfunded Research Registrar. This was initially agreed by the Medical Director plus Surgical Directorate and has resulted from the expansion of the Day Surgery list income.

8. It is also unclear, when the second Urologist post became vacant, whether the Board had supplied the additional finance or whether this has indeed been incorporated again with the new financial recovery plan.

9. At a recent Royal College visit it was noted that the SHO post had an excess commitment to clinics.

10. The Research Registrar post is defined with on call commitment and daytime clinical duties. This has helped with the recent changes required in the junior hospital doctor's hours.

11. The Research Registrar's clinical duties include Mr O'Brien's outpatient clinic, Banbridge Outpatients, Armagh Community Hospital outpatients, under graduate teaching, Flexible Cystoscopy list plus cover when the SpR and SHO are on leave. "Their value for money" is immense in terms of productivity.

12. Further cover may be required to fulfill the stipulated Junior Hospital Doctors Hour.

13. The Consultant rota is 1 in 2 with prospective cover.

14. Current Consultants cannot be expected to pick up the extra activity of service development.

15. Current population base per consultant is in excess of 1:150K

16. Consultant work on Registrar rota regularly.

17. When any manpower levels falls below critical levels, clinical risk becomes an issue, as seen recently with two audio-typists on maternity leave, resulting in significant delays in urgent oncology referral.

18. Waiting lists in term of outpatients and therapy for cancer patients are unacceptable. I believe no other department would accept this standard. It has become so chronic that its importance has been lost.

19. The unit could not attain the activity expected in England and Wales for a maximum two week wait for an oncology referral.

20. Urological equipment needs updating as there are risk management issue pertaining to this area - eg surgical resection scopes, permanent image radiograph data, urodynamic machine.

21. Excluding further new referrals completely, it would take nearly 18 months to see the outpatients already awaiting under the current regimen.

FUTURE ASPIRATIONS

1. Consolidations of existing services are important to maintain quality of service. This can be incorporated into future service development. The areas needing immediate attention are related to reducing waiting times for both outpatients and inpatients.

2. Expansion of the Urology Service will be required to provide this, as efficiency is probably at it peak.

3. Expansion of service requires manpower, further allocation of service space provision, additional bed allocation and specialty provision.

4. The main themes are therefore a third Consultant Urologist with all the associated extra provisions this post requires – namely bed allocation, nursing staff, secretarial staff, outpatient facilities, theatre staff and day list sessions.

5. Recognition that existing workload per consultant is too high.

6. Restructuring of units activity and job plans required with correct expectation of work volume.

7. Improved data recording / audit facilities for clinical governance and appraisal.

8. Development of subspecialty services to improve quality of care and throughput. These services are :

    - A Prostate Assessment Clinic for both symptomatic patients and those requiring a prostate biopsy.

    - Incontinence Service, which has a hospital base.

    - Oncology Service.

    - Andrology Service (possibly as part of a G-U Clinic).

What does this tell us:

- Increased workload being performed.
- Increased waiting times despite this in both inpatients and outpatients.
- Plateau activity now reached.
- Good utilization of bed space
- Well outside BAUS guidelines on manpower and other issues.
- We are well outside the UK average ratio for consultant: population
- The Trust should be concerned about exposure to clinical risk.

The next phase in this plan should urgently address:

- service developments
- third consultant (possibly fourth)
- risk assessment on work pattern and equipment.

2 x O/P
2 x 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.

Since urologist upto a including 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

Lend - X-Ray Machine
- Laser equipment
- TURPS equipment

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

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 - charitable 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.

w 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 or Urology. Who should do it? Could we either Radiologist 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

Craigavon Area Hospital Group Trust
68 Lurgan Road, Portadown, Co. Armagh, BT63 5QQ

Urology Department
Tel; Personal Information redacted by the USI
Fax No; Personal Information redacted by the USI
E-Mail; Personal Information redacted by the USI

Consultant Urologist
Mr MRA Young, MD FRCS (Urol)

Consultant's Secretary
Mrs Michelle McClelland

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31 August 2004

Dr C Humphries
Medical Director
CAHGT

Dear Dr Humphries

RESPONSE TO EXTERNAL REVIEW OF UROLOGICAL SERVICES – AUGUST 2004

The Urology Department, Craigavon Area Hospital has been endeavouring for sometime now to improve its ability to provide an adequate service. This external review was indeed welcomed by all concerned.

- This review has undoubtedly highlighted our previously noted concerns about deficiencies in all areas of the service we provide in relation to the infrastructure and manpower.
- The external review paper was presented to us at our last meeting and comments were requested.

On behalf of the Urology Department I would like to take this opportunity to respond and would be grateful for this response to be included in your final report on the urological review.

- First I would like to thank Mr McClinton, the External Assessor for the immense amount of work he has put into this report – for its clarity, precision and definition. It is also very encouraging for our Department to see interest and co-operation in the endeavour of the Trust and the Board to improve the service.
- It is clearly evident that service investment is very much needed and not just trying to maximize on what we already possess.
- Such is the nature of reviews, there requires to be change and compromise from all parties This is certainly not a concern for the members of the Urology Department as we have been trying to offer a change in practice for sometime now but have been constrained by lack of facilities.

With specific reference to the review document I would like to note:-

- Our full agreement with the executive summary, especially that re-design, modernization and investment is required
- Although the strength of this review is based on NHS norms and BAUS guidelines for expected service delivery – it is the expectation of our Department to implement high standards and exceed norms with the help of the Trust.
- A detailed factual base agreed by all is available and although there are long-term plans, the emphasis of this review is to address the next five years.
- As noted in the introduction, the future direction of the NHS is promptness of therapy with high quality care. Our current belief in the knowledge of the excessive demands placed on our service, has been to emphasize high quality care to those that we already treat – this will continue and be at the forefront of any changes we make.

CURRENT LEVEL SERVICE

The catchment population is noted to be 300,000. I would suggest that the urological catchment is in excess of this, in view of the geographics of the existing urological unit.

- The review clearly defined our current unacceptable manpower levels and quoted the national guidelines. The guidelines have been available for several years now and are used by other urological units to define their needs.
- There is full agreement with the recommendation that a 3rd Consultant needs to be immediately appointed. This will improve the rota, help with the changes required for the new Consultants contract and as the ultimate goal to improve patient access.
- Undoubtedly additional medical staff will be required eventually – as noted in the review, based on BAUS guidelines, this should rise to four Consultants by 2007. We therefore have a period of time to reflect on the nature of this fourth appointment. Changes are afoot in the way urological care is provided. This may offer us the opportunity to consider that future appointments take into account the combination of Academic Senior Lecturer Urologist in conjunction with QUB and the development of "core Urologists"

OUTPATIENTS

- There is full agreement that outpatient activity requires change. Again, national guidelines are available to define the norm for the new patients per year. The review notes the number of new patients seen low and reviews seen high.
- In principal we agree with this statement, but it should be borne in mind that with the data presented using the ten and seven patients per clinic scenario applied to the current position, then 65% and 95% respectively of the expected new patients were indeed seen.
- The number of patients reviewed at Consultant's clinic is indeed excessive and recognized by the Department. Some changes have already been successfully undertaken. However, there is currently no other mechanism in place for satisfactory urological follow up.
- As a Department, we appreciate and wish to stride toward the development of alternative methods for patient review which would still ensure the expected high standard, regular and necessary urological follow up so that outcomes are not compromised.

- We regard this to be most efficiently provided by staff trained in these areas. The principal of Nurse Practitionership lends itself admirably to this role. This does not necessarily exclude discharge to the General Practitioner services.
- This should be the PRIME INITIAL focus of the forth-coming outpatient review changes. This will free slots for new patients at existing clinics. Ideally this principal needs to be in place before new services are introduced but it is appreciated that external pressures may necessitate what has been defined as a "quick fix" to run in tandem. This is an area of debate within the Department. Deliberate steps need to be taken as the introduction of new services fundamentally results in additional outpatient reviews. This timing is of paramount importance.
- Recognition is required by the Trust and Board that a definitive number of slots are available and that excessive referrals are not the responsibility of the Urology Department.
- It is agreed that care pathways and protocols combined with an educational programme will help with an efficient and appropriate referral pattern.

INPATIENT ACTIVITY

- Addressing the issue of insufficient inpatient beds has been one of our top priorities. This has hindered the delivery of urgent therapy to the most needy of patients.
- Again, national guidelines are available defining beds per population, adequate access to five-day facilities and day case facilities.
- Only when all three of these areas are adequately addressed can the guidelines be put in place, if this is not possible then compensation in other areas is necessary.
- As noted earlier the urological catchment area of the Trust extends beyond current boundaries and our rural community may impact on the type of bed balance.
- Although the previous estimate of bed requirements exceeded this review's comments, this was prior to the proposed short stay elective unit.
- The Department recognizes the Trust bed constraints but it is imperative that the extra bed allocation to urology is immediate, as the elective centre is not yet available. The appointment of a locum Consultant, who is planned to have inpatient activity, also is critical in this allocation.
- This is indeed possible as beds were re-allocated by the Chief Executive to the urology department in 2003 but to date have never materialized.
- We welcome the recommendation to increase the inpatient bed allocation to twenty – four beds but would suggest at least twenty-five/twenty-six beds in light of our population base, current constraints on our facilities combined with other factors such as local needs for palliative care, inpatient oncology therapies such as chemo/immunotherapy and high emergency admission rates.

THEATRE ACTIVITY

- It is conspicuously clear that we as a Trust have very much underestimated theatre requirements to provide a complete urology service.
- The review clearly defines these requirements.
- These should be delivered with the appointment of new Consultants and with service improvement schemes.
- It is agreed that there should be enhancement of both the Craigavon Area Hospital and South Tyrone Hospital sites, with the arrangements at Daisy Hill Hospital still to be defined.

- A point in question to be raised at this stage relates to the provision of the Flexible Cystoscopy lists – it is not clear whether the Trust will be able to consistently employ a "Research Registrar" to provide this service. This would have a major impact on contract let alone service delivery.

URO-ONCOLOGY ISSUES

- The review notes that Craigavon Area Hospital is a cancer unit and produced a urology cancer report in 2002. Implementation on the whole failed due to lack of staff and facilities.
- From this cancer report combined with the external review, it would appear obvious that extra clinical space and staff with specialized expertise are urgently required.
- The principal of a "urological multi practical day facility" is not new. It is appreciated that with our new Hospital build, that our ideal facility will be incorporated in the design.
- This however is outside of our five-year plan remit. A facility is required now with the introduction of the Nurse Practitioner service – it is appreciated that this clinical area may not be the ideal.
- It is clearly evident that the principal of Nurse Practitionership needs to be substantially developed in our unit. We have experience of this already, to a degree.
- As a unit, time is required to define this precise configuration, as implementation will profoundly depend upon the imaginative development of the Nurse Practitionership service. It is envisaged that such personnel in addition to providing patient management duties will develop, supervise, educate and audit the practice.
- This service is so critically important to the unit that it should be introduced to the service even before the appointment of a third Consultant.

PATIENT PATHWAY

- Undoubtedly protocols and guidelines for GP referrals and our review situation are required.
- However with respect, we believe there exists a deficit in knowledge of urological assessment, care and communication between primary and secondary care. This will necessitate an education programme involving Consultants, Nurse Practitioners and GP practice staff.

AREAS NOT COVERED IN REPORT

- The report does comment that urology is a high technology specialty with expensive requirement for new equipment and imaging techniques.
- This currently is not recognized by the Trust. The safety, medico-legal and developmental aspects of our urology theatre facilities have been previously drawn to the Trust attention but not heeded.
- Investment in this area is needed. The review notes many recommendations, which by their nature are complex to introduce. It is not possible for the existing staff to co-ordinate this due to current workload/expertise.
- The appointment of a Service Manager to introduce and co-ordinate these changes is required.
- With time, it will also probably require a manager to supervise the overall smooth running of such a unit involving various sites.

RECOMMENDATIONS

- The review offers many excellent recommendations.
- We agree with these in full with some minor changes to the timescale and this with the knowledge of our existing strengths and weaknesses of service, may need a degree of local application.

We do most sincerely hope that this external review now acts as a catalyst for development, as similar recommendations were put to the Trust in the past.

Yours sincerely

Mr MRA Young, MD FRCS (Urol)
Lead Clinician in Urology
/mm

Cc Mr S McClinton
External Assessor

Mr I Stirling
Clinical Director of Surgery
CAHGT

Lead Clinician file

CRAIGAVON AREA HOSPITAL GROUP TRUST

Caring Through Commitment

Proposal for the appointment of a Locum Urologist [6 months duration]

Directorate of Planning & Contracts
Date: Friday, 05 August 2022
Author: Anne Brennan

Proposal for the Appointment of a Locum Urologist

Department of Urology

1.0 Introduction

This current paper details the proposed organisation and planned activity associated with the appointment of a Locum Urologist for a six-month period.

It is envisaged that this post holder will initially provide annual leave cover for the existing consultants and subsequently undertake activities designed to positively impact Urology long waiters.

2.0 General Surgery Current Service Provisions

Urology is part of the Surgical Directorate, which comprises of the specialities of General Surgery, ENT, Urology, Accident & Emergency and Orthodontics.

2.1 Activity:

Outpatient Activity:

In the year 2003/2004 there were a total of 4,031 patients reviewed at the Outpatients department across the three sites of Craigavon Area Hospital, Armagh Community Hospital and Banbridge Polyclinic. 547 of these were new patients and 3,484 were review patients. There is currently a waiting list of 1,053 for a new patient routine appointment, with over 240 of these are currently waiting in excess of 24 months.

Over 326 patients were reviewed in the Stone Treatment Centre facility in 2003/2004.

Inpatient Activity:

In 2003/2004 there were a total of 1,600 Inpatient FCE's. Over 60% of cases being non-elective. There are currently 501 patients on the inpatient waiting list with 71% waiting under 18 months.

Day Case Activity:

In 2003/2004 there were a total of 1,058 Day case activity. There are currently 464 patients on the Day case waiting list with 95% waiting under 18 months.

2.2 Support Services

A wide range of radiological services is provided including digital imaging, radio-isotope and spiral CT scanning. The acquisition of MRI scanning is imminent.

Daisy Hill Hospital has CT scanning on site. Bone densitometry and CT scanning are provided on the South Tyrone Hospital site.

On-site laboratories provide biochemistry, microbiology and haematology services. Histopathology and cytopathology services are also available on site.

An Area Pharmaceutical service is available providing both clinical pharmacy support and pharmaceutical items.

A full range of allied health professionals is available, including physiotherapy, occupational therapy, and dietetics.

2.3 Medical Staffing of Department:

Consultant Staff

Mr. M. Young	Consultant Urologist
Mr. A. O'Brien	Consultant Urologist

Non- Consultant Hospital Doctors:

- Specialist Registrar 1.0
- Research Registrars 2.0
- Senior House Officers 1.0
- Junior House Officers 1.0

Specialised Nursing Support:

- Nurse Lecturer Practitioner 1.0

3.0 Proposal for the appointment of Locum Urologist

The Trust is seeking SH&SSB approval to appoint a Locum Urologist who will work to the following responsibilities:

3.1 Clinical:

The postholder will undertake the following clinical duties:

- The assessment and treatment of **outpatients** as defined in the job plan
- **Day Surgery, Main Theatre** and **Endoscopy** sessions as defined in proposed job plan.
- Partake in **on-call duties** with existing consultants. Patient care would still remain under a nominated existing consultant. It is anticipated that when on call clinical duties in other units would be reduced.
- Out-of-hours holidays, statutory leave, study leave and cover is provided by arrangement with the Clinical Director

3.2 Audit and Clinical Governance:

Attendance and participation in the audit of the structure, process and outcomes relating to these issues is a requirement of the directorate.

The post holder will be expected to adhere to and participate in the Trust's Clinical Governance procedures including:

- Participation in appraisal training according to local arrangements and as appropriate for a locum tenens
- Appraisal by the Lead Consultant according to local arrangements and General Medical Council regulations concerning appraisal and revalidation and as appropriate for a locum tenens. Appraisal will provide the opportunity for annual job plan review and discussion of an annual personal development plan. Communication of issues arising will be through the existing management framework.
- Participation as appropriate in the Trust's Quality Strategy
- Participation in the development of evidence-based medical practice.

3.3 Provisional Job Plan - Fixed Sessions:

- 1.5 Outpatients [1.0 CAH/0.5 STH] [15 pts per week]
- Day Cases 2 X GA Lists STH /1.0 LA List STH
- 0.5 Main Theatre, possibly another 1.0 sessions from Surgeon-on-call [CAH]

Monday	AM	Patient Admin/CPD
	PM	Main Theatre CAH **[1.0]**
Tuesday	AM	Day Procedures Unit – South Tyrone Hospital Endoscopy [weekly] **[1.0] ???? To be Confirmed**
	PM	Outpatients – South Tyrone Hospital [X 2 month] [2nd & 4th] *[need more]*
Wednesday	AM	Patient Administration/CPD
	PM	Day Surgery GA List CAH [1.0] **??? To be Confirmed [option if other Day Sessions not available]**
Thursday	AM	Day Surgery STH – Theatre 1 [weekly] **[1.0] ??? To be Confirmed**
	PM	Theatre 1 South Tyrone Hospital LA List **???? To be Confirmed**
Friday	AM	Patient Administration/CPD
	PM	Outpatients CAH [weekly] **[1.0]**

The above job plan is provisional and will be revised in view of extended Day Surgery Facilities in CAH

Day Surgery & Main Theatre GA cover is dependent on the successful appointment of an additional Consultant Anaesthetist; recruitment is currently underway for this post.

4. 0 The Proposed Model for Workload

Strand 1: Urology Patients who have been offered & refused transfer to another provider outside of Trust

Recent validation exercises have identified a number of patients who have been deemed suitable for transfer but who have declined this offer and opted to remain on CAHGT waiting lists.

Outcome of Patient Transfer Initiative April 2003- June 2004	In patient	Day Cases	Total
Patients declined transfer	74	1	75

Strand 2: Day Case Long waiters

Existing consultants will transfer existing long waiters from their day case lists to the Locum Consultant.

Current lists as of March 2004 demonstrates 464 patients on the existing Day Case lists, while a proportion of these relate to cystoscopy workload it is anticipated that the new post holder could undertake much of the balance of cases.

	0-2 Mths	**3-5 Mths**	**6-8 Mths**	**9-11 Mths**	**12-14 Mths**	**15-17 Mths**	**18-20 Mths**	**21-23 Mths**	**24+ Mths**	**Total**
Total Urology	173	123	47	51	34	13	3	6	14	464

Strand 3: Flexible Cystoscopy Workload:

Currently analysis of the waiting list have indicated that a large proportion of the Day Case waiting lists are for cystoscopy [69%]The postholder, working closely with consultant colleagues will be required to undertake a large proportion this workload.

Flexible Cystoscopy Waiting List:

	0-2 Mths
Day Case Waiting List	321
Planned Day Case Waiting List	40

Strand 4: Long Waiters Outpatients

It is anticipated that the post holder could undertake a number of outpatient sessions across a variety of sites. Specific emphasis would be made on addressing the long waiters on the outpatient's lists at newly established clinics in South Tyrone Hospital, Banbridge Polyclinic and Craigavon Area Hospital.

	0-2 Mths	**3-5 Mths**	**6-8 Mths**	**9-11 Mths**	**12-14 Mths**	**15-17 Mths**	**18-20 Mths**	**21-23 Mths**	**24+ Mths**	**Total**
Total Urology	242	166	100	83	70	45	47	57	243	1053

Strand 5: Inpatient/Main Theatre Activity

It is anticipated that these slots would be utilised for patients who have refused transfer and urgent urology cases.

5.0 Resource Requirements

5.1 Financial Resources Required for Locum

CAHGT - Financial Planning
Resources required for locum urologist
30 July 2004

NON-RECURRING COSTS		**£**	**Notes**	**Assumptions**
TOTAL NON-RECURRING COSTS		**109,675**	**16**	
RECURRING COSTS				
PAYROLL COSTS				**1**
	WTE	**6 month £**		
Medical staff				
Locum consultant urologist	1.00	40,338		
Consultant radiologist	0.30	12,101		
Consultant cellular pathologist	0.10	4,034		
Sub-total	1.40	56,473		
Nursing staff				
Nursing Grade F	1.00	13,537		
Nursing Grade D	1.23	13,235		
Nursing Grade A	0.91	6,161		
Sub-total	3.14	32,933		
Allied Health Professionals				
Senior 2 Radiographer	1.20	15,806		
MLSO 1*	0.10	1,359		
MLSO 1	0.20	2,234		
MLA - Laboratory	0.20	1,322		
Sub-total	1.70	20,720		
Technical				
Radiographer helper	0.50	3,586		
ATO - CSSD	0.57	3,766		
MTO 2 - Pharmacy	0.10	1,033	**9**	
Sub-total	1.17	8,385		
Admin/Secretarial Support				
Admin Grade 3	1.20	9,263	**5, 6, 7**	
Admin Grade 2	0.97	6,768	**1, 2, 3, 4**	
Porter	0.40	2,349	**8**	
Sub-total	2.57	18,380		
Total Payroll	**9.98**	**136,892**		

				£	Notes	Assumptions
GOODS AND SERVICES					**13**	**2**
	Inpatients	**Outpatients**	**Day Cases**	**Total**	**14**	
Area services (pharmacy, CSSD, radiography, labs)	3,776	4,137	7,264	15,177		**3**
Medical & surgical/general disposables/sterile disp	1,156	77	1,935	3,168		
Patients clothing/general services	2,715	3,286	1,825	7,825		
General stationery/postage/telephone	1,772	2,572	2,747	7,092		
	9,420	10,072	13,771	33,262		
Travelling/training/uniforms				27,387		
Portering/hotel services				923	**11, 12**	
Total goods & services				**61,573**		
TOTAL RECURRING COSTS				**198,465**		
TOTAL NON-RECURRING & RECURRING COSTS				**308,140**		

CAHGT - Financial Planning
Resources required for locum urologist
30 July 2004

Notes	Detail
1	Clerical Staff Theatre [0.06 WTE] – Theatre Information System administration
2	Health Records [0.58 WTE] support for Day Surgery, Endoscopy & Outpatients STH [Theatres [0.12 + 0.06+ 0.08 + 0.12 + 0.12] plus outpatients [0.08]
3	Health records [0.173] support for theatre sessions [0.013], outpatient clinics [0.16], -if activity in STH consists of CAH patient then a transfer of funding will be required.
4	Health Records [0.16 WTE] to support Outpatients clinics Banbridge Polyclinic
5	Theatre Sessions [0.25 + 0.13 +0.13 + 0.25] and Outpatients – 0.13 WTE
6	Outpatients 0.14 WTE, and inpatients 0.03 WTE
7	Admin/Clerical Support BBPC [0.14 WTE]
8	Portering Health Records, Radiology, Theatres
9	Additional work will be in supplying medication
10	No physiotherapy support required at this time, however will require review on substantive appointment.
11	Hotel Services CAH [Theatre X 2 sessions per month]
12	Hotel Services STH [costed Armagh & Dungannon Community Trust]
13	Marginal/variable cost per case extracted from 2002/03 specialty costs, uplifted by 2.5% for 2003/04 and a further 2.5% for 2004/05.
14	Appointment - 6 months Estimated activity (provided by A Brennan): Inpatients - 8 per month Daycases - 116 per month Outpatients - 432 per month
15	Number and cost of instruments provided by Mary McCaffrey
16	See appendix 1 for breakdown of non-recurring costs

Appendix I: Non-Recurring Costs:

CAHGT - Financial Planning
Resources required for locum urologist
30 July 2004

APPENDIX 1

NON-RECURRING COSTS

	Quantity	Price per unit £	Total £	Notes
Computer				
PC	2	700	1,400	
Printer	2	185	370	
Software Licences	2	250	500	
Office Furniture				
Desk	2	150	300	
Chair	2	75	150	
Telephone	2	30	60	
Filing cabinet	1	60	60	
Audio transcription set	1	85	85	
Other Equipment				
Flexible Cystoscopes	8	11,000	88,000	**15**
Resectoscopes	3	6,250	18,750	**15**
TOTAL NON-RECURRING COSTS			**109,675**	

Appendix II: Assumptions:

CAHGT - Financial Planning
Resources required for locum urologist
30 July 2004

Assumptions	Detail
1	Payroll is costed using the 2004/05 pay rates (excluding the impact of agenda for change and the GMS contract)
2	Goods & services specialty costs comprise the 2002/03 specialty costs uplifted for inflation
3	Area services include chemicals, films, reagents and drugs associated with the services

6.0 Equality and Human Rights Considerations

The Trust has given due consideration to its obligations under Section 75 of the Northern Ireland Act 1998 and also the Human Rights Act 1998. The Trust believes that this proposal will not breach either Act. Further detail is provided as Appendix A

Appendix III: Equality and Human Rights Considerations

Section 75 of the Northern Ireland Act 1998

Section 75 of the Northern Ireland Act 1998 requires the Trust, in carrying out its functions relating to Northern Ireland, to have due regard to the need to promote equality of opportunity between persons of different religious belief, political opinion, racial group, age, marital status or sexual orientation; between men and women generally; between persons with a disability and persons without; and between persons with dependants and persons without.

Without prejudice to these obligations the Trust is also required, in carrying out its functions, to have regard to the desirability of promoting good relations between persons of different religious belief, political opinion or racial group.

Access to the current and proposed services is based on clinical requirement/priority. As with the existing service there may be a potential for some of the 9 groups, i.e. age, racial group and disability, to have differing needs when accessing the services. Any potential impact from these differing needs can be removed by ensuring that appropriate assistance is provided e.g. awareness of cultural needs, provision of interpreters, alternative formats for information and physical accessibility to the services.

Whilst no consultation has taken place with relevant groups, organisations or individuals it is felt that the service proposals can only lead to improved relations with service users, as it will aid the Trust's ability to meet demand.

It is felt that these proposals will not have an adverse impact on the Trust's requirement to promote equality of opportunity and good relations between the different equality groups.

The Human Rights Act 1998

Under the Human Rights Act 1998 the Trust must ensure that the way in which it carries out its functions does not breach the rights of its service users. It is felt that this proposal will not breach any of the Articles covered within the Act.

CRAIGAVON AREA HOSPITAL GROUP TRUST

Caring Through Commitment

Proposal for Establishment of an Inpatient Endoscopy Service

Directorate of Planning & Contracts
Date: Friday, 05 August 2022

Proposal for the establishment of an Inpatient Endoscopy Service

Anaesthetics, Theatres & ICU Directorate

1.0 Introduction[1]

The Department of Health in the United Kingdom have made recommendations on the minimum provision of Gastro-intestinal Endoscopy in District General Hospitals, which accept emergency patients. [See Appendix A]

This current paper details the proposed organisation and planned activity associated with the establishment of an inpatient Endoscopy session for the Respiratory, Gastroenterology and Surgical Teams in Craigavon Area Hospital designed to meet current demands for the service and utilising Department of Health Guidelines.

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2.0 Current Service Provisions

2.1 Current Facilities/Availability:

Endoscopy facilities are available on an outpatient basis in the Day Procedure Unit in Craigavon Area Hospital and South Tyrone Hospital but no formal, structured facilities/pathway is available for inpatients in Craigavon Area Hospital requiring Endoscopy.

Due to the geographic location of the current Day Procedures Unit in Craigavon Area Hospital it is impracticable for an inpatient to be transferred there for Endoscopy/Bronchoscopy.

While General Surgeons and Physicians have dedicated Day Procedures time, Physicians currently have no dedicated access to Main Theatre time.

2.2 Current Inpatient Situation:

Inpatients requiring endoscopic procedures are retained on wards/A & E Trolley Waits and are scheduled onto main theatres emergency lists. On some occasions it may be possible for General Surgeons to add one or two of these patients to their main operating lists. [This of course is not possible for Physicians]

These patients generally do not take priority on the main theatre emergency list and in many instances may have to wait a number of days for procedures to be carried out. This can result in unnecessary lengthy stays for patients, patient dissatisfaction, and uncertainty of diagnosis for admitting clinicians

2.3 Current Activity:

The current Endoscopic workload undertaken in Main Theatres in Craigavon Area Hospital for inpatients is as follows:

	2002/2003	2003/2004
Surgery		
Surgical OGD	641	721
Surgical Colonoscopy	76	62
Surgical Sigmoidoscopy	77	138
Medicine		
Medical OGD	179	130
Thoracic Bronchoscopy	77	44
Total	**1050**	**1095**

3.0 Current Issues

- No formal structured pathway for inpatients requiring endoscopy exists in Craigavon Area Hospital.
- Due to the geographical isolation of the Day Procedures unit it is not feasible to transfer inpatients for procedures.
- Delays in diagnosis and treatment and patient discharge may occur due to delays in accessing Endoscopic investigations.
- Currently the Gastroenterology [2 Consultants] and Respiratory [2 Consultants] have no dedicated theatre time to undertake inpatient endoscopy work. They are currently using a grace and favour arrangement early morning/break times to undertake this workload in the emergency theatres.
- Surgical Teams while having dedicated theatre time have no allocated slots for inpatient endoscopy. They too are currently utilizing emergency theatre time out of hours to undertake this workload.
- Given the pressures on the emergency theatre, Endoscopic procedures are often carried out in ‘out of hours’ time.
- Given that no formal slots exist patients on wards requiring these diagnostic procedures are forced to wait for an appropriate slot in emergency theatre. This often requires an extended stay for patients while emergency theatre time can be matched to the timetables of consultants.
- Cancellations of endoscopy work on the emergency theatre list often occur due to increased pressure of emergency workload.

4.0 Proposal for the establishment of an inpatient endoscopy session

The Trust is seeking SH&SSB approval to establish a formal daily inpatient endoscopy session in main theatres to deal with patients admitted during the previous 24 hours requiring endoscopic investigations available to all teams. British Society of Gastroenterology guidelines endorse a structured arrangement:

> The majority of requests for emergency of out-of hours endoscopy involve the management of patients with acute gastrointestinal bleeding. Pressure to reduce the hours of work of training grade doctors and restrictions imposed by the European Working Time Directive have led to the gradual disappearance of on call rota's in District General Hospitals for patients with acute bleeds and the introduction of more structured arrangements

4.1 Proposed organisation

- The Dental clinic, located in Main Theatres has been identified as the most appropriate location for this facility; some minor refurbishment work will be necessary to ensure adequate facilities.
- The Dental Clinic is available on Tuesday, Thursday and Friday to commence the session at 8:00am. This area can also be utilised on Monday afternoons and for a 0.5 session Wednesday mornings. This timetable will not impinge on current utilisation of Dental Theatre
- It is anticipated that approximately 6 patients would be seen per session
- Medical and Surgical teams have agreed to share session, which will result in most appropriate patients being prioritised and full utilisation of the session. It is anticipated that a GI Physician/Surgeon will be allocated per day to undertake all GI Endoscopic workload. The Respiratory Physicians will undertake their own bronchoscopies. [This arrangement will link with the pending General Surgeon of the Week project currently in development.]
- No anaesthetic cover is required.

Proposed Timetable for Inpatient Endoscopy Session:

Day	Location	AM/PM	Session
Monday	Dental Clinic	PM	1.0 Session
Tuesday	Dental Clinic	AM	1.0 Session
Wednesday	Dental Clinic	AM	0.5 Session
Thursday	Dental Clinic	AM	1.0 Session
Friday	Dental Clinic	AM	1.0 Session

4.2 Anticipated Proposed workload 2004/2005:

Speciality	Patient Slots
Bronchoscopy	3 per week
Gastroenterolology.G [Upper and Lower GI]	3 per week
General Surgery Upper and Lower GI]	22 per week

4.3 Projected Activity:

	Projected 2004/2005
Surgery	
Surgical OGD	778
Surgical Colonoscopy	70
Surgical Sigmoidoscopy	213
Medicine	
Medical OGD	145
Medical Colonoscopy	12
Medical Sigmoidoscopy	12
Thoracic Bronchoscopy	140
Total	**1,370**

5.0 Benefits of establishing service:

The NHS standards of service recommendations make it quite clear that District General Hospitals must have clear Guidelines and Protocols for the provision of emergency endoscopy, which should be available within 24 hours of admission/or request.

The British Society of Gastroenterology and Royal College of Surgeons' audit into the Management of Acute Gastrointestinal Bleeding[2] revealed that the mortality from gastrointestinal bleeding in District General Hospitals tended to be confined to the elderly with multi-system disease. This constant mortality rate of about 14% contrasts sharply with the fall in mortality that has been achieved over the last 20 years in younger patients with bleeding peptic ulcers, at least in part due to the success of interventional therapeutic endoscopy

In addition, there is strong evidence to show that the concentration of patients with acute gastrointestinal haemorrhage in Specialist Units, leads to a significant reduction in mortality which is achieved by an aggressive endoscopic approach and combined management between physicians and surgeons.[3,4] The low mortality associated with gastrointestinal haemorrhage for patients under the age of 60 (1%), has led to several prospective studies on the requirement for hospital admission for all patients.

There is now data to show that patients with uncomplicated upper gastrointestinal bleeding do not require admission, provided the patients undergo early Gastroscopy with the provision of a definitive diagnosis, and that bleeding has ceased.[5]

Other benefits include:

- Formal allocated time for surgical and medical teams for inpatient endoscopy
- Enhanced patient service, as establishment of session will allow for diagnostic procedures will be carried out within agreed timeframes.
- Ability to release beds/certainty of discharge for those patients ready for discharge pending results for endoscopic procedures, which will have a knock on effect on the Trust's ability to maintain elective surgery workload and reduce trolley waits.
- Freeing of space on emergency lists leaving time free for more appropriate anaesthetic supported workload.
- Enhanced utilisation of previously unused accommodation within Theatres.

6.0 Resource Requirements

6.1 Staffing:

Staff	Post/Grade	WTE	Cost £
Theatre Nursing	Grade D	0.58 WTE	14,978
Theatre Nursing Auxiliary	Grade A	0.58 WTE	9,424
Recovery Nursing	Grade D	0.70 WTE	18,077
Nursing Auxiliary	Grade A	0.58 WTE	9,424
Clerical Support - Theatres	Grade II	0.05 WTE	835
Portering		0.40 WTE	7,262
Total			**60,000**

6.2 Goods & Services:

Non – Recurring

Goods and Services		Cost £
Alteration and move of Overhead lighting	1	2,500
Total Non – Recurring costs		**2,500**

6.2 Goods & Services Cont'd

Recurring[1]

Goods and Services	Cost £
Medical/Surgical/Disposables	55,589
Admin/Postage/Travelling/Training	6,243
Laundry	2,493
General Services	17,856
Total Recurring costs	**82,181**

1. While we acknowledge that the Goods and Services costs associated with this activity is currently being absorbed by emergency theatre Goods & Services funding, we anticipate that this funding stream will be required to support more appropriate use of emergency theatre and will therefore not be transferable to the new service, therefore additional funding is required.

The non-recurring costs associated with this proposal are £2,500 and the total full year recurring revenue costs are £142,181. The recurring costs represent £82,181 for goods and services and £60,000 for payroll.

Appendix A:

Bronchoscopy and Endoscopy

Emergency general medical care requires the support of upper gastrointestinal endoscopy, sigmoidoscopy, colonoscopy and bronchoscopy. Each acute general hospital must have a fully equipped endoscopy unit, staffed by experienced nurses or operating department assistants, with apparatus for continuous cardio respiratory monitoring. There should be mobile equipment for use elsewhere in the hospital….

….. Endoscopy should always be available within twelve hours of request. There should be a rota of available and experienced physician or surgeon endoscopists and experienced endoscopy assistants, which identifies their 24 hour availability. Whenever possible, informed consent must precede endoscopy/bronchoscopy. There should be an endoscopy unit portering service or the protection of sedated and often ill patients and their rapid transfer back to a safe environment. A record of Endoscopy findings must be made on the patient's notes, as should a record of complications of the endoscopy. A system must be in place for making the results of endoscopy immediately available to the referring medical team.

References:

1. Provision of Endoscopy Related Services in District General Hospitals, BSG Working Party Report 2001.

2. Rockall TA Logan RFA Devlin HB et al Incidence of and mortality from acute gastrointestinal haemorrhage in the United Kingdom. BMJ 1995; 311: 222–6.

3. Consensus Development Panel. Consensus statement on therapeutic endoscopy and bleeding ulcers. Gastrointestinal Endoscopy 1990; 36: S62–5.

4. Cook DJ, Guyatt GH, Salera BJ et al. Endoscopictherapy for acute non variceal upper gastrointestinal haemorrhage: a meta-analyses. Gastroenterology 1992;102: 139–48.

5. Rockall TA Logan RFA, Devlin HB, Northfield TC. Selection of patients for early discharge on outpatient care following acute upper gastrointestinal haemorrhage. Lancet 1996; 347: 1138 – 40

CRAIGAVON AREA HOSPITAL GROUP TRUST

Caring Through Commitment

Proposal for the development of Urology Nurse Specialist Led Clinical Services at Craigavon Area Hospital Group Trust

Draft 6

Directorate of Planning & Contracts
Date: Tuesday, 05 April 2005
Author: Anne Brennan

Proposal for the development of Urology Nurse Specialist Led Clinical Services at Craigavon Area Hospital

Surgical Directorate

1.0 Introduction

This current paper details the proposed organisation and planned activity associated with the appointment of two Urology Nurse Specialists and the development of associated clinics at Craigavon Area Hospital Group Trust.

2.0 The key areas where specialist nursing could impact?

- New Outpatient Referrals
- General Urology Review Patients
- Uro-Oncology Patients
- Current Outpatient Waiting Lists

3.0 Current Key Issues:

3.1 New Outpatient Referrals:

- Service receives on average 220 new outpatient referrals per month, this has increased from an average of 194 per month in 2003/2004
- Service currently sees approximately 570 new patients per annum
- Outpatients is the only access point to service outside of emergency admissions
- Pressure of review patients is impacting on the ability to see new patients
- 24% patients waiting over 24+ for 1st appointment

If we had a 'perfect' Urology service & dealt with OP referrals as per BAUS guidelines capacity would be at max 1,260 per annum (based on 3 consultants) V current referrals total 2,640 per annum

3.2 Outpatient Reviews:

- Current new:review ratio is 1:9, BAUS recommends 1:2 [with junior doctor support]
- Reviews totalled 3,800 in 2003/2004 with a 1:7 new: review ratio and YTD 2004/2005, excluding ACH are 2,725 with a new:review ratio of 1:9
- Reviews are generated through outpatients but also through emergency admissions, intra hospital transfers and inter hospital transfers
- Current new: review ratio is having negative impact on ability to see new patients
- There are no other safe channels for review other than referral back to GP under current conditions, this is not always possible/feasible due to complexity of casemix and age profiles.

3.3 Uro-Oncology Workload

- In England, Prostatic cancer is the most commonly diagnosed cancer in men and the second most common cause of death from Cancer in men [after lung cancer] [1]
- CAH Service is provided via a combination of outpatient visits, extra out of hours visits with consultants and ad-hoc clinics. There is no dedicated clinic at this time
- There is no dedicated TRUS Biopsy session and patients are currently added to Ultrasound lists in the Radiology Department
- Urology review estimated 150 cases of prostatic cancer and 60 cases of bladder cancer per annum for CAH
- Urology Review estimates that approximately 600 patients per annum would require some form of prostate investigation
- Research has demonstrated that these figures will rise as the population age profile of men within the SHSSB rise
- Often provide end stage palliative care for patients
- Increased life expectancy has resulting in a growing cohort of ‘stable’ patients who require ongoing specialist care. Five year survival prostate rates improved from around 42% in the late 1980’s to 68% in the late 1990’s.

1. Making Progress on Prostate Cancer – NHS Nov 2004

3.4 Outpatient Waiting Lists:

- 1,300 outpatients on list requiring 1st appointment
- 25% waiting 24+ months

- 70% waiting in excess of 6 months
- 99 GP Practices have referred to the Urology Service
- 35% of referrals emanate from 8 GP practices
- Estimate based on Armagh GP referral patterns pilot demonstrates that ~33% of these patients may have LUTS/Prostatic Symptoms
- Draft PFA Targets unachievable
- Increasing numbers of long waiters converting into emergency admissions/cases

4.0 How we think can specialist nurse can help

4.1 New Patients:

4.1.1 Immediate Objectives:

- Establishment of Nurse Led LUTS Assessment Clinic & follow up
- Establishment of Prostatic Symptom Clinic
- Freeing up of Consultant time to see more new patients in a more timely manner through the establishment of Nurse Led clinics
- Provide patients with time to consider decisions regarding their treatment for prostatic cancer[2]
- Making best use of 1st consultation with Consultant by advising/educating GPs

4.2 Review Patients:

4.2.1 Immediate Objectives

- Adopting the recommendations of Urology Strategy - Modernisation recommendations[3] to ensure that all patients are reviewed by the most appropriate member of the multidisciplinary team.
- Undertaking review of Nurse Led LUTS & Prostatic clinic
- Establishment of TRUS Biospy Service

4.2.2 Medium Term Objectives:

- Establishment of Nurse Led General Urology Review Clinic with clear discharge policies
- Establishment of Uro-Oncology Nurse Led Review Clinic

- Longer term - Development of telephone follow-up for appropriate patients

2,3 NHS Modernisation Agency – Urology Strategy for Spread & Sustainability

4.3 Uro-Oncology Patients:

4.3.1 Immediate Objectives:

- Handling a proportion of the diagnostic workload via the Prostatic Symptom clinic
- Undertaking a review of the Nurse Led Prostatic clinic, freeing up Consultant time through the establishment of a Uro-Oncology Nurse Led Service

4.3.2 Medium Term Objectives:

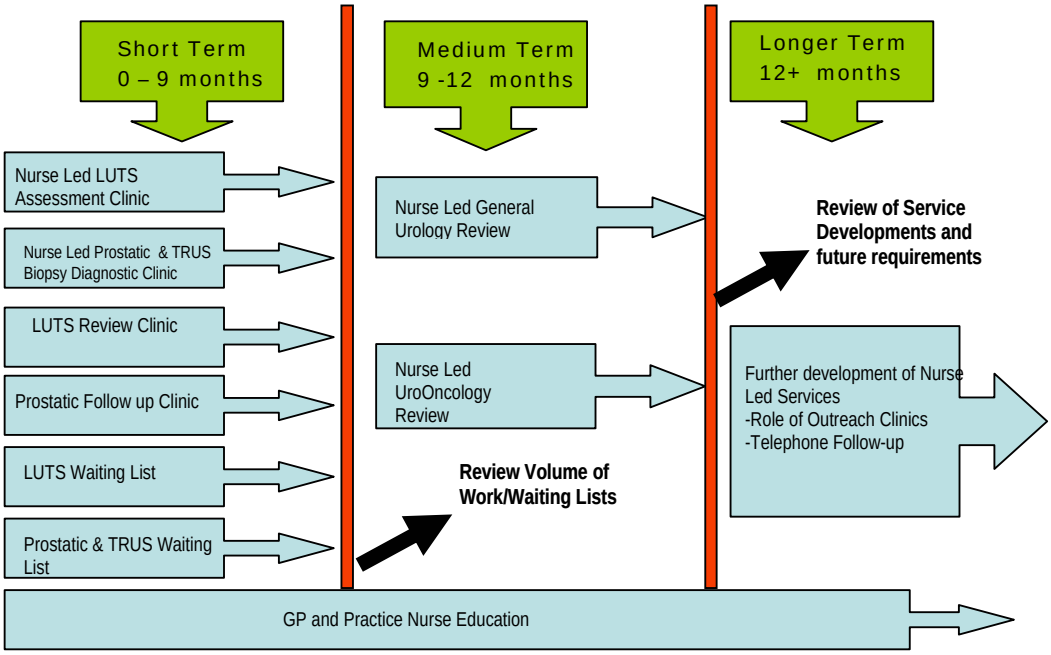
- Ongoing review/care of “stable” oncology patients under appropriate protocols, freeing up consultant time

4.4 Outpatients Waiting List

4.4.1 Immediate Objectives:

- Undertaking additional clinics to handle existing waiting lists

5.0 Timeline for Implementation



6.0 Proposal for the appointment of two Urology Nurse Specialists & associated development of clinical services

The Trust is seeking SH&SSB approval to appoint two Urology Nurse Specialists to develop the following in a phased manner

- Nurse Led LUTS Assessment Clinic & Follow up Review Service
- Nurse Led Prostatic Diagnostic Clinic & Biopsy Service and Follow up Review Service
- Nurse Led LUTS Waiting List Initiative
- Nurse Led Prostatic & TRUS Waiting List Initiative
- Nurse Led General Urology Review Service
- Nurse Led Uro-Oncology Review Service

7.0 Nurse Led LUTS Assessment Clinic & Follow up Reviews

7.1 Anticipated Throughput (per month)

- 8 X Assessment clinics [All day Monday CAH Site]
- 4 X Review Clinic [Tuesday PM CAH Site]
- 32 new patients per month
- 32 Review patients per month

7.2 Projected Demand (per month)

- 220 new referrals
- 33% LUTS/Prostatic Related [72 patients]
- 48 of these suitable for LUTS Assessment clinic

7.3 Modernisation Impact:

- Introduction of LUTS Clinic increases current new patient capacity by 60% alone
- Provides an ability to meet increased needs of demand for services
- Reduction of pressure of referrals to consultant
- Removal of 352 new patients slots per annum from outpatients & 352 Review slots
- More time available for patients & an ability to assess patient satisfaction
- Health Promotion opportunities

8.0 Nurse Led Prostatic Diagnostic Clinic & TRUS Biopsy and Follow up Review Service

8.1 Anticipated Throughput (per month)

- 4 X Symptom Clinics seeing 16 new patients *[as per Belfast City Hospital guidelines, 45mins – 1 hour per patient]*
- 8 X Review Clinics seeing 52 review patients [1 clinic X 5 patients [Trus Biopsy Review]/1 clinic X 8 patients]
- Will oversee TRUS Biopsies, providing patient support and education [184 TRUS Biopsies per annum]

8.2 Projected Demand (per month)

- 184 new referrals
- 33% LUTS/Prostatic Related [72 patients]
- 24 of these suitable for Prostatic Diagnostic clinic

8.3 Modernisation Impact:

- Establishment of rapid assessment clinic reducing the number of visits to diagnosis, currently could take up to 5 visits before diagnosis
- Removal of 184 new patients slots from outpatients & 598 Review slots per annum
- Work with primary care via Dr. Millar to ensure that the right patients are referred through the urgent route through development of referrals proforma templates and GP education
- Ensure patients are counselled appropriately

9.0 Nurse Led LUTS Waiting List Initiative

9.1 Anticipated Throughput (per month)

- 4 X Waiting List Assessment clinics seeing 16 new patients
- 4 X Waiting List Review Clinic seeing 32 review patients

9.2 Projected Demand

- Current waiting list estimated at 291 patients awaiting first assessment

9.3 Modernisation Impact:

- Yearly – 184 new patients /368 review patients per annum from waiting list
- Clearance within 18 months

10.0 Nurse Led Prostatic Waiting List Initiative

10.1 Anticipated Throughput (per month)

- 4 X Waiting List Symptom Clinics seeing 16 new patients
- 4 X Prostatic Review Clinics seeing 32 review patients

10.2 Projected Demand:

- Currently waiting list estimated at 145 patients

10.3 Modernisation Impact:

- 184 new patients seen per annum from current waiting lists
- 368 Review patients per annum
- Clearance within 9 months

11.0 Nurse Led General Urology Review Service

11.1 Anticipated Throughput (per month)

- 4 X Review clinics [Year 1] seeing 32 patients
- Clear concise, strict discharge policy
- Combination of clinic/telephone review [Phased approach]

11.2 Projected Demand:

- Existing cohort of (new:review) patients 1:9 ratio
- Post operative patients/outpatients

11.3 Modernisation Impact:

- 368 Reviews from Consultants main outpatient service per annum
- Potential to offer outreach to Banbridge Polyclinic and Armagh Community Hospital sites

12.0 Nurse Led General Uro-Oncology Review Service

12.1 Anticipated Throughput (per month)

- 4 X Review clinics [Year 1] seeing 32 patients
- Designed for “stable”/counselling oncology patients
- No discharge policy possible

12.2 Projected Demand:

- Existing cohort of patients 1:9 ratio
- Estimate stable patients require 6 monthly review

12.3 Modernisation Impact:

- 368 Reviews from Consultants main outpatient service per annum

- Enables increase in duration of per-patient-review when conducted by specialist nurse
- Enables patient more discussion time
- Potential to offer at Banbridge Polyclinic and Armagh Community Hospital sites

13.0 Timetable of Proposed Activities

Monday AM	Nurse Led LUTS Assessment Clinic – Craigavon Area Hospital, Macmillan Unit	Nurse Led Prostatic Assessment Clinic – CAH, Macmillan Unit TRUS Biopsy Clinic – CAH, Macmillan Unit
Monday PM	Nurse Led LUTS Assessment Clinic – CAH, Macmillan Unit	TRUS Biopsy Review Clinic, CAH Macmillan Unit
Tuesday PM	Nurse Led LUTS Review – CAH Macmillan Unit	Nurse Led Prostatic Review – CAH, Macmillan Unit
Thursday AM	LUTS Waiting List Assessment Clinic, CAH, Stone Treatment Centre	Prostatic Waiting List Assessment Clinic CAH, Stone Treatment Centre
Thursday PM	Nurse Led General Review [Alternate weeks] 1st/3rd BBPC]	Nurse Led Uro-Oncology Review [alternate weeks] [2nd/4th Thursday]
Friday AM	LUTS Waiting List Review Clinic CAH, Stone Treatment Centre	Prostatic Waiting List Review Clinic CAH, Stone Treatment Centre
Friday PM	Nurse Led General Review [Alternate weeks] CAH, Outpatients Department [2nd/4th CAH]	Nurse Led Uro-Oncology Review [alternate weeks] CAH, Outpatients Department [1st/3rd]

14.0 Specialist Urology Nursing – Northern Ireland Analysis

Centre	**Specialist Nurses / Nursing Roles**	**Consultants**
Altnagelvin	4	2
Belfast City	3	6
Causeway	0	1+1 to be recruited
Craigavon	0	2+1 to be recruited
Ulster	1	1

Mater	0	1

15.0 So why do we need two Nurse Specialists?

- Workload – 2,600 referrals per annum
- Introduction of four new specialist clinics from scratch - nothing exists at present
- Implementation of massive change for GPs in terms of service delivery, one nurse will bring little or no impact for such immense change
- No compromise between establishment of LUTS/Prostatic possible – both are equally needed
- No back up/cross cover possible
- Services demand experienced personnel requiring higher grading.
- Service has already suffered from training lower grade staff who then move to higher grade posts elsewhere

16.0 Why cant these Nurses Process More Patients

- Reviewed services in other sites in Northern Ireland
- Have viewed the establishment of these clinics in light of the capacity of the service in terms of consultant manpower, theatres, beds and diagnostics --- given current capabilities this is the optimum number

17.0 Comparison of Consultant V Nurse Specialist

CAHGT - Financial Planning				
Nurse Led Specialist Clinics				
1 March 2005				
Comparison of Consultant v Nurse Specialist				
	Consultant	*Nurse Specialist*	*Difference*	*Note*
	£	£	£	
Hourly rate	37.89	17.87	20.02	*1, 3, 6, 7*
Sessional rate	132.62	62.54	70.08	*2*
Cost per new patient	33.15	15.63	17.52	*8*
Cost per review patient	16.58	7.82	8.76	*9*
Estimated number of new patients to be seen by nurse specialist			500	*4*
Estimated number of review patients to be seen by nurse specialist			2,000	*4*
Differential from nurse specialist seeing new patient			8,760	
Differential from nurse specialist seeing review patient			17,520	
Total differential per annum from employing a nurse specialist			**26,279**	*5, 6, 7*
Annual cost of H grade nurse specialist			**34,842**	*1, 6, 7*

Notes	Detail
1	Payroll is costed using the 2004/05 pay rates (excluding the impact of agenda for change where applicable).
2	Sessions are calculated as 3.5 hours per session.
3	Hourly rate is caluclated based on 52 weeks per annum.
4	Estimated number of new and review patients are based on figures included in the 'impact summary' slide.
5	Differential is based on a comparison of the cost of a patient being seen by a consultant v a nurse specialist.
6	Consultant and H Grade nurse specialist were both costed at mid-point.
7	Costs exclude all elements of goods & services required for new staff and additional patients in the system,
	i.e. pure payroll costs.
8	Cost per new patient based on an average of 4 new patients being seen in 1 session.
9	Cost per review patient based on an average of 8 review patients being seen in 1 session.

19.0 Impact Summary

19.1 New Patients

- Capacity for 368 new LUTS Referrals to be seen by Nurse Specialist
- Capacity for 184 New Prostatic Assessments to be undertaken by Nurse Specialist
- Access for 552 new patients to access the Urology Service
- Doubling our current outpatient capacity to see new patients

19.2 Review Patients

- Undertaking review of new patients entering the service via Nurse Led Services
- Development of innovative discharge focused general Urology service – capacity of 368 patients per annum
- Development of Uro-Oncology Review service for 'stable' oncology patient cohort with a capacity of 368 patients per annum
- Frees consultants from review services: allows for more new patients and a movement toward BAUS new:review guidelines
- Potential to offer outreach to Banbridge Polyclinic and Armagh Community Hospital sites

19.3 Waiting Lists

- Identification of Persons suitable for nurse led LUTS/Prostatic services
- Capacity to clear waiting lists in 9 to 18 months [based on Armagh GP referral patterns]
- Ability to identify 'clinically urgent' patients on waiting lists and fast track them

20.0 Resource Requirements Summary

20.1 Summary Projected Activity

Clinic Description	New	Review	Total
Nurse Led LUTS Assessment	368	368	736
Nurse Led Prostatic Symptom clinic & Follow up	184	414	598
TRUS Biopsy Service	230	-	230
Nurse Led LUTS Waiting List Initiative	184	368	552
Nurse Led Prostatic Waiting List Initiative	145	290	435
TRUS Waiting List	145	-	145
Nurse Led General Urology Review	-	368	368
Nurse Led Uro-Oncology Review	-	368	368
Total Projected Annual Activity	**1256**	**2176**	**3,432**

20.2 Summary Resource Requirement by Clinic

Staff Description	Grade	Nurse Led LUTS Assessment	Nurse Led Prostatic Symptom clinic & Follow up	Nurse Led LUTS Waiting List Initiative	Nurse Led Prostatic Waiting List Initiative	Nurse Led General Urology Review	Nurse Led Uro-Oncology Review	Total
Specialist Nursing [1]	Grade H	0.50	0.55	0.30	0.25	0.20	0.20	**2.0**
Nursing Auxillary[2]	Grade A	0.235	0.125	0.125	0.125	-	-	**0.61**
Radiographer[3]	Senior 1	0.125	0.125	0.125	0.125	-	-	**0.50**
Radiology Clerical Support[4]	Grade II	0.062	0.062	0.062	0.062	-	-	**0.25**
Consultant Radiologist[5]	-	-	-	0.15	0.09	-	-	**0.24**
Secretarial Support[6]	Grade III	0.16	0.14	0.12	0.12	0.08	0.08	**0.70**
Reception	Grade II	0.02	0.03	-	-	-	-	**0.05**
Health Records[7]	Grade II	0.14	0.12	0.10	0.10	0.07	0.07	**0.60**
Portering[8]	Grade II	0.023	0.019	0.017	0.017	0.012	0.012	**0.10**
Facilities [9]	Domestic	From existing Resources	From existing Resources	0.025	0.025	From existing Resources	From existing Resources	**0.05**
Laboratory[10]	BMS 1	0.06	0.07	0.03	0.03	0.03	0.03	**0.25**
Pharmacy[11]	No Resources required	No Resources required	No Resources required	No Resources required	No Resources required	No Resources required	No Resources required	**0**

1. Specialist Nursing based on the following allocation between clinics:

    General Review 20%, LUTS Assessment & Review 50%, LUTS Waiting List 30%

    Prostatic Assessment/Review 55%, Uro-Oncology Review 20%, Prostatic Waiting List 25%

2. Nursing Auxiliary based on:

    3 sessions LUTS & Prostatic Assessment/Review, 2 sessions LUTS/Prostatic Waiting List Initiatives

    Existing outpatient staff nursing will undertake Review clinic workload from existing resources

3 Radiographer based on:

    5 sessions Prostatic & LUTS Assessment & Prostatic & LUTS Waiting List – Scanning and reporting of same.

4. Radiology Clerical Support based on:

    Reporting of above sessions

5. Consultant Radiologist

6. Secretarial Support based on:

    Activity relating to all 6 clinics

    Nurse Led LUTS 23%, Nurse Led Prostate 19%, Nurse Led LUTS Waiting List 17%, Nurse Led Prostate Waiting List 17%, General Urology Review 12%, Uro-Oncology Review 12%

7. Health Records based on:

    Activity relating to all clinics

    Nurse Led LUTS 23%, Nurse Led Prostate 19%, Nurse Led LUTS Waiting List 17%, Nurse Led Prostate Waiting List 17%, General Urology Review 12%, Uro-Oncology Review 12%

8. Portering based on:

Requirements for chart moving relating to all clinics above

9. Facilities based on:

Cleaning of rooms utilized by clinics above

10. Laboratory based on:

Increased activity associated y introduction of additional 6 clinics

11. Pharmacy based on:

Increased activity associated y introduction of additional 6 clinics

20.3 Financial Requirement Summary

CAHGT - Financial Planning
Summary of Nurse Led Clinics
31 March 2005

			Notes	Assumptions
NON-RECURRING CAPITAL COSTS		**FYE £**		
TOTAL NON-RECURRING CAPITAL COSTS		**23,501**		
NON-RECURRING REVENUE COSTS				1
PAYROLL COSTS				
	WTE			
Nursing staff				
Nursing Grade A	0.25	3,385		
Sub-total	0.25	3,385		
Radiology				
Consultant radiologist	0.09	6,896		
Senior I radiographer	0.25	7,862		
Sub-total	0.34	14,758		
Clerical				
Grade 2 radiology clerical support	0.12	1,725		
Sub-total	0.12	1,725		
Portering				
Grade 2 porter	0.03	450		
Sub-total	0.03	450		
Total Non-Recurring Payroll	**0.75**	**20,318**		
GOODS AND SERVICES				2
		Outpatients £	1, 2	
Area services (pharmacy, radiography, labs)		13,804		3
Medical & surgical/general disposables/sterile disp		2,986		
General/stationery/postage/telephone		3,501		
Portering		81		
Domestic services - cleaning		731	3	
		21,104		
Travelling/training/uniforms		4,064		
Total non-recurring goods & services		**25,168**		
TOTAL NON-RECURRING REVENUE COSTS		**45,487**		
TOTAL NON-RECURRING COSTS		**68,988**		

RECURRING REVENUE COSTS 1

PAYROLL COSTS

	WTE	£
Nursing staff		
Nursing Grade H	2.00	69,685
Nursing Grade A	0.36	4,875
Sub-total	2.36	74,559
Radiology		
Consultant radiologist	0.15	11,378
Senior I radiographer	0.25	7,862
Sub-total	0.40	19,241
Laboratories		
BMS 1	0.24	13,125
Sub-total	0.24	13,125
Clerical		
Grade 3 secretarial support	0.70	10,807
Grade 2 health records	0.60	8,348
Grade 2 reception	0.05	696
Grade 2 radiology clerical support	0.12	1,725
Sub-total	1.47	21,576
Portering		
Grade 2 porter	0.07	873
Sub-total	0.07	873
Total Recurring Payroll	**4.54**	**129,375**

GOODS AND SERVICES 2

	Outpatients £
Area services (pharmacy, radiography, labs)	25,794
Medical & surgical/general disposables/sterile disp	4,732
General/stationery/postage/telephone	5,593
Portering	190
	36,309
Travelling/training/uniforms	25,875
Total recurring goods & services	**62,184**
TOTAL RECURRING REVENUE COSTS	**191,559**
TOTAL NON-RECURRING & RECURRING COSTS	**260,546**

CAHGT - Financial Planning
Summary of Nurse Led Clinics
31 March 2005

APPENDIX 1

NON-RECURRING CAPITAL COSTS

	Quantity	Price per unit £	Total £
Urinary Flow Meter	1	5,600	5,600
Transrectal ultrasound transducer for ATL HDI 5000 scanner	1	13,500	13,500
Computer Equipment (Nurse Specialists & Secretarial Support)			
PC	3	700	2,100
Printer	3	185	555
Software Licences	3	250	750
Office Furniture (Nurse Specialists & Secretarial Support)			
Filing cabinet	3	60	180
Telephone	3	30	90
Desk	3	100	300
Pedestel	3	80	240
Chair	3	62	186
TOTAL NON-RECURRING CAPITAL COSTS			**23,501**

CAHGT - Financial Planning
Summary of Nurse Led Urology Clincs
31 March 2005

Notes	Detail
1	See appendicies for projected throughput of clinics.
2	Marginal/variable cost per case extracted from 2003/04 specialty costs, uplifted by 2.5% for inflation.
3	See appendix 1 for breakdown of non-recurring costs.
4	Cleaning services provided by an external company. Hourly cost provided by the contracts services coordinator.

CAHGT - Financial Planning
Summary of Nurse Led Urology Clincs
31 March 2005

Assumptions	Detail
1	Payroll is costed at mid point using the 2004/05 pay rates (excluding the impact of agenda for change and the new consultants' contract).
2	Goods & services specialty costs comprise the 2003/04 specialty costs uplifted for inflation.
3	Area services include chemicals, films, reagents and drugs associated with the services.

21.0 Reform, Modernisation and Efficiency Impact

21.1 Modernisation:

With reference to the impact assessment (19.0), this proposal clearly demonstrates the ability to deliver progress against both of the key reform strands.

- "Improving health and social well–being and reducing reliance on hospital services" by offering patients a more timely first and review appointment for the conditions dealt with by the Nurse specialists. The prevention of lengthy waits for an out patient appointment will also prevent conversion into an emergency hospital admission, as has been previously demonstrated in a data validation exercise where 0.6% of people awaiting a first outpatient had already had an inpatient admission for that specific urological condition.

- "Improving patient flows and throughput in the hospital sector" by offering an alternative to Consultant Out patient Management both for first and review appointments for 552 and 736 patients respectively, and thus increasing outpatient capacity for Consultant led services.

- The proposal also makes a major contribution to achievement of Priorities for Action targets for this specialty

  I. 2.11 "The total number of patients waiting for a first hospital outpatient appointment at 31 March 2006 should not exceed the level at 31 March 2005… and for 2007 should be reduced by 10%.

  II. 2.12 " 75% of patients requiring an initial outpatient appointment in 2005/2006 should be seen within three months of referral.

  III. " Other than in exceptional circumstances, no patient should be waiting more for a first outpatient appointment more than 12 months by March 2006 and more than 6 months by March 2007"

Increasing outpatient capacity by the numbers outlined above will contribute significantly to achieving the above targets.

- Demonstrable contributions towards achievement of efficiencies (RR or NRR).

- Demonstrates value for money.
  As outlined in 17.0, and using BAUS guidelines a Consultant Outpatient service should see 420 new referrals per annum. This service model provides the capacity to see additional 552 new referrals at a cost substantially (£ 8,760) less than that of a Consultant led service, while also significantly reducing the pressure for Consultant led review, and allowing the current service to achieve BAUS good practice guidelines.

- Involves implementing best practice based on current guidelines / evidence

This care model has been derived from the Modernisation Agency Urology Strategy for Spread and Sustainability, and formed part of the recommendations of the independent Review of CAHGT Urology Services carried out in partnership with the SHSSB.

- Can be implemented in full or in part within the 3 year planning period.

  This proposal will be rolled out within year 1 and will have achieved its full capacity by the beginning of year 2.

21.2 Potential Key Performance Indicators:

- Number of new patients seen per month by each clinic type
- Number of DNA's and CAN's for new patients per month, compared with those for Consultant clinics
- Number of review patients seen per month by each clinic type
- Number of DNA's and CAN's for review patients per month, compared with those for Consultant clinics
- Number of patients discharged from each type of Nurse led clinic without requiring Consultant review
- Number of patients from each clinic type requiring Consultant review
- Number of patients referred from Consultant clinics for review
- New to review ratio for each clinic type
- Average number of reviews per patient per clinic type

Appendix A: Nurse Led LUTS Assessment Clinic & Follow Up

CRAIGAVON AREA HOSPITAL GROUP TRUST

Caring Through Commitment

Appendix A:
Proposal for the Nurse Led LUTS Assessment & Review Service

Draft 6

Directorate of Planning & Contracts
Date: Tuesday, 05 April 2005
Author: Anne Brennan

Proposal for the Nurse Led LUTS Assessment & Review Service

Surgical Directorate

1.0 Introduction

This current paper details the proposed organisation and planned activity associated with the establishment of a Nurse Led Lower Urinary Tract Symptom (LUTS) Assessment and Review Service at Craigavon Area Hospital.

2.0 Background

Current best evidence concerning the need for a LUTS service exists in guidelines published by the British Association of Urology Nurses (BAUN) working party (BAUN, 2003). In his foreword to these guidelines, Professor Roger Kirby notes that benign prostatic hyperplasia (BPH) is the commonest benign neoplasm to afflict men beyond middle age with up to 50% of men developing urinary symptoms or BPH by the age of 60 and 80% by the age of 80 years old. Whilst these figures point to the need for such a service they do not take into account those men who will present to the service with symptoms caused by conditions other than BPH or women who will present with LUTS. In addition, with an ageing population across Northern Ireland (+30,000 by 2010[1])and particularly in the Southern area, it is suggested that the pressure on health services created by people experiencing LUTS will only increase in the coming years.

Approximately 220 new referrals are made to CAH outpatients by GPs each month. Applying an estimate based on Armagh GP referral patterns suggests that approximately one third of these patients may have LUTS/Prostatic symptoms. Furthermore two thirds of that group would be assumed to have symptoms requiring a LUTS oriented consultation. This paper is based on the assumption, therefore, that approximately 48 new patients are referred and will require a LUTS oriented first appointment session.

3.0 Current Patient Pathway

Currently patients referred to the service with LUTS Symptoms are dealt with through the normal outpatient channels. There is currently no dedicated patient pathway for this group of patients.

4.0 Proposed Organisation

The BAUN guidelines (pages 16 and 17) offer some explanation of the overall structure of the LUTS service beginning with GP referral. Whilst a clear pathway outlining what will occur to patients when attending the service is essential, it is equally important that local

[1] A Healthier Future: A Twenty Year Vision for Health & Wellbeing in Northern Ireland 2005 – 2025, DHSSPSNI, Jan 2005

agreement exists between GP's and those providing the LUTS service in terms of referral pathways.

Such agreement would include:

- Capacity of LUTS service
- Investigations to be completed by GPs prior to referral
- Development of proforma referral form
- Pathways of care following assessment

The Craigavon Area Hospital LUTS service will include:

- GP visit and agreed initial investigations with referral to Urology service on specific documentation.
- Review of referral by Consultant/Nurse Specialist and identification of clinical pathway to Nurse Led LUTS Service.
- Letter from LUTS service to patient with appropriate educational literature
- LUTS assessment inclusive of:
  - Patient history
  - International Prostate Symptom Score (IPSS) [men only]
  - Standardised physical examination including genitalia and possibly digital rectal examination [DRE] [The inclusion of the DRE is still under discussion]
  - Clinical tests [if not already done or requiring repeating] including urinalysis, urinary flow rate, post micturation residual, blood analysis of serum urea and creatinine [U&E] and prostate specific antigen [PSA]
  - Ultrasound of Bladder for residual Urine [Nurse]
  - Ultrasound Scanning of Kidney [Radiographer]

The following investigations may also be undertaken/arranged as relevant to the individual patient. It is estimated that ¼ of patients will require further investigations:

- Urine cytology
- Further Upper tract imaging
- Urodynamic pressure/flow studies
- Midstream sample of urine [MSU]
- Flexible cystoscopy
- Referral for Transrectal ultrasound [TRUS) and prostate biopsies

5.0 Proposed Workload

5.1 Initial Assessment:

Initial suggestions on this matter are in agreement with the practice at Belfast City Hospital [BCH] with 45 minutes being suggested as the minimum necessary for initial assessment of new patients presenting with LUTS.

It is suggested that approximately 4 new patients would be suitable per session. If the service was operational with 2 sessions per week and on the basis of a 46 week year the annual number seen might approximate 368 new patient referrals per annum

5.2 Follow up Review:

Patients who require review should be seen at a separate and dedicated nurse led service that does not confuse the complex issues of initial assessment and ongoing review. It is proposed to establish a session be dedicated for follow up assessment, once per week dealing with 8 patients (368 review patients per annum). Patients requiring further interventions will be referred to Prostatic or main outpatient services. Depending on outcomes of these review assessments patients will be:

- Referred back to their GP for treatment and review of prostatic enlargement via agreed treatment regime and re-referral to LUTS service within agreed parameters.
- Referred from the LUTS service to inpatient admission under the care of a urologist for agreed procedures such as TRUS biopsy of prostate
- Referral to urologist for further investigation for presenting symptoms that fall outside working protocol.

5.3 Referral Pathways:

It has also been recognised that clear guidelines for referrals to this service will be necessary. It is planned that the Nurse Specialist would assist in the formulation and communication of these to GPs and participate in GP training and education.,

5.4 Projected Throughput

	New [per week]	Review [per week]	Total per annum]
Nurse Led LUTS Diagnostic Clinics (2)	8	0	368
Nurse Led LUTS Review Clinic (1)		8	368

* [based on 46 weeks per annum]

5.5 Weekly Timetable:

Clinic Description	Estimated Workload	Staff Involved	Location & Time	Referral From
Nurse Led LUTS Diagnostic Clinics (2)	8 New Patients	Nurse Specialist, Nursing Auxiliary, Clerical Staffing, Radiographer	Glennane Suite Monday AM & PM	• GP referrals via consultant • Urology Outpatients • Urology Emergency Admissions
Nurse Led LUTS Review Clinic (1)	8 Review Patients	Nurse Specialist, Nursing Auxiliary, Clerical Staffing,	Glennane Suite Tuesday PM	• Nurse Led LUTS Diagnostic Clinic

5.6 Current Urology Waiting Lists:

It is anticipated that on appointment the Nurse Specialist could undertake a review of current outpatient referrals and through working closely with the Consultants could identify a cohort of patients suitable for assessment via the Nurse Led LUTS Waiting List Assessment Service. Provisionally it is estimated that approximately 300 patients currently on the lists could be dealt with effectively in this manner. [See Appendix E for further details]

6.0 Resource Requirements

6.1 Nursing:

6.1.1 Nurse Specialist:

It is suggested that the hallmarks of the service must be availability and excellence of patient experience and outcome and these can only be met with adequate staffing provision. Nursing input for the service must be provided at a level of expertise that allows full understanding of the issues involved and that can support the degree of clinical decision-making that is necessary. For this reason it is proposed that the nurse providing the service will be at least at Practitioner level and graded at Grade H or above..

It is proposed to appoint a doctor supported 1.0 WTE Grade H nurse who will be dedicated to the delivery of this LUTS assessment service for Craigavon Area Hospital Group Trust. It is envisaged that this post holder will, additionally, retain total operational responsibility for the efficient operation of the following:

- Nurse led LUTS waiting list assessment & review service [Appendix E]

It is also anticipated that while full participating in the Urology Multidisciplinary team this postholder will develop the Urology Nurse Led Review clinic [See Appendix C]. This clinic would enable stable review patients to be removed from the standard Urology Outpatients setting without compromising their care enabling a higher proportion of new patients to be seen. [See Appendix G for Urology Nurse Specialist Job Plan]

6.1.2 Nursing Auxiliary:

The nurse specialist providing the service will require the support of a nursing auxiliary (Grade A) to administrate the patient flow and practical management of the patients attending the services and to ensure that issues such as bladder filling were carried out. . It is anticipated that post could be shared with the Prostatic Clinics

6.2 Clerical Support:

Appropriate secretarial support is also required to deal with reception duties, patient registration, appointment scheduling and patient correspondence. Health records staff would also be required.

6.3 Radiology Support:

In order to facilitate Ultrasound scanning Radiographer & Consultant Radiologist support would also be required for the morning session. It is anticipated that this post holder could also be shared across the Prostatic Diagnostic clinic and the LUTS Clinic.

6.4 Computer Storage and Management

Computer storage and management is deemed important. Programs are available to collate the clinical variables, process the ultrasound scanned images and the flow rate graphs. This can present a statement for the notes, the GP and is important for audit purposes. Some systems being developed also have an integrated biochemistry testing kit for PSA and urinalysis.

6.5 Location:

The Glennane Suite has been identified as the most suitable location for all proposed Nurse led LUTS/Prostatic assessment and review clinics. Agreement has been reached with the Cancer Services Directorate for this usage. This location provides adequate toilet facilities for urinalysis, flow rate assessment and a waiting area for questionnaire completion and hydration with fluids for repeated flow rate tests.

7.0 Resource Requirements

7.1 Staffing:

Staff	Post/Grade	WTE
Urology Nurse Specialist	Grade H	0.50
Nursing Auxillary	Grade A	0.235
Clerical Officer	Grade III	0.16
Health Records	Grade II	0.14
Reception	Grade II	0.02
Radiographer	Senior 1 Sonographer	0.125
Radiology Clerical	Grade II	0.062
Portering		0.023
Cleaning		From existing Resources
Consultant Radiologist		From Existing Resources
Laboratory	BMS 1	0.06

7.2 Equipment:

Urinary Flow Meter – Barry Haughey	1.0
PC/Printer – Nurse Specialist & Secretary	2.0
Office Furniture Nurse Specialist & Secretary	2.0

* Blood pressure monitors, thermometers etc will be supplied by the Manderville Unit

7.3 Financial Implications:

CAHGT - Financial Planning
Nurse Led LUTS Assessment
31 March 2005

			Notes	Assumptions
NON-RECURRING CAPITAL COSTS		**FYE £**		
TOTAL NON-RECURRING CAPITAL COSTS		**8,534**	3	
RECURRING REVENUE COSTS				1
PAYROLL COSTS				
	WTE			
Nursing staff				
Nursing Grade H	0.50	17,421		
Nursing Grade A	0.24	3,182		
Sub-total	0.74	20,603		
Radiology				
Senior I radiographer	0.13	3,931		
	0.13	3,931		
Laboratories				
BMS 1	0.06	1,396		
	0.06	1,396		
Clerical				
Grade 3 secretarial support	0.16	2,470		
Grade 2 health records	0.14	1,948		
Grade 2 reception	0.02	278		
Grade 2 radiology clerical support	0.06	863		
Sub-total	0.38	5,559		
Portering				
Grade 2 porter	0.02	304		
Sub-total	0.02	304		
Total Recurring Payroll	**1.33**	**31,794**		
GOODS AND SERVICES				2
		Outpatients £	1, 2	
Area services (pharmacy, radiography, labs)		10,294		3
Medical & surgical/general disposables/sterile disp		2,227		
General/stationery/postage/telephone		2,611		
Portering		61		
		15,192		
Travelling/training/uniforms		6,359		
Total recurring goods & services		**21,551**		
TOTAL RECURRING REVENUE COSTS		**53,345**		
TOTAL NON-RECURRING & RECURRING COSTS		**61,879**		

CAHGT - Financial Planning
Nurse Led LUTS Assessment
31 March 2005

APPENDIX 1

NON-RECURRING CAPITAL COSTS

	Quantity	Price per unit £	Total £
Urinary Flow Meter	1	5,600	5,600
Computer Equipment (Nurse Specialist & Secretarial Support)			
PC	2	700	1,400
Printer	2	185	370
Software Licences	2	250	500
Office Furniture (Nurse Specialist & Secretarial Support)			
Filing cabinet	2	60	120
Telephone	2	30	60
Desk	2	100	200
Pedestel	2	80	160
Chair	2	62	124
TOTAL NON-RECURRING CAPITAL COSTS			**8,534**

CAHGT - Financial Planning
Nurse Led LUTS Assessment
31 March 2005

Notes	Detail
1	See section 5.4 for details of projected throughput.
2	Marginal/variable cost per case extracted from 2003/04 specialty costs, uplifted by 2.5% for inflation.
3	See appendix 1 for breakdown of non-recurring costs.

CAHGT - Financial Planning
Nurse Led LUTS Assessment
31 March 2005

Assumptions	Detail
1	Payroll is costed at mid point using the 2004/05 pay rates (excluding the impact of agenda for change and the new consultants' contract).
2	Goods & services specialty costs comprise the 2003/04 specialty costs uplifted for inflation.
3	Area services include chemicals, films, reagents and drugs associated with the services.

8.0 Conclusion

The development of a dedicated nurse-led LUTS Assessment and Review clinic is an effective means of addressing the volume of new urology outpatient referrals. This service has the ability to clear over 700 (assessment and review) appointment slots from outpatients while additionally improving the quality of service that referrals receive through the proposed LUTS oriented clinic.

Appendix B Nurse Led Prostatic Assessment & Follow up

CRAIGAVON AREA HOSPITAL GROUP TRUST

Caring Through Commitment

Appendix B:
Proposal for the development of a Nurse Led Prostate Clinic and Biopsy Service at Craigavon Area Hospital

Draft 6

Directorate of Planning & Contracts
Date: Tuesday, 05 April 2005
Author: Anne Brennan

Proposal for the Development of a Nurse Led Prostate Clinic & Biopsy Service

Surgical Directorate

1.0 Introduction

This current paper details the proposed organisation and planned activity associated with the development of a nurse led prostate clinic and biopsy service at Craigavon Area Hospital. This case is put forward to enhance the quality of the urological care of these conditions and reduce the already considerable waiting list time for investigations and therapy.

2.0 Background

There are two main avenues for this type of clinic. The aspect is the "symptom" clinic which primarily addresses the management of men with benignly, enlarged prostates causing outlet obstruction. The second main issue is prostate cancer. Although prostate cancer causes symptoms in its advanced stages, the prime purpose of such a clinic is the detection of the condition. Ideally this will amount to early detection, but it will also cater for those patients with more advanced staging of this disease. It is appreciated that men with prostate cancer may also have lower urinary tract symptoms (LUTS) and hence will be best served by specific clinics providing symptom oriented treatments. Requirements for a LUTS oriented clinic are defined in a separate document.

The proposed prostate diagnostic service envisages that:

- Patient focussed information is provided along with appropriate counselling and the facilitation of informed consent on all aspects of the diagnostic process and its consequences.
- Prostate symptoms are assessed via standard means
- If prostate cancer is suspected then a TRUS [Transrectal ultrasound scan] is arranged to enable prostate biopsies to be taken.
- Urodynamic and ultrasound assessment may also be required as part of the LUTS workup
- Other health parameters noted in the history, biochemistry and urinalysis will contribute to the overall assessment.
- After a diagnosis has been made a patient focussed treatment pathway is devised.

With an ageing population across Northern Ireland (+30,000 by 2010[1])and particularly in the Southern area, it is suggested that the pressure on health services created by people experiencing prostatic related illness will only increase in the coming years.

Approximately 220 new referrals are made to CAH outpatients by GPs each month. Applying an estimate based on Armagh GP referral patterns suggests that approximately one third of these patients may have LUTS/Prostatic symptoms. Furthermore one third of that group would be assumed to have symptoms requiring a Prostatic oriented

[1] A Healthier Future: A Twenty Year Vision for Health & Wellbeing in Northern Ireland 2005 – 2025, DHSSPSNI, Jan 2005

consultation. This paper is based on the assumption, therefore, that approximately 24 new patients are referred and will require a Prostatic oriented first appointment session.

3.0 Current Patient Pathway

There is currently no dedicated patient pathway for this group of patients. Currently in Craigavon Area Hospital patients with prostatic related complaints are referred by GPs to general urology outpatient. In some instances the consultant may arrange a number of diagnostic tests to be conducted in advance of the outpatient clinic attendance.

Subsequently for designated patients a TRUS Biopsy will be arranged, these are currently conducted in the Radiology department. Patients are then required to re-attend to the ward for results of same. This current arrangement is unsatisfactory in terms of patient education and follow up and the development of this clinical service will help address current concerns.

Depending on the outcome of the biopsy/diagnostics patients are divided into 2 categories:

3.1 Malignant

These patients follow a clinical management pathway which may involve, surgery, radiotherapy, hormonal therapy or a combination of these.

3.2 Inconclusive/Non Malignant:

Typically these patients are either referred back to their GPs with advice on on-going management, or are reviewed periodically at the Urology outpatient clinics.

4.0 Proposed Organisation

4.1 Nurse Led – Doctor Supported Symptom clinic with non-invasive assessment.

The symptom clinic component, as previously defined, requires a separate waiting area conducive with relaxation and fluid intake, a consultation room and toilet facilities for flow rate. This service will be designed to determine the need for further investigation of both prostate symptoms and the requirement for a TRUS biopsy.

The clinic would typically involve the following:

- history taking
- questionnaire explanation and subsequent evaluation
- blood and urine testing
- urinary flow rate assessment and ultrasound scanning for bladder volumes (where required)
- Urinary tract ultrasound imaging (where required) [to be undertaken by Radiographer, with results interpreted by Consultant Radiologist]

- Patient counselling
- Transrectal ultrasound scanning, Urodynamics and Flexible Cystoscopies to be performed on a separate occasion.

4.2 TRUS Biopsy Service:

It is proposed to format the current adhoc TRUS biopsy services into formal and dedicated services each with a specific time and location. These patients will be booked for biopsy either from an outpatient referral to the Consultants or from an earlier prostatic assessment clinic.

4.2.1 Background:

- TRUS Biopsies are currently conducted by 3 Consultant Radiologists on an adhoc basis on the Craigavon Area Hospital site.
- These procedures are normally added to the end of an ultrasound list and each Consultant endeavours to undertake 1 each per week
- There is no formal funding allocated for this procedures
- Consent and counselling for the patient is conducted in advance of the biopsy and each procedures including the above normally takes 1 hour

4.2.2 Activity:

	2003/04	2004/05 [To Date]
TRUS Biopsies	51	108

4.2.3 Current Waiting Lists

	March 2005
TRUS Biopsy Waiting List	12

4.2.4 Proposed Organisation:

- Co-locate clinic with Prostatic Assessment and LUTS Assessment clinic in the Glennane Suite, Macmillian building on Monday AM
- Consultant Radiologist staff will rotate to provide full cover to the clinic
- 5 patients will be booked per session
- Nursing support will be provided by Nurse Specialists and Nursing Auxiliary where appropriate
- Patients will receive counselling pre and post procedure
- Patients will be referred from Prostatic Assessment Clinic and the General Urology Service – there will be no direct access for GPs

The introduction of an additional Prostatic Assessment Waiting list Clinic will inevitably create additional demand for TRUS Biopsies. IT is therefore proposed to initiate and additional TRUS Biopsy Clinic per week for the duration of the waiting list initiative to support this service.

4.3 TRUS Biopsy Review:

It is planned to formalise into a dedicated clinic the TRUS biopsy review service currently held in an adhoc manner on the inappropriate setting of the Urology ward. Medical staff and Specialist Nursing will review results of biopsies with patients and for those patients with a diagnosis of prostate cancer; a clinical management program will be developed. This will include referral to the Prostatic review clinic for further education and counselling by the Nurse Specialist.

4.4 Nurse Led Prostatic Assessment Review of patients with cancer:

Patients who have only prostate symptoms and no diagnosis of cancer will be referred to the LUTS service. Patients with cancer will require ongoing investigation and counselling and it is proposed that this service will facilitate this time consuming, but essential, element of the patient's care.

5.0 Proposed Workload

5.1 Initial Assessments:

Initial suggestions on this matter are in agreement with the practice at Belfast City Hospital [BCH] with 45 minutes being suggested as the minimum necessary for initial assessment of new patients presenting with Prostatic symptoms.

It is suggested that approximately 4 new patients would be attend a Prostatic diagnostic clinic operating with 1 session per week. A concurrent TRUS biopsy clinic will operate and cater for up to 5 new patients. Although the associated Radiologist will primarily deal with these patients, the nurse specialist will deliver counselling care pre- and post-biopsy and ensure the patient is aware of their subsequent treatment path including the TRUS biopsy review. On the basis of a 46 week year the annual number seen might approximately 184 new patient referrals and 230 TRUS biopsy patients per annum.

5.2 Follow up Reviews:

Patients who have only prostate symptoms and no diagnosis of cancer will be referred to the LUTS service. Patients with cancer will require ongoing investigation and counselling and it is proposed that this service will facilitate this time consuming, but essential, element of the patient's care. This review should be conducted in separate and dedicated nurse led sessions that does not confuse the complex issues of initial assessment and ongoing review. It is proposed to establish a single, dedicated review session per week for each of the diagnostic and TRUS biopsy clinics which therefore deals with 4 and 5 patients respectively each session (again 184 and 230 patients per year respectively). 5.3 Projected Throughput

	New [per week]	Review [per week]	Total [per annum]
Nurse Led Symptom clinic with non-invasive assessment.	4	0	184
TRUS Biopsy Service:	5	0	230
Nurse Led Prostatic Assessment Review:		4	184
Nurse Led Prostatic Review/TRUS Biopsy Review:		5	230

* based on 46 weeks per annum

5.4 Weekly Timetable:

Clinic Description	Estimated Workload	Staff Involved	Location & Time	Referral Pt
Nurse Led – Doctor Supported Symptom clinic with non-invasive assessment.	4 New Patients	Nurse Specialist, Nursing Auxiliary, Clerical Staffing, Radiographer, Radiologist. Supervised by Consultant Urologist	Glennane Suite Monday AM	• GP referrals via consultant • Urology Outpatients • Urology Emergency Admissions
*+9-TRUS Biopsy Service:	5 Patients	Nurse Specialist, Radiologist	Glennane Suite Monday AM	• Nurse Led Symptom clinic • LUTS Clinic • GP referrals via consultant • Urology Outpatients • Urology Emergency Admissions
Nurse Led Prostatic Assessment Review:	8 Review Patients	Nurse Specialist, Nursing Auxiliary, Clerical Staffing,	Consulting Room, Glennane Suite Tuesday PM	• Symptom Clinic • TRUS Biopsy Review clinic
TRUS Biopsy Review:	5 Patients	Consultant, Specialist Registrar, Nursing	Glennane Suite Monday PM	• TRUS Biopsy Clinic

5.6 Current Urology Waiting Lists:

It is anticipated that on appointment the Nurse Specialist could undertake a review of current outpatient referrals and through working closely with the Consultants could identify a cohort of patients suitable for assessment via the Nurse Led Prostatic Waiting List Assessment Service. Provisionally it is estimated that approximately 150 patients currently on the lists could be dealt with effectively in this manner. [See Appendix F for further details]

6.0 Resource Requirements

6.1 Nursing:

6.1.1 Nurse Specialist

It is suggested that the hallmarks of the service must be availability and excellence of patient experience and outcome and these can only be met with adequate staffing provision. Nursing input for the service must be provided at a level of expertise that allows full understanding of the issues involved and that can support the degree of clinical decision-making that is necessary. For this reason it is proposed that the nurse providing the service will be at least at Practitioner level and graded at Grade H or above..

It is proposed to appoint a doctor supported 1.0 WTE Grade H nurse who will be dedicated to the delivery of this Prostatic waiting list service for Craigavon Area Hospital Group Trust. It is envisaged that this post holder will, additionally, have total operational responsibility for:

- Nurse Led Prostatic Waiting List Assessment Review Clinics [Appendix F]

It is planned that this post holder will also develop a counselling service when prostate cancer is either suspected or confirmed, these sessions may have to be accommodated outside the timeframe of the clinics outlined above, and ultimately develop agreed protocols to develop the concept of Urological Oncology Nurse Led Review [Appendix D]. [See Appendix G for Nursing Job Plan]

6.1.2 Nursing Auxiliary

The nurse specialist providing the service will require the support of a nursing auxiliary (Grade A) to administrate the patient flow and practical management of the patients attending the services and to ensure that issues such as bladder filling were carried out. . It is anticipated that post could be shared with the LUTS Clinics.

6.2 Clerical Support:

Appropriate secretarial support is also required to deal with reception duties, patient registration, appointment scheduling and patient correspondence. Health records staff would also be required. Again this post can be shared with the LUTS clinic.

6.3 Radiology Support:

A Consultant Radiologist will be required to conduct the TRUS biopsies for the morning session and in order to facilitate Ultrasound scanning Radiographer support would also be required. It is anticipated that this post holder could also be shared across the Prostatic Diagnostic clinic and the LUTS Clinic.

6.4 Computer Storage and Management

Computer storage and management is deemed important. Programs are available to collate the clinical variables, process the ultrasound scanned images and the flow rate graphs. This can present a statement for the notes, the GP and is important for audit purposes. Some systems being developed also have an integrated biochemistry testing kit for PSA and urinalysis.

6.5 Location:

The Glennane Suite has been identified as the most suitable location for all proposed Nurse led LUTS/Prostatic assessment and review clinics. Agreement has been reached with the Cancer Services Directorate for this usage. This location provides adequate toilet facilities for urinalysis, flow rate assessment and a waiting area for questionnaire completion and hydration with fluids for repeated flow rate tests. There is also adequate facilities to conduct TRUS biopsies.

6.6 Equipment

Equipment requirements:

- urinary flow rate apparatus, [From LUTS Clinic]
- an abdominal ultrasound scanner,
- laboratory facilities for biochemistry and pathology.
- For Prostate Biopsy a **separate** Transrectal probe with biopsy facilities are required.

7.0 Resource Requirements

7.1 Staffing:

Staff	Post/Grade	WTE
Urology Nurse Specialist	Grade H	0.35
Nursing Auxiliary	Grade A	0.125
Secretary	Grade III	0.14
Health Records	Grade II	0.12
Reception	Grade II	0.03
Radiographer	Senior 1 Sonographer	0.125
Clerical Radiology	Grade II	0.062
Portering		0.019
Cleaning		From Existing Resources
Consultant Radiologist [TRUS}		0.15
Laboratory	BMS 1	0.07

7.2 Equipment:

Abdominal ultrasound scanner		
Transrectal probe with biopsy facilities		
PC/Printer – Nurse Specialist		
Office Furniture Nurse Specialist		

* Blood pressure monitors, thermometers etc will be supplied by the Manderville Unit

7.3 Financial Implications:

CAHGT - Financial Planning
Nurse Led Prostate Clinic & Biopsy Service
31 March 2005

			Notes	Assumptions
NON-RECURRING CAPITAL COSTS		**FYE £**		
TOTAL NON-RECURRING CAPITAL COSTS		**14,967**	3	
RECURRING REVENUE COSTS				1
PAYROLL COSTS				
	WTE			
Nursing staff				
Nursing Grade H	0.55	19,163		
Nursing Grade A	0.13	1,693		
Sub-total	0.68	20,856		
Radiology				
Consultant radiologist (TRUS)	0.15	11,378		
Senior I radiographer	0.13	3,931		
	0.28	15,310		
Laboratories				
BMS 1	0.07	1,536		
	0.07	1,536		
Clerical				
Grade 3 secretarial support	0.14	2,161		
Grade 2 health records	0.12	1,670		
Grade 2 reception	0.03	417		
Grade 2 radiology clerical support	0.06	863		
Sub-total	0.35	5,111		
Portering				
Grade 2 porter	0.02	251		
Sub-total	0.02	251		
Total Recurring Payroll	**1.39**	**43,064**		
GOODS AND SERVICES				2
		Outpatients £	1, 2	
Area services (pharmacy, radiography, labs)		11,581		3
Medical & surgical/general disposables/sterile disp		2,505		
General/stationery/postage/telephone		2,937		
Portering		68		
		17,091		
Travelling/training/uniforms		8,613		
Total recurring goods & services		**25,704**		
TOTAL RECURRING REVENUE COSTS		**68,768**		
TOTAL NON-RECURRING & RECURRING COSTS		**83,735**		

CAHGT - Financial Planning
Nurse Led Prostate Clinic & Biopsy Service
31 March 2005

APPENDIX 1

NON-RECURRING CAPITAL COSTS

	Quantity	Price per unit £	Total £
Transrectal ultrasound transducer for ATL HDI 5000 scanner	1	13,500	13,500
Computer Equipment (Nurse Specialist)			
PC	1	700	700
Printer	1	185	185
Software Licences	1	250	250
Office Furniture (Nurse Specialist)			
Filing cabinet	1	60	60
Telephone	1	30	30
Desk	1	100	100
Pedestel	1	80	80
Chair	1	62	62
TOTAL NON-RECURRING CAPITAL COSTS			**14,967**

CAHGT - Financial Planning
Nurse Led Prostate Clinic & Biopsy Service
31 March 2005

Notes	Detail
1	See section 5.3 for details of projected throughput.
2	Marginal/variable cost per case extracted from 2003/04 specialty costs, uplifted by 2.5% for inflation.
3	See appendix 1 for breakdown of non-recurring costs.

CAHGT - Financial Planning
Nurse Led Prostate Clinic & Biopsy Service
31 March 2005

Assumptions	Detail
1	Payroll is costed at mid point using the 2004/05 pay rates (excluding the impact of agenda for change and the new consultants' contract).
2	Goods & services specialty costs comprise the 2003/04 specialty costs uplifted for inflation.
3	Area services include chemicals, films, reagents and drugs associated with the services.

8.0 Conclusion

The combination of a Prostatic diagnosis and a TRUS biopsy service is the only logical way to proceed for Craigavon Area Hospital Group Trust if the quantity of referrals is to be effectively dealt with, never mind improving the quality of the service.

The development of dedicated nurse-led Prostatic Diagnostic and TRUS biopsy clinics are an effective means of addressing the volume of new urology outpatient referrals. This service has the ability to clear approximately 800 (assessment and review) appointment slots from outpatients while additionally improving the quality of service that referred patients would receive through the proposed Prostatic oriented clinic.

Appendix C: Nurse Led General Urology Review

CRAIGAVON AREA HOSPITAL GROUP TRUST

Caring Through Commitment

Appendix C:
Proposal for the development of Nurse Led General Urology Review

Draft 4

Directorate of Planning & Contracts
Date: Tuesday, 05 April 2005
Author: Anne Brennan

Proposal for the development of Nurse Led General Urology Review

Surgical Directorate

1.0 Introduction

This current paper details the proposed organisation and planned activity associated with the development of Nurse Led General Urology Review at Craigavon Area Hospital Group Trust.

2.0 CAH Urology Outpatient Reviews Key Issues

- Current new : review ratio for the Urology Outpatients service is 1:9, BAUS recommends 1:2 [with junior doctor support]
- Reviews totalled 3,800 in 2003/2004 with a 1:7 new: review ratio and YTD 2004/2005 [excluding ACH are 2,725 with a new:review ratio of 1:9
- Reviews are generated not only through outpatients but also through emergency admissions, intra hospital transfers and inter hospital transfers
- Current new: review ratio having negative impact on ability to see new patients
- There are no other safe channels for review other than referral back to GP under current conditions, this is not always possible/feasible due to complexity of casemix/age profiles etc
- As the number of new referrals and emergency admissions continues to increase, the general urology clinic had become over whelmed. This has resulted in a reduction in the number of new patients slots to accommodate patients that are currently on a cycle of review.
- In some instances it has also led to patients not being seen as frequently as planned or when review is required [e.g. post operatively].

3.0 Proposed Organisation:

3.1 Proposed Concept:

The follow-up of patients has a significant impact on the workload of the Urology department. The introduction of nurse-led clinics offers the department a highly satisfactory and efficient, safe method of follow-up.

3.2 Methodology

There is currently a trend within urological medicine to develop nurse led services, particularly within the field of prostate health (Holland 1996). The specialist nurse can be viewed as a catalyst for change, a reflective practitioner using science based theory, entwined with sound clinical judgment, intuitive knowledge from experiential learning, adding that something special to the equation, the non measurable caring approach (Gavin 1994 1995).

It is proposed to take the methodology of currently existing [in other centres] Uro-Oncology Nurse Led Review and apply this general urology outpatients.

3.3 Proposed Service Delivery:

- The establishment of an Nurse Led General Urology Review service to provide a review pathway for identified, suitable Urology outpatients
- The clinic will take referrals from the Urology Consultants and Junior Staff who may have seen the patient in the general urology outpatient clinic or on discharge from ward. New protocols on Review Follow up from ward discharge will be developed and agreed.
- The clinic will be held weekly, catering for 8 patients and will be run concurrently with the General Urology Outpatients. A discharge policy and protocols will be developed and the Nurse will endeavour to review and discharge patients where appropriate. Patients deviating from this protocol may be referred back to the General Urology Outpatient service.
- All patients will be given a contact number for the urology nurses, should they require communications between the allocated review times.
- Patients will be allocated a 20-minute consultation, which will be arranged, via a new PAS template.
- The urology nurse will be able to refer to other disciplines, eg AHP's

3.4 Proposed Location

The clinic will be held in the Outpatients Department in Craigavon Area Hospital and Armagh Community Hospital/Banbridge Polyclinic on a rotational basis.

Thursday PM	Nurse Led General Review [Alternate weeks] 1st/3rd BBPC]	Nurse Led Uro-Oncology Review [alternate weeks] [2nd/4th Thursday]
Friday PM	Nurse Led General Review [Alternate weeks] CAH, Outpatients Department [2nd/4th CAH]	Nurse Led Uro-Oncology Review [alternate weeks] CAH, Outpatients Department [1st/3rd]

4.0 Patient Pathway at Review Clinic

- The patients will be assessed on their general well being, including bowel habits, mobility and appetite with assessment specificThe willl be asked specific questions relating to their Urological Review as appropriate.
- Under Proforma the nurse will discuss specific aspects of urological health with the patient and anomalies identified will be acted upon within the protocol or when outside its remit discussed with a Urologist for further action.
- The patients will be questioned re. their compliance to treatment, and any new issues or worries they have.
- Following assessment, the case notes will be appropriately dated, and communications documented in legible handwriting. The entry will be signed, and the name and designation of the nurse printed.
- A dictated letter will also be done at this time, to communicate information to the GP
- A further follow-up appointment will be made If appropriate

5.0 Audit/Performance Indicators

All patients completed a questionnaire assessing satisfaction in the following categories:

- waiting times;
- information given to patients
- level of service received.

6.0 Resource Requirements

6.1 Staffing:

Staff	Post/Grade	WTE
Urology Nurse Specialist	Grade H	0.20
Secretarial Support	Grade III	0.08
Outpatients Nursing		*From Existing Resources*
Health Records	Grade II	0.07
Portering	Grade II	0.012
Laboratory	BMS 1	0.03

6.2 Financial Implications:

CAHGT - Financial Planning
Nurse Led General Urology Review
31 March 2005

			Notes	Assumptions
NON-RECURRING CAPITAL COSTS		**FYE £**		
TOTAL NON-RECURRING CAPITAL COSTS		**0**		
RECURRING REVENUE COSTS				1
PAYROLL COSTS				
	WTE			
Nursing staff				
Nursing Grade H	0.20	6,968		
Sub-total	0.20	6,968		
Clerical				
Grade 3 secretarial support	0.08	1,235		
Grade 2 health records	0.07	974		
Sub-total	0.15	2,209		
Laboratories				
BMS 1	0.03	559		
	0.03	559		
Portering				
Grade 2 porter	0.01	159		
Sub-total	0.01	159		
Total Recurring Payroll	**0.39**	**9,895**		
GOODS AND SERVICES				2
		Outpatients £	1, 2	
Area services (labs)		1,960		3
General/stationery/postage/telephone		23		
Portering		30		
		2,013		
Travelling/training/uniforms		1,979		
Total recurring goods & services		**3,992**		
TOTAL RECURRING REVENUE COSTS		**13,887**		
TOTAL NON-RECURRING & RECURRING COSTS		**13,887**		

CAHGT - Financial Planning
Nurse Led General Urology Review
31 March 2005

Notes	Detail
1	Projected throughput estimated at 8 patients on 1 weekly session (for 46 weeks), as per section 3.3.
2	Marginal/variable cost per case extracted from 2003/04 specialty costs, uplifted by 2.5% for inflation.

CAHGT - Financial Planning
Nurse Led General Urology Review
31 March 2005

Assumptions	Detail
1	Payroll is costed using the 2004/05 pay rates (excluding the impact of agenda for change and the new consultants' contract).
2	Goods & services specialty costs comprise the 2003/04 specialty costs uplifted for inflation.
3	Area services include chemicals, films, reagents and drugs associated with the services.

Appendix D: Nurse Led Uro-Oncology Review

CRAIGAVON AREA HOSPITAL GROUP TRUST

Caring Through Commitment

Appendix D:
Proposal for the development of Nurse Led Uro-Oncology Review

Draft 5

Directorate of Planning & Contracts
Date: Monday, 14 March 2005
Author: Anne Brennan

Proposal for the development of Nurse Led Uro-Oncology Review

Surgical Directorate

1.0 Introduction

This paper details the proposed organisation and planned activity associated with the development of Nurse Led Uro-Oncology Review at Craigavon Area Hospital Group Trust.

2.0 Background

In Western men, cancer of the prostate is responsible for 20% of all malignancies, and after cancer of the lung, is the second leading cause of death (Coptcoat 1996) Prostate cancer is now the most common neoplasm in men in the Western world. It has been estimated that, in most Western countries, the lifetime risk of developing microscopic prostate cancer is approximately 30%. However, as many of these cancers are slow growing, the risk of developing clinical disease is about 10%; and the lifetime risk of dying from prostate cancer is approximately 3%.

3.0 Key Issues

- The incidence and death rate from prostate cancer is set to rise due to an increasing aging population, and the fact that the disease affects men of 50 years and over. It has been suggested that prostate cancer is an “epidemic in waiting” [Kirby, Osterling, and Denis 1996].
- Approximately 9500 men die from prostate cancer in the United Kingdom each year while 18000 new cases are registered. [Cancer Research Campaign 1998]
- As 80% of prostate cancers can be very slow growing, and patients often have to make life-changing decisions concerning their treatment, provision is made within the waiting times system so that patients are not forced to take decisions they are not ready to make too quickly. This provision, primarily about patient choice, is also there for all cancers. [Making Progress on Prostate Cancer – NHS Nov 2004]
- 5 Year survival prostate rates improved from around 42% in the late 1980’s to 68% in the late 1990’s.

4.0 CAH Uro-Oncology Key Issues

- CAH Service is provided via a combination of outpatient visits, extra out of hours visits with consultants and ad-hoc clinics. There is no dedicated clinic at this time
- The recently conducted Urology Review estimated 150 cases of prostatic cancer and 60 cases of bladder cancer per annum for CAH
- The Urology Review also estimates that approximately 600 patients per annum would require some form of prostate investigation
- Research has demonstrated that these figures will rise as the population age profile of men within the SHSSB rise
- Often provide end stage palliative care for patients
- Increased life expectancy has resulting in a growing cohort of 'stable' patients who require ongoing specialist care. [Making Progress on Prostate Cancer – NHS Nov 2004]
- Current new:review ratio is 1:9, BAUS recommends 1:2 [with junior doctor support]
- Reviews totalled 3,800 in 2003/2004 with a 1:7 new: review ratio and YTD 2004/2005 [excluding ACH are 2,725 with a new:review ratio of 1:9
- Reviews are generated not only through outpatients but also through emergency admissions, intra hospital transfers and inter hospital transfers
- Current new: review ratio having negative impact on ability to see new patients
- There are no other safe channels for review other than referral back to GP under current conditions, this is not always possible/feasible due to complexity of casemix/age profiles etc
- As the number of new referrals and emergency admissions continues to increase, the general urology clinic had become over whelmed. This has resulted in increasing difficulties in reviewing patients, in a timely manner and in order to address this a reduction in new patient slots had taken place.

5.0. Key Recommendations relevant to the establishment of Nurse Led Uro-Oncology Review

5.1 NICE Improving Outcomes in Urological Cancers

- All patients with urological cancers should be managed by multidisciplinary urological cancer teams. These teams should function in the context of dedicated specialist services, with working arrangements

and protocols agreed throughout each cancer network. Patients should be specifically assured of:

- Streamlined services, designed to minimise delays;
- Balanced information about management options for their condition;
- Improved management for progressive and recurrent disease.
- Members of urological cancer teams should have specialised skills appropriate for their roles at each level of the service. Within each network, multidisciplinary teams should be formed in local hospitals (cancer units); at cancer centres, with the possibility in larger networks of additional specialist, teams serving populations of at least one million; and at supra network level
- Major improvements are required in information and support services for patients and carers. Nurse specialist members of urological cancer teams will have key roles in these ser vices.

5.2 Cancer Services Collaborative (CSC) – Improvement Partnership

The CSC has provided support in the redesign of the prostate cancer patient's journey, through reducing the journey time from referral from a GP to treatment. Specifically:

- There has been an increase in the number of rapid assessment clinics, reducing the number of visits to diagnosis and shortening this part of the patient's journey.
- There are more non-medical staff undertaking Trans Rectal Ultrasound (TRUS) and biopsy procedures which have had a significant impact on waiting times to diagnosis.
- Work continues with CSC primary care national teams to ensure that the right patients are referred through the urgent route and that patients are counselled appropriately prior to PSA testing using the DH support pack.
- There are a number of services being set up to redesign after care, including nurse led follow up either in a clinic or by telephone following treatment, and nurse led PSA surveillance.

5.3 Making progress on information for prostate Cancer Patients

Almost all men with prostate cancer want information about their condition, possible treatments and services and the support which is available to help them lead as normal a life as possible. However, different men will want to access information in different ways and at different levels of detail. The challenge, therefore, is to ensure that reliable information is easily available to men in a format that meets their needs.

Informed decision making

There has been rising interest in the use of decision support systems for patients in the UK over the past 5 years.

Assessment of informed decision making research concluded there was ‘a paucity of well designed, theoretically driven and adequately operationalised research assessing informed decision making’.

That year Professor Angela Coulter, writing in the British Medical Journal, called for a national strategy for evidence based information after the national survey of patients in the NHS demonstrated patients feel they are not sufficiently included in decision-making

By 2002 “Learning from Bristol” advocated that the patient should be at the centre of the NHS and “improve quality, reliability and the range of information which supports decision-making.”.A sub-group of the Prostate Cancer Advisory Group (PCAG) was formed to look at information for prostate cancer patients. The group quickly decided that the most difference could be made by developing a decision making aid formen diagnosed with localised prostate cancer. At the same time, the Modernisation Agency’s Action-On Urology Programme was in discussion with the Foundation for Informed Decision Making with a view to acting as a test bed for the use of US materials in this country. To combine their efforts,

Action on Urology and PCAG decided to hold a joint workshop on decision support aids in London on 12th May 2004.

Dr Chris Parker, Senior Lecturer and Honorary Consultant in Clinical Oncology at the Institute of Cancer Research and Royal Marsden Hospital, and chair of the PCAG working group on information for patients, chaired the workshop. The workshop was attended by a wide range of interested parties, including patients, the voluntary sector, professional groups, clinicians, the NHS and the Department of Health.

Action on Urology: Informed Decision Making in Urology Project

A patient centred NHS with a strong emphasis upon patient choice relies upon patients and professionals being equipped both with good information and an understanding of process involved in making complex decisions.

There is considerable high quality research evidence that the use of properlydesigned and structured decision aids and the use of trained nurse coaches brings a number of significant benefits. It has been shown that they lead tobetter quality decisions by patients about their treatment and better use of resources by medical providers. This project will evaluate their use in the urology departments of 6 hospitals in England and will report the outcome to the NHS in 2005.

6.0 Proposed Organisation:

6.1 Proposed Concept:

The follow-up of patients treated for prostate cancer has a significant impact on the workload of the Urology department. The introduction of nurse-led clinics offers the department a highly satisfactory and efficient method of follow-up.

6.2 Methodology

There is currently a trend within urological medicine to develop nurse led services, particularly within the field of prostate health (Holland 1996). The specialist nurse can be viewed as a catalyst for change, a reflective practitioner using science based theory, entwined with sound clinical judgment, intuitive knowledge from experiential learning, adding that something special to the equation, the non measurable caring approach (Gavin 1994 1995).

The follow-up of patients with locally advanced, or metastatic disease, is basically palliative care. Cancer of the prostate can be particularly challenging. Bone pain is very common, and in the late stages can prove difficult to control, however disease progression can be slow, with the late involvement of vital organs. The management of prostate cancer therefore needs the skills of a variety of professionals, the relative importance of whose roles changes over the course of the illness (Tookman and Kurowska1999).

6.3 Proposed Service Delivery:

- The establishment of an Uro-Oncology Nurse Led Review service to provide a review for all oncology patients.
- The clinic will take referrals from the Urology Consultants and Junior Staff who will may have seen the patient in the general urology outpatient clinic/ ward and also the Nurse Led Prostatic Assessment Clinic/TRUS Biopsy Review Clinic.
- The clinic will be held weekly, catering for 8 patients and will be run concurrently with the General Urology Outpatients. Patients will be reviewed on a 6 monthly basis, unless their need changes or the doctors requests a variable review date.
- All patients will be given a contact number for the urology nurses, should they require communications between the allocated review times.
- Patients will be allocated a 20-minute consultation, which will be arranged, via a new PAS template. If a patient requires further consultation/time this can be arranged separately with the Nurse Specialist outside of clinic time.
- The urology nurse will be able to refer to other disciplines, eg AHP's

6.4 Proposed Location

The clinic will be held in the Outpatients Department in Craigavon Area Hospital and Armagh Community Hospital on a rotational basis.

Thursday PM	Nurse Led General Review [Alternate weeks] 1st/3rd BBPC]	Nurse Led Uro-Oncology Review [alternate weeks] [2nd/4th Thursday]
Friday PM	Nurse Led General Review [Alternate weeks] CAH, Outpatients Department [2nd/4th CAH]	Nurse Led Uro-Oncology Review [alternate weeks] CAH, Outpatients Department [1st/3rd]

7.0 Patient Pathway at Review Clinic

- The patients will be assessed on their general well being, including bowel habits, mobility and appetite.
- The patients will be questioned on their lower urinary tract status, and can be further assessed, in the Prostate Assessment clinic, should their condition dictate this.
- The patients will be questioned re. their compliance to treatment, and any new issues or worries they have.
- A P.S.A. blood test will be done on every patient routinely. The nurse may also assess the general appearance of the patient, and can order further blood tests, as the condition dictates. E.g. F.B.C. / Renal Profile.
- If the general condition of the patient necessitates, then the urologist will be available to discuss the case with the nurse, and appropriate action taken regarding further investigation and/or urologist review.
- Following assessment, the case notes will be appropriately dated, and communications documented in legible handwriting. The entry will be signed, and the name and designation of the nurse printed.
- A dictated letter will also be done at this time, to communicate information to the GP
- A further follow-up appointment will be made.

8.0 Audit/Performance Indicators

All patients completed a questionnaire assessing satisfaction in the following categories:

- waiting times;
- information given to patients regarding PSA results, their implications and further follow up;
- level of service received.

9.0 Resource Requirements

9.1 Staffing:

Staff	Post/Grade	WTE
Urology Nurse Specialist	Grade H	0.20
Secretarial Support	Grade III	0.08
Outpatients Nursing		From Existing Outpatient Resources
Health Records	Grade II	0.07
Portering	Grade II	0.012
Laboratory	BMS 1	0.03

9.2 Financial Implications:

CAHGT - Financial Planning
Nurse Led Uro-Oncology Review
31 March 2005

			Notes	Assumptions
NON-RECURRING CAPITAL COSTS		**FYE £**		
TOTAL NON-RECURRING CAPITAL COSTS		**0**		
RECURRING REVENUE COSTS				1
PAYROLL COSTS				
	WTE			
Nursing staff				
Nursing Grade H	0.20	6,968		
Sub-total	0.20	6,968		
Clerical				
Grade 3 secretarial support	0.08	1,235		
Grade 2 health records	0.07	974		
Sub-total	0.15	2,209		
Laboratories				
BMS 1	0.03	559		
	0.03	559		
Portering				
Grade 2 porter	0.01	159		
Sub-total	0.01	159		
Total Recurring Payroll	**0.39**	**9,895**		
GOODS AND SERVICES				2
		Outpatients £	1, 2	
Area services (pharmacy, radiography, labs)		1,960		3
General/stationery/postage/telephone		23		
Portering		30		
		2,013		
Travelling/training/uniforms		1,979		
Total recurring goods & services		**3,992**		
TOTAL RECURRING REVENUE COSTS		**13,887**		
TOTAL NON-RECURRING & RECURRING COSTS		**13,887**		

CAHGT - Financial Planning
Nurse Led Uro-Oncology Review
31 March 2005

Notes	Detail
1	Projected throughput estimated at 8 patients on 1 weekly session (for 46 weeks), as per section 6.3.
2	Marginal/variable cost per case extracted from 2003/04 specialty costs, uplifted by 2.5% for inflation.

CAHGT - Financial Planning
Nurse Led Uro-Oncology Review
31 March 2005

Assumptions	Detail
1	Payroll is costed at mid point using the 2004/05 pay rates (excluding the impact of agenda for change and the new consultants' contract).
2	Goods & services specialty costs comprise the 2003/04 specialty costs uplifted for inflation.
3	Area services include chemicals, films, reagents and drugs associated with the services.

Appendix E: Nurse Led LUTS Waiting List

CRAIGAVON AREA HOSPITAL GROUP TRUST

Caring Through Commitment

Appendix E:
Proposal for the Nurse Led LUTS Waiting List Assessment & Review Service

Draft 6

Directorate of Planning & Contracts
Date: Tuesday, 05 April 2005
Author: Keith Bailey

Proposal for the Nurse Led LUTS Waiting List Assessment & Review Service

Surgical Directorate

1.0 Introduction

This current paper details the proposed organisation and planned activity associated with the establishment of a Nurse-Led Lower Urinary Tract Symptoms Waiting List Assessment & Review Service at Craigavon Area Hospital

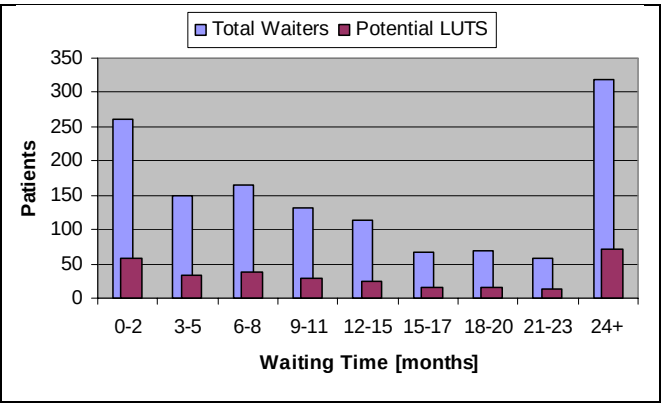
2.0 Background

The current waiting list length for patients referred with LUTS symptoms is in excess of 1300 patients. Approximately 70% of these patients have been waiting longer than 6 months for their first appointment. Those waiting for over 24 months comprise 24% of the waiting list. This volume of backlog has two key impacts: draft PfA targets are unlikely to be met in the coming year and critically, an increasing number of long waiters are converting to emergency admission cases.

The ability to reduce and clear this waiting list is hindered by the growing proportion of new referrals (and indeed emergency cases) presenting and the associated reviews required subsequent to first consultation. This situation is likely to become more problematic when considering the ageing population and the boom in the pensionable age group (+30,000 across Northern Ireland by 2010[1])

Applying an estimate based on Armagh GP referral patterns suggests that approximately one third of these waiting patients may have LUTS/Prostatic symptoms. Furthermore two thirds of that group would be assumed to have symptoms requiring a LUTS oriented consultation. This paper is based on the assumption, therefore, that approximately 300 patients on the waiting list will require a LUTS oriented first appointment session. The relevant data is tabulated and chart below:

Months	Total Waiters	Potential LUTS	% Waiting
0-2	260	58	100%
3-5	149	33	80%
6-8	166	37	69%
9-11	132	29	57%
12-15	113	25	47%
15-17	67	15	38%
18-20	68	15	33%
21-23	58	13	28%
24+	318	71	24%
Totals	1331	296	0%



[1] A Healthier Future: A Twenty Year Vision for Health & Wellbeing in Northern Ireland 2005 – 2025, DHSSPSNI, Jan 2005

3.0 Current Patient Pathway

Historically patients referred to the service with LUTS Symptoms are dealt with through the normal outpatient channels. There is currently no dedicated patient pathway for this group of patients.

4.0 Proposed Organisation

The organisation of a dedicated nurse-led waiting list assessment and review clinic would be aligned with that proposed for the new referral assessment and follow-up clinical sessions. The Craigavon Area Hospital LUTS waiting list service would therefore include:

- Review of referral by Consultant/Nurse Specialist and identification of clinical pathway to Nurse Led LUTS Service.
- Letter from LUTS service to patient with appropriate educational literature
- LUTS assessment inclusive of:
    - Patient history
    - International Prostate Symptom Score (IPSS) [men only]
    - Standardised physical examination including genitalia and possibly digital rectal examination [DRE] [The inclusion of the DRE is still under discussion]
    - Clinical tests [if not already done or requiring repeating] including urinalysis, urinary flow rate, post micturation residual, blood analysis of serum urea and creatinine [U&E] and prostate specific antigen [PSA]
    - Ultrasound of Bladder for residual Urine [Nurse]
    - Ultrasound Scanning of Kidney [Radiographer]

The following investigations may also be undertaken/arranged as relevant to the individual patient. It is estimated that ¼ of patients will require further investigations:

- Urine cytology
- Further Upper tract imaging
- Urodynamic pressure/flow studies
- Midstream sample of urine [MSU]
- Flexible cystoscopy
- Referral for Transrectal ultrasound [TRUS] and prostate biopsies

5.0 Proposed Workload

5.1 Initial Assessment:

Initial suggestions on this matter are in agreement with the practice at Belfast City Hospital [BCH] with 45 minutes being suggested as the minimum necessary for initial assessment of new patients presenting with LUTS.

It is suggested that approximately 4 new patients would be suitable per session. If the service was operational with 1 dedication session per week and on the basis of a 46 week year the annual number seen might approximate 184 new patient referrals per annum.

5.2 Waiting List Clearance:

It is estimated that the current waiting list for initial LUTS assessment would be cleared after 18 months of operation at the above level of activity.

5.3 Follow up Review:

Patients who require review should be seen at a separate and dedicated nurse led service that does not confuse the complex issues of initial assessment and ongoing review. Based on estimated 1:1 new-to-review ratio, it is proposed to establish a single, dedicated session per week for follow up assessment which therefore deals with 8 patients each session (again 368 patients per year). Depending on the outcome of this follow-up assessment patients will be:

- Referred back to their GP for treatment and review of prostatic enlargement via agreed treatment regime and re-referral to LUTS service within agreed parameters.
- Referred from the LUTS service to inpatient admission under the care of a urologist for agreed procedures such as TRUS guided biopsy of prostate
- Referral to urologist for further investigation for presenting symptoms that fall outside working protocol.

5.4 Projected Throughput

	New [per week]	Review [per week]	Total [per annum]
Nurse Led LUTS Waiting List Assessment Clinic (1)	4	0	184
Nurse Led LUTS Waiting List Review Clinic (1)		8	368

* [based on 46 weeks per annum]

5.5 Weekly Timetable:

Clinic Description	Estimated Workload	Staff Involved	Location & Time	Referral Pt
Nurse Led LUTS Waiting List Assessment Clinic	4 New Patients	Nurse Specialist, Nursing Auxiliary, Clerical Staffing, Radiographer	Stone Treatment Centre Thursday AM	• Urology Outpatients Waiting List
Nurse Led LUTS Waiting List Review Clinic	8 Review Patients	Nurse Specialist, Nursing Auxiliary, Clerical Staffing	Stone Treatment Centre Friday AM	• Nurse Led LUTS Waiting List Assessment Clinic

6.0 Resource Requirements

6.1 Nursing:

6.1.1 Nurse Specialist

It is suggested that the hallmarks of the service must be availability and excellence of patient experience and outcome and these can only be met with adequate staffing provision. Nursing input for the service must be provided at a level of expertise that allows full understanding of the issues involved and that can support the degree of clinical decision-making that is necessary. For this reason it is proposed that the nurse providing the service will be at least at Practitioner level and graded at Grade H.

It is proposed to appoint a doctor supported 1.0 WTE Grade H nurse who will be dedicated to the delivery of this LUTS waiting list service for Craigavon Area Hospital Group Trust. It is envisaged that this post holder will, additionally, retain total operational responsibility for the efficient operation of the following:

- Nurse led LUTS assessment & review service [Appendix A]

It is also anticipated that while full participating in the Urology Multidisciplinary team this postholder will develop the Urology Nurse Led Review clinic [Appendix C]. This clinic would enable stable review patients to be removed from the standard Urology Outpatients setting without compromising their care enabling a higher proportion of new patients to be seen. [Nursing Job Plans Appendix G]

Nursing Auxiliary

The nurse specialist providing the service will require the support of a nursing auxiliary (Grade A) to administrate the patient flow and practical management of the patients attending the services and to ensure that issues such as bladder filling were carried out. It is anticipated that post could be shared with the Prostatic Clinics

6.2 Clerical Support:

Appropriate secretarial support is also required to deal with reception duties, patient registration, appointment scheduling and patient correspondence. Health records staff would also be required.

6.3 Radiology Support:

In order to facilitate Ultrasound scanning Radiographer & Consultant Radiologist support would also be required for the assessment session. It is anticipated that this post holder could also be shared across the LUTS and Prostatic Diagnostic waiting list clinics.

6.4 Computer Storage and Management

Computer storage and management is deemed important. Programs are available to collate the clinical variables, process the ultrasound scanned images and the flow rate graphs. This can present a statement for the notes, the GP and is important for audit purposes. Some systems being developed also have an integrated biochemistry testing kit for PSA and urinalysis.

6.5 Location:

The Stone Treatment Centre has been identified as the most suitable location for all proposed Nurse led LUTS/Prostatic waiting list assessment and review clinics. This location provides adequate toilet facilities for urinalysis, flow rate assessment and a waiting area for questionnaire completion and hydration with fluids for repeated flow rate tests.

7.0 Resource Requirements

7.1 Staffing:

Staff	Post/Grade	WTE
Urology Nurse Specialist	Grade H	0.25
Nursing Auxiliary	Grade A	0.125
Clerical Officer	Grade III	0.12
Health Records	Grade II	0.10
Radiographer	Senior 1 Sonographer	0.125
Clerical Support Radiology	Grade II	0.062
Portering	Grade II	0.017
Cleaning		0.025
Consultant Radiologist		From Existing Resources
Laboratory	BMS 1	0.03

7.2 Equipment:

Costs for equipment (urinary flow meter, IT and furniture requirements) have been wholly included under the proposals for the nurse led LUTS and Prostatic assessment clinics.

7.3 Financial Implications:

CAHGT - Financial Planning
Nurse Led LUTS Waiting List Assessment & Review Service
31 March 2005

			Notes	Assumptions
NON-RECURRING CAPITAL COSTS		**FYE £**		
TOTAL NON-RECURRING CAPITAL COSTS		**0**		
NON-RECURRING REVENUE COSTS				
PAYROLL COSTS	**WTE**			
Nursing staff				
Nursing Grade A	0.13	1,693		
Sub-total	0.13	1,693		
Radiology				
Senior I radiographer	0.13	3,931		
	0.13	3,931		
Clerical				
Grade 2 radiology clerical support	0.06	863		
Sub-total	0.06	863		
Portering				
Grade 2 porter	0.02	225		
Sub-total	0.02	225		
Total Recurring Payroll	**0.33**	**6,711**		
GOODS AND SERVICES				2
		Outpatients £	1, 2	
Area services (pharmacy, radiography, labs)		7,720		3
Medical & surgical/general disposables/sterile disp		1,670		
General/stationery/postage/telephone		1,958		
Portering		46		
Domestic services - cleaning		366	3	
		11,760		
Travelling/training/uniforms		1,342		
Total goods & services		**13,102**		
TOTAL NON-RECURRING REVENUE COSTS		**19,813**		
TOTAL NON-RECURRING COSTS		**19,813**		
RECURRING REVENUE COSTS				1
PAYROLL COSTS	**WTE**			
Nursing staff				
Nursing Grade H	0.30	10,453		
Sub-total	0.30	10,453		
Clerical				
Grade 3 secretarial support	0.12	1,853		
Grade 2 health records	0.10	1,391		
Sub-total	0.22	3,244		
Laboratories				
BMS 1	0.03	8,378		
	0.03	8,378		
Total Recurring Payroll	**0.55**	**22,075**		
GOODS AND SERVICES				2
Travelling/training/uniforms		4,415		
Total recurring goods & services		**4,415**		
TOTAL RECURRING REVENUE COSTS		**26,489**		
TOTAL NON-RECURRING & RECURRING COSTS		**46,303**		

CAHGT - Financial Planning
Nurse Led LUTS Waiting List Assessment & Review Service
31 March 2005

Notes	Detail
1	See section 5.4 for details of projected throughput.
2	Marginal/variable cost per case extracted from 2003/04 specialty costs, uplifted by 2.5% for inflation.
3	Cleaning services provided by an external company. Hourly cost provided by the contracts services coordinator.

CAHGT - Financial Planning
Nurse Led LUTS Waiting List Assessment & Review Service
31 March 2005

Assumptions	Detail
1	Payroll is costed at mid point using the 2004/05 pay rates (excluding the impact of agenda for change and the new consultants' contract).
2	Goods & services specialty costs comprise the 2003/04 specialty costs uplifted for inflation.
3	Area services include chemicals, films, reagents and drugs associated with the services.

8.0 Conclusion

The development of a dedicated nurse-led LUTS Waiting List Assessment and Review clinic is an effective means of addressing the current Urology waiting list. On the basis of current patient patterns it is expected that those waiting their initial LUTS oriented assessment will be seen within 18 months of commencement of this service.

The revenue costs to establish this clinic are:

Appendix F: Nurse Led Prostatic Assessment & Follow Up [Waiting List]

CRAIGAVON AREA HOSPITAL GROUP TRUST

Caring Through Commitment

Appendix F:
Proposal for the Nurse Led Prostatic Assessment & Review & TRUS Biopsy Waiting List Initiative

Draft 6

Directorate of Planning & Contracts
Date: Tuesday, 05 April 2005
Author: Keith Bailey

Proposal for the Nurse Led Prostatic Waiting List Assessment & Review & TRUS Biopsy Waiting List Initiative

Surgical Directorate

1.0 Introduction

This current paper details the proposed organisation and planned activity associated with the establishment of a Nurse-Led Prostatic Assessment & Review and TRUS Biopsy Waiting List Initiative at Craigavon Area Hospital dedicated to the initial assessment (and clearance) of patients on the current Urology waiting list with Prostatic symptoms.

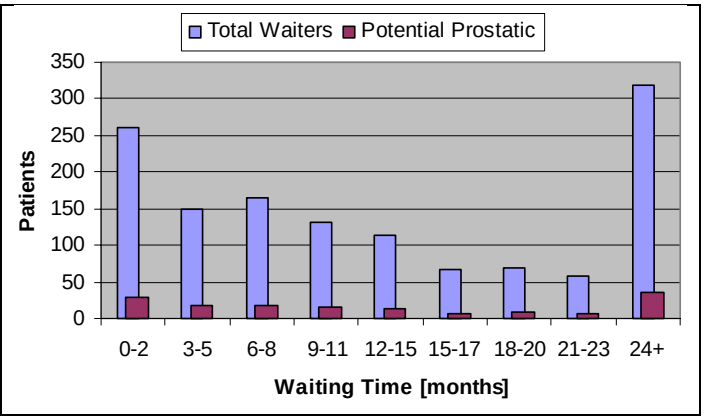
2.0 Background & Demand

The current waiting list length for patients referred with LUTS/Prostatic like symptoms is in excess of 1300 patients. Approximately 70% of these patients have been waiting longer than 6 months for their first appointment. Those waiting for over 24 months comprise 24% of the waiting list. This volume of backlog has two key impacts: (draft) PfA targets are unlikely to be met in the coming year and critically, an increasing number of long waiters are converting to emergency admission cases.

The ability to reduce and clear this waiting list is hindered by the growing proportion of new referrals (and indeed emergency cases) presenting and the associated reviews required subsequent to first consultation. This situation is likely to become more problematic when considering the ageing population and the boom in the pensionable age group (+30,000 across Northern Ireland by 2010[1])

Applying an estimate based on Armagh GP referral patterns suggests that approximately one third of these waiting patients may have LUTS/Prostatic symptoms. Furthermore one third of that group would be assumed to have symptoms requiring a Prostatic oriented consultation. This paper is based on the assumption, therefore, that approximately 150 patients on the waiting list will require a Prostatic oriented first appointment session. The relevant data is tabulated and chart below:

Months	Total Waiters	Potential LUTS	% Waiting
0-2	260	29	100%
3-5	149	17	80%
6-8	166	18	69%
9-11	132	15	57%
12-15	113	13	47%
15-17	67	7	38%
18-20	68	8	33%
21-23	58	6	28%
24+	318	35	24%
Totals	1331	148	0%



[1] A Healthier Future: A Twenty Year Vision for Health & Wellbeing in Northern Ireland 2005 – 2025, DHSSPSNI, Jan 2005

3.0 Current Patient Pathway

There is currently no dedicated patient pathway for this group of patients. Currently in Craigavon Area Hospital patients with prostatic related complaints are referred by GPs to general urology outpatients and commonly placed on a waiting list for initial assessment. In some instances the consultant may arrange a number of diagnostic tests to be conducted in advance of the outpatient clinic attendance. Subsequently for designated patients a TRUS Biopsy will be arranged, these are currently conducted in the Radiology department. Patients are then required to re-attend to the ward for results of same. Depending on the outcome of the biopsy/diagnostics patients are divided into 2 categories:

3.1 Malignant

These patients follow a clinical management pathway which may involve, surgery, radiotherapy, hormonal therapy or a combination of these.

3.2 Inconclusive/Non Malignant

Typically these patients are either referred back to their GPs with advice on on-going management, or are reviewed periodically at the Urology outpatient clinics.

4.0 Proposed Organisation

4.1 Nurse Led – Doctor Supported Waiting List Symptom clinic with non-invasive assessment.

The Nurse led Doctor supported symptom clinic component requires a separate waiting area conducive with relaxation and fluid intake, a consultation room and toilet facilities for flow rate. This service will be designed to determine the need for further investigation of both prostate symptoms and the requirement for a TRUS biopsy.

The clinic would typically involve the following:

- history taking
- questionnaire explanation and subsequent evaluation
- blood and urine testing
- urinary flow rate assessment and ultrasound scanning for bladder volumes (where required)
- urinary tract ultrasound imaging (where required) [to be undertaken by Radiographer, with results interpreted by Consultant Radiologist]
- patient counselling

- Transrectal ultrasound scanning (TRUS), urodynamics and flexible cystoscopies to be performed on a separate occasion.

5.0 Proposed Workload

5.1 Initial Assessment:

Initial suggestions on this matter are in agreement with the practice at Belfast City Hospital [BCH] with 45 minutes being suggested as the minimum necessary for initial assessment of new patients presenting with Prostatic symptoms.

It is suggested that approximately 4 new patients would be suitable per session. If the service was operational with 1 dedicated session per week and on the basis of a 46 week year the annual number seen might approximate 184 patients from waiting list per annum.

5.2 Waiting List Clearance:

It is estimated that the current waiting list for initial prostatic assessment would be cleared after 9 months of operation at the above level of activity.

5.3 Follow up Review:

Patients who have only prostate symptoms and no diagnosis of cancer will be referred to the LUTS service. Patients with cancer will require ongoing investigation and counselling and it is proposed that this service will facilitate this time consuming, but essential, element of the patient's care. This review should be conducted in a separate and dedicated nurse led session that does not confuse the complex issues of initial assessment and ongoing review. Based on estimated 1:1 new-to-review ratio, it is proposed to establish a single, dedicated session per week for follow up assessment which therefore deals with 4 patients each session (again 184 patients per year).

5.4 TRUS Biopsy

Having considered fully the requirement for TRUS Biopsy for the majority of these patients, it is proposed to establish a complementary TRUS Biopsy Waiting List Initiative Clinic to support the Nurse Led Assessment Initiative. Failure to do so would result in the flooding of the Monday AM TRUS Clinic and the creation of a waiting list. This complementary clinic will ensure equity of access for both new referrals and those patients on the waiting lists.

5.5 Projected Throughput

	New	Review	Total
Nurse Led Prostatic Waiting List Assessment Clinic	4	0	145
TRUS Biopsy Initiative	4		145
Nurse Led Prostatic Waiting List Review Clinic		4	145

* [based on 9 months estimate]]

5.6 Weekly Timetable:

Clinic Description	Estimated Workload	Staff Involved	Location & Time	Referral Pt
Nurse Led Prostatic Waiting List Assessment Clinic	4 New Patients	Nurse Specialist, Nursing Auxiliary, Clerical Staffing, Radiographer	Stone Treatment Centre Thursday AM	• Urology Outpatients Waiting List
Nurse Led Prostatic Waiting List Review Clinic	4 Review Patients	Nurse Specialist, Nursing Auxiliary, Clerical Staffing	Stone Treatment Centre Friday AM	• Nurse Led Prostatic Waiting List Assessment Clinic
TRUS Biopsy Clinic	4 New Patients	Consultant Radiologist	To be Confirmed	• Nurse Led Prostatic WL assessment clinic

6.0 Resource Requirements

6.1 Nursing:

6.1.1 Nurse Specialist

It is suggested that the hallmarks of the service must be availability and excellence of patient experience and outcome and these can only be met with adequate staffing provision. Nursing input for the service must be provided at a level of expertise that allows full understanding of the issues involved and that can support the degree of clinical decision-making that is necessary. For this reason it is proposed that the nurse providing the service will be at least at Practitioner level and graded at Grade H.

It is proposed to appoint a doctor supported 1.0 WTE Grade H nurse who will be dedicated to the delivery of this Prostatic waiting list service for Craigavon Area Hospital Group Trust. It is envisaged that this post holder will, additionally, retain responsibility for the efficient operation of the following:

- TRUS Biopsy and Review Clinics

And total operational responsibility for:

- Nurse Led – Doctor Supported Symptom clinic with non-invasive assessment.
- Nurse Led Prostatic Assessment Review Service

It is planned that this post holder will also develop a counselling service when prostate cancer is either suspected or confirmed, these sessions may have to be accommodated outside the timeframe of the clinics outlined above, and ultimately develop agreed protocols to develop the concept of Urological Oncology Nurse Led Review clinic.

6.1.2 Nursing Auxiliary

The nurse specialist providing the service will require the support of a nursing auxiliary (Grade A) to administrate the patient flow and practical management of the patients

attending the services and to ensure that issues such as bladder filling were carried out. It is anticipated that post could be shared with the LUTS Clinics

6.2 Clerical Support:

Appropriate secretarial support is also required to deal with reception duties, patient registration, appointment scheduling and patient correspondence. Health records staff would also be required.

6.3 Radiology Support:

In order to facilitate Ultrasound scanning Radiographer & Consultant Radiologist support would also be required for the assessment session. It is anticipated that this post holder could also be shared across the LUTS and Prostatic Diagnostic clinics.

6.4 Computer Storage and Management

Computer storage and management is deemed important. Programs are available to collate the clinical variables, process the ultrasound scanned images and the flow rate graphs. This can present a statement for the notes, the GP and is important for audit purposes. Some systems being developed also have an integrated biochemistry testing kit for PSA and urinalysis.

6.5 Location:

The Stone Treatment Centre has been identified as the most suitable location for all proposed Nurse led LUTS/Prostatic waiting list assessment and review clinics. This location provides adequate toilet facilities for urinalysis, flow rate assessment and a waiting area for questionnaire completion and hydration with fluids for repeated flow rate tests.

7.0 Resource Requirements

7.1 Staffing:

Staff	Post/Grade	WTE
Urology Nurse Specialist	Grade H	0.25
Nurse Auxiliary	Grade A	0.125
Clerical Officer	Grade III	0.12
Health Records	Grade II	0.10
Radiographer	Senior 1 Sonographer	0.125
Clerical Radiology	Grade II	0.062
Portering		0.017
Cleaning		0.025
Consultant Radiologist		1 session per week
Laboratory	BMS 1	0.03

7.2 Equipment:

Costs for equipment (urinary flow meter, IT and furniture requirements) have been wholly included under the proposals for the nurse led LUTS and Prostatic assessment clinics.

7.3 Financial Implications:

CAHGT - Financial Planning
Nurse Led Prostatic Assessment & Review & TRUS Biopsy Waiting List Initiative
31 March 2005

			Notes	Assumptions
NON-RECURRING CAPITAL COSTS		**FYE £**		
TOTAL NON-RECURRING CAPITAL COSTS		**0**		
NON-RECURRING REVENUE COSTS				1
PAYROLL COSTS				
	WTE			
Nursing staff				
Nursing Grade A	0.13	1,693		
Sub-total	0.13	1,693		
Radiology				
Consultant radiologist	0.09	6,896		
Senior I radiographer	0.13	3,931		
	0.22	10,827		
Clerical				
Grade 2 radiology clerical support	0.06	863		
Sub-total	0.06	863		
Portering				
Grade 2 porter	0.02	225		
Sub-total	0.02	225		
Total Payroll	**0.42**	**13,607**		
GOODS AND SERVICES				2
		Outpatients £	1, 2	
Area services (pharmacy, radiography, labs)		6,084		3
Medical & surgical/general disposables/sterile disp		1,316		
General/stationery/postage/telephone		1,543		
Portering		36		
Domestic services - cleaning		366	3	
		9,345		
Travelling/training/uniforms		2,721		
Total goods & services		**12,066**		
TOTAL NON-RECURRING REVENUE COSTS		**25,673**		
TOTAL NON-RECURRING COSTS		**25,673**		

RECURRING REVENUE COSTS			1
PAYROLL COSTS			
	WTE		
Nursing staff			
Nursing Grade H	0.25	8,711	
Sub-total	0.25	8,711	
Laboratories			
BMS 1	0.03	698	
	0.03	698	
Clerical			
Grade 3 secretarial support	0.12	1,853	
Grade 2 health records	0.10	1,391	
Sub-total	0.22	3,244	
Total Payroll	**0.50**	**12,653**	
GOODS AND SERVICES			2
Travelling/training/uniforms		2,531	
Total recurring goods & services		**2,531**	
TOTAL RECURRING REVENUE COSTS		**15,183**	
TOTAL NON-RECURRING & RECURRING COSTS		**40,857**	

CAHGT - Financial Planning
Nurse Led Prostatic Assessment & Review & TRUS Biopsy Waiting List Initiative
31 March 2005

Notes	Detail
1	See section 5.5 for details of projected throughput.
2	Marginal/variable cost per case extracted from 2003/04 specialty costs, uplifted by 2.5% for inflation.
3	Cleaning services provided by an external company. Hourly cost provided by the contracts services coordinator.

CAHGT - Financial Planning
Nurse Led Prostatic Assessment & Review & TRUS Biopsy Waiting List Initiative
31 March 2005

Assumptions	Detail
1	Payroll is costed at mid point using the 2004/05 pay rates (excluding the impact of agenda for change and the new consultants' contract).
2	Goods & services specialty costs comprise the 2003/04 specialty costs uplifted for inflation.
3	Area services include chemicals, films, reagents and drugs associated with the services.

8.0 Conclusion

The development of a dedicated nurse-led Prostatic Assessment and Review clinic is an effective means of addressing the current Urology waiting list. On the basis of current patient patterns it is expected that those waiting their initial Prostatic oriented assessment will be seen within 9 months of commencement of this service.

Appendix G: Job Plans for Specialist Nursing Posts

<table>
<tr><th colspan="2">Urology Nurse Specialist 1: Weekly Commitment</th></tr>
<tr><td colspan="2"></td></tr>
<tr><td colspan="2">2.0 Sessions LUTS Assessment</td></tr>
<tr><td colspan="2">1.0 LUTS Review</td></tr>
<tr><td colspan="2">1.0 Administration of LUTS Service / GP Education and Advice</td></tr>
<tr><td colspan="2">1.0 Development of General Urology Nurse Led Review</td></tr>
<tr><td>Year 1</td><td>Year 2</td></tr>
<tr><td>1.0 LUTS Waiting List Assessment

1.0 LUTS Waiting List Review</td><td>1.0 General Urology Review

1.0 LUTS Waiting List Assessment

then

2.0 General Urology Review following clearance of LUTS waiting list migration</td></tr>
<tr><td colspan="2">0.50 Administration of Urology Review Workload</td></tr>
<tr><td colspan="2">2.5 Support Professional Activities [Role development/MDT etc]</td></tr>
</table>

Urology Nurse Specialist No. 2 Weekly Commitment	
1.0 Sessions Prostatic Assessment + TRUS Clinic	
1.0 Prostatic Review of New patients [Histology]	
1.0 Prostatic Review Clinic	
1.0 Administration of Prostatic service / GP Education and Advice	
Year 1	*Year 2*
1.0 Prostatic Assessment Waiting List + 1.0 Prostatic Waiting List Review Clinic	1.0 session Further specialist clinic development such as: * Outreach * Telephone follow up
1.0 Uro-Oncology Review [existing patients, prostatic patients]	2.0 Uro-Oncology Review
0.50 Administration of Uro-Oncology Review / GP Education and Advice	
2.5 Support Professional Activities [Role development/MDT etc]	

20 June 2005

Dear John

I write with reference to the recent urology meeting with the Board. I find it a little disappointing that the only communication I have received from the Executive office with regards to this meeting was a copy of a letter from the Board's Chief Executive, Mr C. Donaghy. There is a distinct impression from the Board's view that the decision to 'reopen' was made in advance of the meeting. I do however appreciate your views and acknowledge your course of action in light of the advice from other outside agencies, albeit that we are all not in complete agreement on the finer points.

As a clinician I find all this very frustrating. Unfortunately there has been a long delay in enacting on our clinical concerns over the years. Indeed to date, there also has been little direct installation of the recommendations of the external urology service review, which was completed almost a year ago. I do not know why these things take so long or why they are not given higher priority, as everyone appears so concerned about equity of service provision within the NHS.

You may be aware that our requirements are ranked in order of priority and need. Although the list is not exhaustive we have not got past the top four requests as yet - especially since the need for these is virtually self-explanatory, we are made to produce lengthy documentation which is extremely time consuming. The Board is fully aware that we laid out a timetable for this work to be carried out and the Trust has only recently defining the finances to put this into action.

I wish to express my deep concern that once this current batch of 'actions to be implemented' are put in place, that this will be all that is done and urology will be put on the 'back boiler' yet again. As pointed out in the external review, we all have signed up to this process. This fact requires to be reinforced to all parties.

At least it does appear that the Board now acknowledges the significant amount of urgent workload that exists and the need to find portals for this to be carried out. Analysis shows that if no more work is added to our waiting list it will take a full year of operating with our current resources to get through this. At our pre-meeting session, I expressed concerns about the length of waiting time our patients have, especially those

with a potential sinister diagnosis. This would certainly be compounded by a full reopening strategy. Since it is the clinicians who have the responsibility of looking after these patients, the addition of even more patients has a major governance issue.

It appears from the discussions at this recent meeting, that the Board and the Trust expect all the referred patients to be added to our waiting list in date order and by priority status, in the full knowledge of the patient's condition. This puts the clinicians in an uncomfortable position both professionally and personally. In full appreciation of the overall urology situation I note your view that referral letters need to be sent to an acute hospital, but given the existing consultant workload that it would not be feasible to expect the current consultant body to undertake this additional work.

Since it appears that the Urology department has indeed reopened, it is therefore necessary to gain reassurance that the Trust and Board is fully responsible for this. It is unclear who is taking charge/responsibility of these patients if it is deemed that the existing consultants can not undertake this additional work. However again by default, this would appear to have fallen on the staff, since these patients will probably be added to the waiting list no matter what their diagnosis is. We have to take a professional view on this according to the GMC by doing what is appropriate and to the best of our ability. This is conflicting with the current reopening strategy.

It is therefore necessary for our unit to have the support and reassurance that the Trust, Board and Health Department take the responsibility for this reopening strategy.

There has also been great emphasis placed on clearing the 'long waiters'. Thankfully the Board now views all urology patients in the same light. In taking this policy line, the Board and Department will somehow have to waive, in some capacity, its need for 'long-waiter' target figures.

The lecture by Dr Connor last week was very interesting. He notes that when capacity is reached then the responsibility of provision falls on the commissioning body. If it has already been defined by the external review process that this unit is performing at twice the level of an equivalent unit in Scotland, then why are we being perceived by others as underachieving?

Despite the fact that over the years we have been asking for all forms of additional staff, it takes a crisis meeting with the Board to come

up with the idea that employing a locum GP will salvage the situation. This will indeed help but I believe it is naïve to think that sorting letters will solve the problem. Letters are not the problem, it is the resultant work generated that is.

In saying all this, there has been a tremendous amount of work and 'theoretical progress' put into the follow-up of the external review (mostly by the Trust). The amount of detail the Board needs is very tedious, despite their Chief Executive's comments on co-operation. It is appreciated that the general lack of investment in urology over the years has brought this to a head. At least this is acknowledged and an attempt to address this is being made. I do however have grave concerns, as noted above, that the points raised in the review and the subsequent list of requirements will not be fully honored by all parties.

I appreciate that the 'urology problem' has been such a difficulty over the years. It is not unique to our hospital as there is a shortage of urology services throughout N.I. We as clinicians have the responsibility of reporting shortfalls in health care. Although this has all resulted in some antagonism over the years, we all do actually have a common goal.

However the situation is easily salvageable by some investment in the service. With so much work and understaffing in the past any achievement whatsoever was lost in the magnitude of the problem. Several years ago we asked and eventually got a urology day list. This has indeed had a major positive impact on our service. Our list of requirements is not actually excessive but it is necessary to listen to the clinicians for future pathways.

I would be grateful if you could take these points into account at future meetings. Finally, I would like to end on a positive note by saying that the Urology Review and its follow-up process has had an immense impact and although this is a struggle we are going to have a service 'second to none'. We do appreciate your input.

M Young MD FRCS(Urol)
Consultant Urologist

cc. C.Humphreys

G676

Decomtamination
6.80 sq m

Treatment Room No. 1
29.60 sq m

Toilet 1

Consultant /
Examination Room 1
16.17 sq m

Store 1
7.60 sq m

Multi-Functional Room 1
11.00 sq m

Treatment Room No. 2
30.00 sq m

Disposal

Changing 2

Toilet 3

Scope

Store 2
5.10 sq m

Consultant /
Examination Room 2
14.34 sq m

Consultant /
Examination Room 3
14.34 sq m

Multi-Functional Room 2
14.34 sq m

Sluice
8.20 sq m

Toilet 2

Changing 1

Consultant /
Examination Room 5
16.93 sq m

Toilet 4

Re-located Blood / Weights
16.79 sq m

Consultant /
Examination Room 4
14.37 sq m

male
G602

female
G603

Controlled Access

Electrics

Disposal
G09

Store
G08

Sisters
Office
G07

Plaster Room
(sound-proof walls)
G10

3 work stations

Reception

Subwaiting
G14

Corridor
G15

A.H.T.
G13

Changing
Room
G12

G11
Uni-Strut ceiling system

Subwaiting
G16

Outcomes
Practitioner
G17

Examination
Room
2
G18

Examination
Room
1
G20

Consultant
Room 1
G19

workroom store
G639

haemotology
G633

sub waiting

haemotology
G634

work room
G636

othoptic
G635

dental office
G637

dental surgery
G638

eye treatment
G642

eye surgery
G640

Ceiling Light well exist. rooflight

prop. rooflight

exist. rooflight

REVISION	DESCRIPTION	INITIALS	DATE
C	Layout revised	JK	25 9 12
B	Layout revised	JK	19 9 12
A	Layout revised	JK	13/9/12

PRELIMINARY

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ARCHITECTS ▪ ENGINEERS

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JOB TITLE
CRAIGAVON AREA HOSPITAL
OUTPATIENTS UROLOGY

CLIENT:
SOUTHERN HEALTH
AND SOCIAL CARE TRUST

DRAWING TITLE
PROPOSED FLOOR PLANS

SCALE	DRAWN BY	CHECKED BY	DATE
1:50@A1	JK	JK	AUGUST 2012

JOB NUMBER	DRAWING NUMBER	REVISION
C3313	A202	C

Year	Non Consultant Funded posts	Non Consultant Posts Occupied with comments (note this does not include Clinical Nurse Specialists)
2009	3	1 Substantive post filled by (Dr Rogers x 7 clinical sessions and Jerome Marley x 2 clinical sessions) 2 vacant Trust Staff Grade Posts
2010	3	1 Substantive post filled by (Dr Rogers x 7 clinical sessions and Jerome Marley x 2 clinical sessions) 2 vacant Trust Staff Grade Posts
2011	3	1 Substantive post filled by (Dr Rogers x 7 clinical sessions and Jerome Marley x 2 clinical sessions) 2 vacant Trust Staff Grade Posts until November 2011 then Dr Sani Aminu commenced
2012	3	1 Substantive post filled by (Dr Rogers x 7 clinical sessions and Jerome Marley x 2 clinical sessions) 1 post filled by Dr Sani Aminu (resigned July 2012) Dr Hirron Fernando took up locum post October 2012 Dr Maurice Fernando commenced November 2012 J Marley stopped providing clinical sessions in December 2012
2013	3	Dr H Fernando Personal Information redacted by the USI Dr Rogers resigned in April 2013 Dr M Fernando resigned in August 2013 3 vacant posts from August 2013 Continued to advertise through agencies and usual media forums
2014	3	1 substantive post holder (J Martin) commenced October 2014 Continued to advertise through agencies and usual media forums
2015	3	1 substantive post holder (J Martin) 2 vacancies and continued to advertise through agencies and usual media forums
2016	3	Dr Martin resigned in August 2016 L Devlin took up locum post in December 2016 3 vacancies from August 2016 and continued to advertise through agencies and usual media forums
2017	3	L McAuley took up Staff Grade post in January 2017 as full-time and in September reduced her hours to 3 days per week which is whole time equivalent of 0.60 L Devlin resigned her post in February 2017 1 vacant post and continue to advertise through agencies and usual media forums
2018	3	1 part-time staff grade in post (L McAuley) 1 vacant post filled with locum (Hasnain) Posts advertised – one successful applicant S Hasnain
2019	3	2 staff in substantive post (McAuley/Hasnain)

		Post advertised – no applicants
2020	3	2 staff in substantive post (McAuley/Hasnain) In December 2020 it was agreed by Chief Executive to go back out to advert for clinical fellows and to appoint at least 3 this was successful and three appointed with Whole Time Equivalent of 2.60
2021	3	1.63 whole time equivalent substantive post holders (McAuley and Hasnain) 2.60 whole time equivalent substantive post holders (Cull/Griffin/Asingel)
2022	3	1.63 whole time equivalent substantive post holders (McAuley and Hasnain) 2.60 whole time equivalent substantive post holders (Cull/Griffin/Asingel)

CRAIGAVON AREA HOSPITAL GROUP TRUST
Caring Through Commitment

Southern Area Urology ICATS Implementation Plan

Version 0.6

Directorate of Planning & Contracts

Author: Claire Kelly

Date: 3rd November 2006

Urology ICATS – Implementation Plan

Project Team:	
Mrs Claire Kelly	Planning Manager, Craigavon Area Hospital Group Trust
Mr Barry Haughey	Finance Manager, Craigavon Area Hospital Group Trust
Mrs Deborah Burns	Acting Director of Operations, Craigavon Area Hospital Group Trust
Mr Michael Young	Lead Consultant Urologist, Craigavon Area Hospital Group Trust
Mr Aidan O'Brien	Consultant Urologist, Craigavon Area Hospital Group Trust
Mr Robin Brown	Consultant General Surgeon, Newry and Mourne HSS Trust
Mrs Kate O'Neill	Urology Nurse Specialist, Craigavon Area Hospital Group Trust
Mrs Jenny McMahon	Urology Nurse Specialist, Craigavon Area Hospital Group Trust
Mr Jerome Marley	Lecturer Practitioner in Urology, Craigavon Area Hospital Group Trust
Dr Philip Rogers	GPwSI Urology
Mrs Shirley Tedford	Ward Manager – Urology, Craigavon Area Hospital Group Trust
Mrs Louise Devlin	Outpatients Improvement Manager, Craigavon Area Hospital Group Trust
Mrs Sharon Glenny	Project Manager – Urology ICATS, Craigavon Area Hospital Group Trust
Mrs Alexis Davidson	Radiology Services Manager, Craigavon Area Hospital Group Trust
Mrs Katherine Robinson	Medical Records Manager, Craigavon Area Hospital Group Trust
Mr Brian Beattie	Head of Physiotherapy, Craigavon Area Hospital Group Trust
Mr Brian Magee	Pathology Services Manager, Craigavon Area Hospital Group Trust

Urology ICATS – Implementation Plan

1.0 Introduction

In January 2006, the Health Minister announced a reform of outpatient services to reduce waiting times.

The DHSSSPNI tasked the four Boards with implementing Integrated Clinical Assessment and Treatment Services (ICATS) diagnostic and Tier 2 services by September 2006 for four specialities, which are:

- Ophthalmology;
- Orthopaedics;
- Urology; and
- Plastic Surgery.

A project group within the Southern Health and Social Services Board (SHSSB) was established, with representation from each of the Trusts. From this forum it was decided that Craigavon Area Hospital Group Trust (CAHGT) would lead the development of a model for Urology ICATS.

The key objectives of the project are as follows:

- To develop a fit for purpose model;
- To raise awareness of this service within the Trust and the Southern Board economy, including GPs, of this service and referral pathway;
- To recruit and train the necessary staff to deliver the service;
- To ensure that the new team receive the necessary training and accreditation to deliver an optimum service;
- To implement new referral and care pathways in line with Regional recommendations, and to engage with General Practice in doing so;
- To agree and implement performance management mechanisms to allow monitoring of service delivery and reporting to the Commissioner;
- To implement administrative systems to deliver the service (e.g. ERMS);
- To establish a timely, efficient service to assist in the delivery of waiting list targets;
- To agree arrangements for accountability, governance and audit of service; and
- To negotiate host facilities and ensure that these facilities have the appropriate equipment etc. to deliver the service.

This implementation plan document includes the following elements:

- Phased implementation plan;
- The full costs of an interim model;
- The anticipated costs of the final model;
- An assessment of additional diagnostics requirements arising from the implementation of the new service;
- An outline of the review and evaluation processes;
- The timescale for implementation; and
- A draft project structure.

2.0 Phased Implementation Plan

The SHSSB and CAHGT have developed and implemented pilots of the following ICATS initiatives **(Phase A)**:

- Outpatient clinics of GPwSI in Urology (commenced July 2005);
- Nurse-led LUTS (commenced Oct 2005);
- Nurse-led Prostate Diagnostic (commenced April 2006); and
- Nurse-led Haematuria.

These services (with the exception of Nurse-led Haematuria) are currently funded non-recurrently by the SHSSB. For the purposes of this document we will refer to these services as '**Phase A**' of Urology ICATS for the Southern Area.

The SHSSB has agreed to support the further implementation of the Urology ICATS Programme on a phased basis, the following phases are indicated:

- **Phase B** – substantive establishment and expansion of **Phase A** pilots aimed at handling new referrals as per the ICATS model (Nurse-led LUTS, GPwSI in Urology, Nurse-led Prostate Diagnostic and Nurse-led Haematuria,) plus the establishment of Nurse-led Uro-Dynamics, Nurse-led Stone Service, Nurse-led Oncology Review and Nurse-led Andrology.

  Note: The project team is currently engaging with CAHGT Estates Department to evaluate accommodation options for the new services and has identified a preferred option being construction of temporary accommodation. The project team understands that the DHSSPS will make available a certain amount of funding for this estates work and for equipment costs associated with the establishment of these services.

- **Phase C** - Nurse-led Female Urology. The development of this service in conjunction with community and primary care will follow.

3.0 Full Costs of an Interim Model

The SHSSB have advised that the following annual funding will be made available for Phases A and B, see Table 1.

Table 1: Yearly costs of Phases A and B (Excluding Diagnostics)

	Total Yearly Cost [excluding diagnostics]
Phase A & B	
GP with Special Interest	61,907
Grade IV	10,891
Nurse Led LUTS New	13,185
Nurse Led LUTS Review	9,372
Nurse Led Prostate - Day 1	9,482
Nurse Led Prostate - Day 2	23,154
Nurse Led Prostate - Day3	10,269
Nurse Led Haematuria	23,113
Nurse Led Urodynamics	22,496
Nurse Led Stone	21,637
Nurse Led Oncology Review	16,944
Nurse Led Andrology - ED	5,814
Nurse Led Andrology - SS	4,231
Nurse Led Andology Review	9,675
	242,167

The SHSSB have indicated that funding for Phase C (Female Urology) is dependent on agreement of a model. As noted in Section 2.0, the development of this service in conjunction with community and primary care will follow.

4.0 Anticipated Costs of the Final Model

Full costs of the final model will be confirmed when the final phase (Phase C - Female Urology) has been agreed and will be provided in a further version of this document.

5.0 An Assessment of the Additional Diagnostics Requirements

Table 2 provides an analysis of the annual cost of diagnostics required to implement Phases A and B.

Table 2: Yearly costs of Diagnostics Costs for Phases A and B

	Total Diagnostic Cost
Phase A & B	
GP with Special Interest	-
Grade IV	-
Nurse Led LUTS New	11,751
Nurse Led LUTS Review	709
Nurse Led Prostate - Day 1	8,958
Nurse Led Prostate - Day 2	32,762
Nurse Led Prostate - Day3	29,383
Nurse Led Haematuria	33,653
Nurse Led Urodynamics	709
Nurse Led Stone	15,473
Nurse Led Oncology Review	709
Nurse Led Andrology - ED	998
Nurse Led Andrology - SS	4,222
Nurse Led Andology Review	-
	139,327

6.0 An Outline of the Review and Evaluation Processes

Tasks and activities relating to review and evaluation have been defined within the project plan. The review and evaluation processes will be agreed with the SHSSB once the project has been initiated.

7.0 Timescales for Implementation

Project plans/timelines have been developed while remaining cognisant of capital requirements.

As a guide the Trust expects to have all of Phase B services operational by 1st February 2007.

Substantive establishment of the Nurse-led LUTS service should be achieved by 1st December 2006.

To assist with completion of his GPwSI Accreditation Course the GPwSI will be attending a weekly Consultant outpatient clinic from 3rd November 2006. This is to facilitate case study development, attendance at the clinic will allow the GPwSI to identify relevant cases, with the Consultant mentoring the GPwSI in the understanding of these cases. It is planned that this will continue to the end of 2006, thereafter the GPwSI will assist with communication with primary regarding referral pathways and education about the new Urology ICATS services. We expect that the third GPwSI session (providing input to the Haematuria, Prostate Diagnostic and Oncology services) will be operational from 1 March 2007, once these services are established.

Achievement of the target timescales will be dependent upon the Trust securing capital expenditure approval for the estates work and equipment costs required. However the Trust has identified a preferred option for accommodation and expects that accommodation will be available to enable the target start dates to be realised.

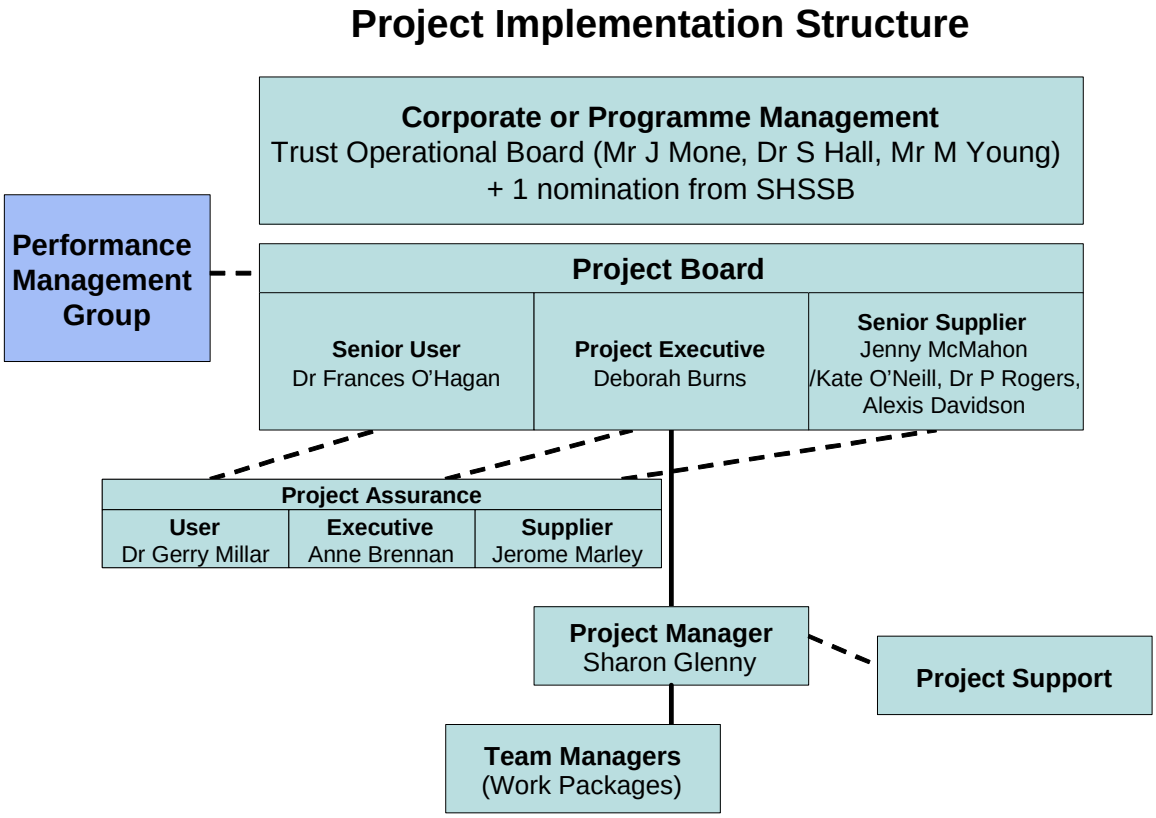
Tasks and timescales relating to the implementation of Phase C (Female Urology) will be determined over the coming months, however the Trust expects that Phase C could be operational by 1st September 2007. This date is indicative and is dependent upon the outcomes of further discussions with primary and community care representatives.

The current version of the Project Plan is included as Appendix I.

8.0 Project Structure

8.1 Project Implementation Structure

A Project Structure, based on PRINCE 2 methodology for Project Management is provided below and identifies the key stakeholders and interfaces throughout the project lifespan.



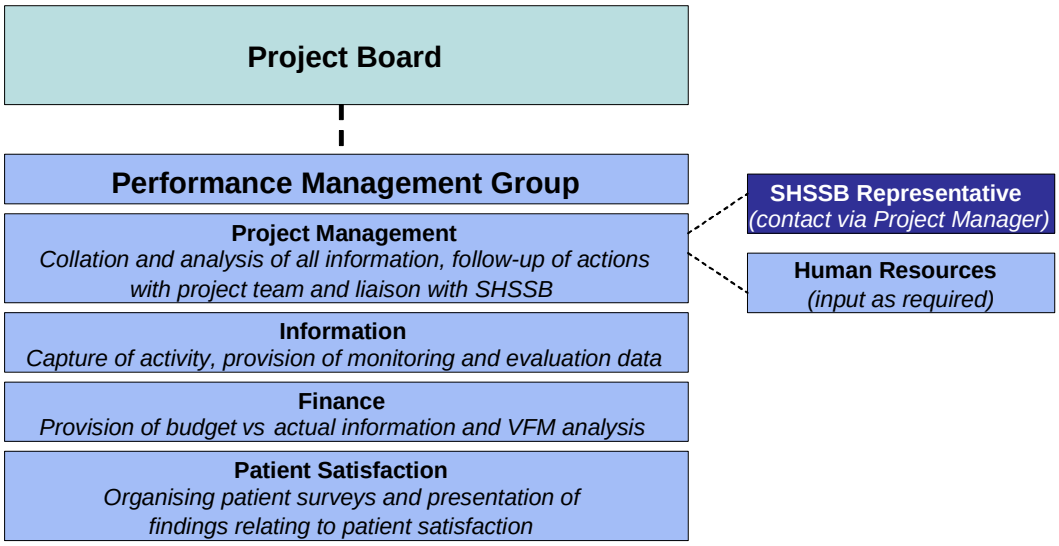
The following work packages are indicated for this project:

- Job Descriptions and Recruitment;
- Host Facilities and Capital Work;
- Referral Guidelines;
- Administration (including ERMS);
- Training, Accreditation and Audit;
- Communication Strategy;
- Care Pathways;
- Female Urology; and
- Accountability and Monitoring.

8.2 Performance Management Structure

The following Performance Management Structure will operate alongside the Project Implementation Structure, the Performance Management Group will provide information to the Project Implementation Structure via the Project Board.

Performance Management Structure



The following terms of reference are suggested for the Performance Management Structure, led by the Project Board:

- Provide a strategic focus to take the work forward;
- To ensure that the work is rooted in the wider reform and modernisation plan;
- To ensure that the work in ICATS is also connected to the wider reform of Urology Services;
- To develop critical success factors;
- To establish a performance management framework to ensure that the outcomes set for the programme in general and specific initiatives are delivered;
- To continuously review services to identify opportunities for rolling out the ICATS principles to as many areas of work as possible;
- To review service delivery in line with targets;
- Audit triage decisions;
- Identify outstanding training and competency requirements;
- Identify need for pathway/ protocol development and amendment;
- Review and monitor ICATS performance indicators e.g.:
  - Follow- up rates;

- Onward referral rates from nurses to consultants;
- Investigation waiting times;
- Average access times for patients to tier 2 assessment;
- Non attendance rates; and
- Patient satisfaction.

Appendix I
Project Plan v6

Task Name	Duration	Start	Finish	Predecessors	Resource Names
Agree Funding	**181 days?**	**04/08/2006**	**13/04/2007**		
Secure Funding for Project Manager	1 day?	04/08/2006	04/08/2006		Planning Manager
Secure Funding for Phase 1	6 days?	04/08/2006	11/08/2006		Planning Manager
Secure Funding for Phase 2	12 days?	14/09/2006	29/09/2006		Planning Manager
Secure Funding for Phase 3	10 days?	02/04/2007	13/04/2007		Planning Manager
Recruit Project Manager	**47 days?**	**11/08/2006**	**16/10/2006**		
Agree Job description	1 day?	11/08/2006	11/08/2006		Deborah Burns
Advertise post	1 day?	11/08/2006	11/08/2006		Deborah Burns
Interview post	1 day?	01/09/2006	01/09/2006		Deborah Burns
Appoint project manager	1 day?	04/09/2006	04/09/2006	9	Deborah Burns
Project Manager in post	1 day?	16/10/2006	16/10/2006		Deborah Burns
Agree Project Structure	**14 days?**	**16/10/2006**	**02/11/2006**		
Draft Project Struture	1 day?	25/10/2006	25/10/2006		Deborah Burns
Agree Project Structure	1 day?	26/10/2006	26/10/2006	13	Deborah Burns
Establish Project Structure	5 days	27/10/2006	02/11/2006	14	Deborah Burns
Identify Work Packages	5 days?	16/10/2006	20/10/2006		Sharon Glenny
Draft Work Packages	8 days?	23/10/2006	01/11/2006	16	Sharon Glenny
Agree Work Packages	1 day?	02/11/2006	02/11/2006	17	Sharon Glenny
Establish Lead for Work Packages	1 day	26/10/2006	26/10/2006		Sharon Glenny
Establish Team for Work Packages	5 days	27/10/2006	02/11/2006	19	Sharon Glenny
Establish Team Meetings	**110 days**	**26/10/2006**	**29/03/2007**		
Meeting 1	0 days	26/10/2006	26/10/2006		Project Team
Meeting 2	0 days	02/11/2006	02/11/2006		Project Team
Meeting 3	0 days	09/11/2006	09/11/2006		Project Team
Meeting 4	0 days	16/11/2006	16/11/2006		Project Team
Meeting 5	0 days	23/11/2006	23/11/2006		Project Team
Meeting 6	0 days	30/11/2006	30/11/2006		Project Team
Meeting 7	0 days	07/12/2006	07/12/2006		Project Team
Meeting 8	0 days	14/12/2006	14/12/2006		Project Team
Meeting 9	0 days	21/12/2006	21/12/2006		Project Team
Meeting 10	0 days	04/01/2007	04/01/2007		Project Team
Meeting 11	0 days	11/01/2007	11/01/2007		Project Team
Meeting 12	0 days	18/01/2007	18/01/2007		Project Team
Meeting 13	0 days	25/01/2007	25/01/2007		Project Team
Meeting 14	0 days	01/02/2007	01/02/2007		Project Team
Meeting 15	0 days	08/02/2007	08/02/2007		Project Team
Meeting 16	0 days	15/02/2007	15/02/2007		Project Team
Meeting 17	0 days	22/02/2007	22/02/2007		Project Team
Meeting 18	0 days	01/03/2007	01/03/2007		Project Team
Meeting 19	0 days	08/03/2007	08/03/2007		Project Team
Meeting 20	0 days	15/03/2007	15/03/2007		Project Team
Meeting 21	0 days	22/03/2007	22/03/2007		Project Team
Meeting 22	0 days	29/03/2007	29/03/2007		Project Team

Task Name	Duration	Start	Finish	Predecessors	Resource Names
Work Package 1 - Recruitment	**120 days**	**21/08/2006**	**02/02/2007**		
Agree Lead for Work Package	0 days	26/10/2006	26/10/2006		Project Team
Agree GPSI Job Plan	14 days	18/10/2006	06/11/2006		Sharon Glenny,Deborah Burns
Identify staffing for each service	14 days	21/08/2006	07/09/2006		Planning Manager
Establish Resource Allocation	4 days	19/10/2006	24/10/2006		Sharon Glenny,Barry Haughey
Agree Job Description for Clerical Staff	2 days	25/10/2006	26/10/2006	48	Sharon Glenny,Kelly Jones
Approval to recruit Clerical Staff	5 days	26/10/2006	01/11/2006	45	Barry Haughey
Advertise Clerical staff	14 days	02/11/2006	21/11/2006	50	Kelly Jones,Sharon Glenny
Interview Clerical Staff	4 days	22/11/2006	27/11/2006	51	Sharon Glenny,Kelly Jones
Appoint Clerical Staff	3 days	28/11/2006	30/11/2006	52	Sharon Glenny,Kelly Jones
Clerical Staff in Post	22 days	01/12/2006	01/01/2007	53	Sharon Glenny,Kelly Jones
Agree Job Description for Nursing Staff	2 days	19/10/2006	20/10/2006		Noleen O'Donnell,Sharon Glenny
Approval to recruit Nursing Staff	5 days	19/10/2006	25/10/2006		Barry Haughey
Advertise Nursing staff	14 days	26/10/2006	14/11/2006	56	Noleen O'Donnell,Sharon Glenny
Interview Nursing Staff	8 days	15/11/2006	24/11/2006	57	Noleen O'Donnell
Appoint Nursing Staff	6 days	27/11/2006	04/12/2006	58	Noleen O'Donnell
Nursing Staff in Post	44 days	05/12/2006	02/02/2007	59	Noleen O'Donnell
Agree Job Description for Radiology Staff	2 days	19/10/2006	20/10/2006		Sharon Glenny,Alexis Davidson
Approval to recruit Radiology Staff	5 days	19/10/2006	25/10/2006		Barry Haughey
Advertise Radiology staff	14 days	26/10/2006	14/11/2006	62	Alexis Davidson
Interview Radiology Staff	8 days	15/11/2006	24/11/2006	63	Alexis Davidson
Appoint Radiology Staff	6 days	27/11/2006	04/12/2006	64	Alexis Davidson
Radiology Staff in Post	44 days	05/12/2006	02/02/2007	65	Alexis Davidson
Work Package 2 - Host Facilities and Capital Work	**171 days?**	**04/08/2006**	**30/03/2007**		
Agree Lead for Work Package	0 days	26/10/2006	26/10/2006		Project Team
Liaison with DHSSPS/SHSSB re funding for capital works and equipment	50 days?	24/08/2006	01/11/2006		Planning Manager,Lindsay Stead,Alan Metcalf,Sharon Glenny
Identify Accommodation Requirements	20 days?	04/08/2006	31/08/2006		Project Team
Establish capital spend	60 days?	04/08/2006	26/10/2006		Sharon Glenny,Finance Manager
Consider Options for facility	39 days?	04/09/2006	26/10/2006		Project Team
Draft Plan Chosen Option with Estates	5 days	20/10/2006	26/10/2006		Project Team,Alan Metcalf
Agree Plans with Estates	7 days	19/10/2006	27/10/2006		Project Team,Alan Metcalf
Commission Facility	56 days	30/10/2006	15/01/2007	74	Alan Metcalf
Undertake Capital Works	86 days	01/12/2006	30/03/2007		Alan Metcalf
Identify Equipment Requirements	54 days?	14/08/2006	26/10/2006		Clinical Team,Sharon Glenny
Order Equipment for phase 1 + 2	5 days	27/10/2006	02/11/2006	77	Sharon Glenny
Equipment in place	42 days	03/11/2006	01/01/2007	78	Sharon Glenny
Identify any additional equipment requirements re proposed facility	6 days?	19/10/2006	26/10/2006		Clinical Team,Sharon Glenny

Task Name	Duration	Start	Finish	Predecessors	Resource Names
Work Package 3 - Referral Guidelines	**38 days**	**19/10/2006**	**11/12/2006**		
Agree Lead for Work Package	0 days	26/10/2006	26/10/2006		Project Team
Draft Referral Guidelines	10 days	19/10/2006	01/11/2006		Clinical Team,Sharon Glenny
Agree Referral Guidelines	7 days	02/11/2006	10/11/2006	83	Clinical Team,Sharon Glenny
Implement Referral Guidelines	21 days	13/11/2006	11/12/2006	84	Clinical Team,Sharon Glenny
Draft Referral Template	10 days	19/10/2006	01/11/2006		Clinical Team,Sharon Glenny
Agree Referral Template	7 days	02/11/2006	10/11/2006	86	Clinical Team,Sharon Glenny
Implement Referral Template	21 days	13/11/2006	11/12/2006	87	Clinical Team,Sharon Glenny
Work Package 4 - Administration	**31 days**	**19/10/2006**	**30/11/2006**		
Agree Lead for Work Package	0 days	26/10/2006	26/10/2006		Project Team
Draft Guidelines for Referral Process	14 days	19/10/2006	07/11/2006		Clinical Team
Agree Guidelines for Referral Process	7 days	08/11/2006	16/11/2006	91	Clinical Team
Draft Requirements for electronic system	14 days	19/10/2006	07/11/2006		Clinical Team
Agree Requirements for electronic system	7 days	08/11/2006	16/11/2006	93	Clinical Team
Implement Admininistrative system	10 days	17/11/2006	30/11/2006	94	Clinical Team
Work Package 5 - Training, Accredibility, Audit, Accountability	**112 days?**	**26/10/2006**	**30/03/2007**		
Agree Lead for Work Package	0 days	26/10/2006	26/10/2006		Project Team
Identify Training Needs Clerical	14 days	13/11/2006	30/11/2006		Sharon Glenny,Kelly Jones
Agree Training Programme Clerical	14 days	15/12/2006	03/01/2007	98	Kelly Jones,Sharon Glenny
Complete Training Clerical	10 days?	01/01/2007	12/01/2007		Sharon Glenny,Kelly Jones
Identify Trainng Needs Nursing	14 days	13/11/2006	30/11/2006		Sharon Glenny,Lead Nurse
Agree Training Programme Nursing	14 days	01/12/2006	20/12/2006	101	Lead Nurse
Complete Training Nursing	23 days?	01/01/2007	31/01/2007		Sharon Glenny,Lead Nurse
Establish financial support for Training programme	14 days	20/12/2006	08/01/2007		Sharon Glenny,Barry Haughey
Complete GPSI Accreditation Course	106 days?	03/11/2006	30/03/2007		Dr Rodgers,Mr Young,Deborah Burns
Mentoring session as part of Accreditation Course	41 days?	03/11/2006	29/12/2006		Dr Rodgers,Mr Young
Draft Quality Assurance Guidelines	15 days	26/10/2006	15/11/2006		Clinical Team
Agree Quality Assurance Guidelines	10 days	17/11/2006	30/11/2006	107	Clinical Team
Implement Quality Assurance Guidelines	86 days	01/12/2006	30/03/2007	108	Clinical Team
Draft Audit Guidelines	15 days	26/10/2006	15/11/2006		Clinical Team
Agree Audit Guidelines	10 days	17/11/2006	30/11/2006	110	Clinical Team
Implement Audit Guidelines	86 days	01/12/2006	30/03/2007	111	Clinical Team
Establish Accountability Framework	20 days	26/10/2006	22/11/2006		Clinical Team,Deborah Burns

Task Name	Duration	Start	Finish	Predecessors	Resource Names
Work Package 6 - Communication Strategy	**112 days**	**26/10/2006**	**30/03/2007**		
Agree Lead for Work Package	0 days	26/10/2006	26/10/2006		Project Team
Draft communication document for internal organisation awareness	7 days	26/10/2006	03/11/2006		Sharon Glenny,Jane McKimm
Finalise intermal communication document	7 days	06/11/2006	14/11/2006	116	Sharon Glenny,Deborah Burns,Corporate
Agreement from Management Team to Progress	7 days	15/11/2006	23/11/2006	117	Corporate Group
Liaison with Communication Manager re approach	22 days	26/10/2006	24/11/2006		Sharon Glenny
Draft communication document for external awareness	10 days	26/10/2006	08/11/2006		Project Team
Liaison with SHSSB regarding approach	10 days	26/10/2006	08/11/2006		Sharon Glenny
Finalise external communication document	10 days	09/11/2006	22/11/2006	121	Sharon Glenny,Deborah Burns
Provide Awareness with Community Groups	27 days	23/11/2006	29/12/2006	122	Project Team
Provide Awareness with GP Groups	65 days	01/01/2007	30/03/2007		
Issue communication document	27 days	23/11/2006	29/12/2006		Sharon Glenny
Implement changes from communication document	27 days	23/11/2006	29/12/2006		Deborah Burns,Sharon Glenny

Task Name	Duration	Start	Finish	Predecessors	Resource Names
Work Package 7 - Care Pathways	**73 days?**	**19/10/2006**	**29/01/2007**		
Agree Lead for Work Package	0 days	26/10/2006	26/10/2006		Project Team
Draft Care Pathway for LUTS	10 days?	19/10/2006	01/11/2006		Jenny McMahon
Agree Care Pathway for LUTS	11 days?	02/11/2006	16/11/2006	129	Jenny McMahon
Implement Care Pathway for LUTS	11 days?	17/11/2006	01/12/2006	130	Jenny McMahon
Draft Care Pathway for TRUS	16 days?	19/10/2006	09/11/2006		Kate O'Neill
Agree Care Pathway for TRUS	11 days?	10/11/2006	24/11/2006	132	Kate O'Neill
Implement Care Pathway for TRUS	26 days?	27/11/2006	01/01/2007	133	Kate O'Neill
Draft Care Pathway for NL Urodynamics	16 days	19/10/2006	09/11/2006		Jenny McMahon
Agree Care Pathway for NL Urodynamics	11 days	10/11/2006	24/11/2006	135	Jenny McMahon
Implement Care Pathway for NL Urodynamics	26 days	27/11/2006	01/01/2007	136	Jenny McMahon
Draft Care Pathway for NL Stone Service	16 days	19/10/2006	09/11/2006		Jerome Marley
Agree Care Pathway for NL Stone Service	11 days	10/11/2006	24/11/2006	138	Jerome Marley
Implement Care Pathway for NL Stone Service	26 days	27/11/2006	01/01/2007	139	Jerome Marley
Draft Care Pathway for NL Andrology	16 days	19/10/2006	09/11/2006		Jerome Marley
Agree Care Pathway for NL Andrology	11 days	10/11/2006	24/11/2006	141	Jerome Marley
Implement Care Pathway for NL Andrology	26 days	27/11/2006	01/01/2007	142	Jerome Marley
Draft Care Pathway for Haematuria	28 days	19/10/2006	27/11/2006		Jenny McMahon
Agree Care Pathway for Haematuria	14 days	28/11/2006	15/12/2006	144	Jenny McMahon
Implement Care Pathway for Haematuria	31 days	18/12/2006	29/01/2007	145	Jenny McMahon
Draft Care Pathway for Oncology	28 days	19/10/2006	27/11/2006		Kate O'Neill
Agree Care Pathway for Oncology	14 days	28/11/2006	15/12/2006	147	Kate O'Neill
Implement Care Pathway for Onolocy	31 days	18/12/2006	29/01/2007	148	Kate O'Neill

Task Name	Duration	Start	Finish	Predecessors	Resource Names
Work Package 8 - Monitoring	**112 days?**	**26/10/2006**	**30/03/2007**		
Agree Lead for Work Package	1 day?	26/10/2006	26/10/2006		Project Team
Establish Performance Management Team	5 days	26/10/2006	01/11/2006		Deborah Burns
Define Objectives for Project	14 days	02/11/2006	21/11/2006	152	Sharon Glenny,Deborah Burns
Set Measurements/targets for Project	7 days	22/11/2006	30/11/2006	153	Sharon Glenny,Deborah Burns
Monitor Performance of Project	86 days	01/12/2006	30/03/2007	154	Performance Management Team
Work Package 9 - Phase 3 Planning	**11 days**	**01/03/2007**	**15/03/2007**		
Establish links with Community for planning	11 days	01/03/2007	15/03/2007		Planning Manager,Project Board
Implementation of New Services	**117 days?**	**19/10/2006**	**30/03/2007**		
Planned Implementation of LUTS	86 days?	01/12/2006	30/03/2007		Project Team
Planned Implementation of GPwSI sessions	22 days	01/03/2007	30/03/2007		Project Team
Planned Implemetation of GPwSI third session	1 day?	19/10/2006	19/10/2006		Project Team
Planned Implementation of TRUS	65 days?	01/01/2007	30/03/2007		Project Team
Planned Implementation of NL Urodynamics	65 days?	01/01/2007	30/03/2007		Project Team
Planned Implementation of Stone Service	65 days?	01/01/2007	30/03/2007		Project Team
Planned Implementation of NL Andrology	65 days?	01/01/2007	30/03/2007		Project Team
Planned Implementation of Haematuria	42 days?	01/02/2007	30/03/2007		Project Team
Planned Implementation of NL Oncology	42 days?	01/02/2007	30/03/2007		Project Team

CRAIGAVON AREA HOSPITAL GROUP TRUST
Caring Through Commitment

Southern Area Urology ICATS Implementation Plan

Draft Version 0.5

Directorate of Planning & Contracts

Author: Claire Kelly

Date: 2nd November 2006

Urology ICATS – Implementation Plan

Project Team:	
Mrs Claire Kelly	Planning Manager, Craigavon Area Hospital Group Trust
Mr Barry Haughey	Finance Manager, Craigavon Area Hospital Group Trust
Mrs Deborah Burns	Acting Director of Operations, Craigavon Area Hospital Group Trust
Mr Michael Young	Lead Consultant Urologist, Craigavon Area Hospital Group Trust
Mr Aidan O'Brien	Consultant Urologist, Craigavon Area Hospital Group Trust
Mr Robin Brown	Consultant General Surgeon, Newry and Mourne HSS Trust
Mrs Kate O'Neill	Urology Nurse Specialist, Craigavon Area Hospital Group Trust
Mrs Jenny McMahon	Urology Nurse Specialist, Craigavon Area Hospital Group Trust
Mr Jerome Marley	Lecturer Practitioner in Urology, Craigavon Area Hospital Group Trust
Dr Philip Rogers	GPwSI Urology
Mrs Shirley Tedford	Ward Manager – Urology, Craigavon Area Hospital Group Trust
Mrs Louise Devlin	Outpatients Improvement Manager, Craigavon Area Hospital Group Trust
Mrs Sharon Glenny	Project Manager – Urology ICATS, Craigavon Area Hospital Group Trust
Mrs Alexis Davidson	Radiology Services Manager, Craigavon Area Hospital Group Trust
Mrs Katherine Robinson	Medical Records Manager, Craigavon Area Hospital Group Trust
Mr Brian Beattie	Head of Physiotherapy, Craigavon Area Hospital Group Trust
Mr Brian Magee	Pathology Services Manager, Craigavon Area Hospital Group Trust

Urology ICATS – Implementation Plan

1.0 Introduction

In January 2006, the Health Minister announced a reform of outpatient services to reduce waiting times.

The DHSSSPNI tasked the four Boards with implementing Integrated Clinical Assessment and Treatment Services (ICATS) diagnostic and Tier 2 services by September 2006 for four specialities, which are:

- Ophthalmology;
- Orthopaedics;
- Urology; and
- Plastic Surgery.

A project group within the Southern Health and Social Services Board (SHSSB) was established, with representation from each of the Trusts. From this forum it was decided that Craigavon Area Hospital Group Trust (CAHGT) would lead the development of a model for Urology ICATS.

The key objectives of the project are as follows:

- To develop a fit for purpose model;
- To raise awareness of this service within the Trust and the Southern Board economy, including GPs, of this service and referral pathway;
- To recruit and train the necessary staff to deliver the service;
- To ensure that the new team receive the necessary training and accreditation to deliver an optimum service;
- To implement new referral and care pathways in line with Regional recommendations, and to engage with General Practice in doing so;
- To agree and implement performance management mechanisms to allow monitoring of service delivery and reporting to the Commissioner;
- To implement administrative systems to deliver the service (e.g. ERMS);
- To establish a timely, efficient service to assist in the delivery of waiting list targets;
- To agree arrangements for accountability, governance and audit of service; and
- To negotiate host facilities and ensure that these facilities have the appropriate equipment etc. to deliver the service.

This implementation plan document includes the following elements:

- Phased implementation plan;
- The full costs of an interim model;
- The anticipated costs of the final model;
- An assessment of additional diagnostics requirements arising from the implementation of the new service;
- An outline of the review and evaluation processes;
- The timescale for implementation; and
- A draft project structure.

2.0 Phased Implementation Plan

The SHSSB and CAHGT have developed and implemented pilots of the following ICATS initiatives **(Phase A)**:

- Outpatient clinics of GPwSI in Urology (commenced July 2005);
- Nurse-led LUTS (commenced Oct 2005);
- Nurse-led Prostate Diagnostic (commenced April 2006); and
- Nurse-led Haematuria.

These services (with the exception of Nurse-led Haematuria) are currently funded non-recurrently by the SHSSB. For the purposes of this document we will refer to these services as '**Phase A**' of Urology ICATS for the Southern Area.

The SHSSB has agreed to support the further implementation of the Urology ICATS Programme on a phased basis, the following phases are indicated:

- **Phase B** – substantive establishment and expansion of **Phase A** pilots aimed at handling new referrals as per the ICATS model (Nurse-led LUTS, GPwSI in Urology, Nurse-led Prostate Diagnostic and Nurse-led Haematuria,) plus the establishment of Nurse-led Uro-Dynamics, Nurse-led Stone Service, Nurse-led Oncology Review and Nurse-led Andrology.

  Note: The project team is currently engaging with CAHGT Estates Department to evaluate accommodation options for the new services and has identified a preferred option being construction of temporary accommodation. The project team understands that the DHSSPS will make available a certain amount of funding for this estates work and for equipment costs associated with the establishment of these services.

- **Phase C** - Nurse-led Female Urology. The development of this service in conjunction with community and primary care will follow.

3.0 Full Costs of an Interim Model

The SHSSB have advised that the following annual funding will be made available for Phases A and B, see Table 1.

Table 1: Yearly costs of Phases A and B (Excluding Diagnostics)

	Total Yearly Cost [excluding diagnostics]
Phase A & B	
GP with Special Interest	61,907
Grade IV	10,891
Nurse Led LUTS New	13,185
Nurse Led LUTS Review	9,372
Nurse Led Prostate - Day 1	9,482
Nurse Led Prostate - Day 2	23,154
Nurse Led Prostate - Day3	10,269
Nurse Led Haematuria	23,113
Nurse Led Urodynamics	22,496
Nurse Led Stone	21,637
Nurse Led Oncology Review	16,944
Nurse Led Andrology - ED	5,814
Nurse Led Andrology - SS	4,231
Nurse Led Andology Review	9,675
	242,167

The SHSSB have indicated that funding for Phase C (Female Urology) is dependent on agreement of a model. As noted in Section 2.0, the development of this service in conjunction with community and primary care will follow.

4.0 Anticipated Costs of the Final Model

Full costs of the final model will be confirmed when the final phase (Phase C - Female Urology) has been agreed and will be provided in a further version of this document.

5.0 An Assessment of the Additional Diagnostics Requirements

Table 2 provides an analysis of the annual cost of diagnostics required to implement Phases A and B.

Table 2: Yearly costs of Diagnostics Costs for Phases A and B

	Total Diagnostic Cost
Phase A & B	
GP with Special Interest	-
Grade IV	-
Nurse Led LUTS New	11,751
Nurse Led LUTS Review	709
Nurse Led Prostate - Day 1	8,958
Nurse Led Prostate - Day 2	32,762
Nurse Led Prostate - Day3	29,383
Nurse Led Haematuria	33,653
Nurse Led Urodynamics	709
Nurse Led Stone	15,473
Nurse Led Oncology Review	709
Nurse Led Andrology - ED	998
Nurse Led Andrology - SS	4,222
Nurse Led Andology Review	-
	139,327

6.0 An Outline of the Review and Evaluation Processes

Tasks and activities relating to review and evaluation have been defined within the project plan. The review and evaluation processes will be agreed with the SHSSB once the project has been initiated.

7.0 Timescales for Implementation

Project plans/timelines have been developed while remaining cognisant of capital requirements.

As a guide the Trust expects to have all of Phase B services operational by 1st February 2007.

Substantive establishment of the Nurse-led LUTS service should be achieved by 1st December 2006.

To assist with completion of his GPwSI Accreditation Course the GPwSI will be attending a weekly Consultant outpatient clinic from 3rd November 2006. This is to facilitate case study development, attendance at the clinic will allow the GPwSI to identify relevant cases, with the Consultant mentoring the GPwSI in the understanding of these cases. It is planned that this will continue to the end of 2006, thereafter the GPwSI will assist with communication with primary regarding referral pathways and education about the new Urology ICATS services. We expect that the third GPwSI session (providing input to the Haematuria, Prostate Diagnostic and Oncology services) will be operational from 1 March 2007, once these services are established.

Achievement of the target timescales will be dependent upon the Trust securing capital expenditure approval for the estates work and equipment costs required. However the Trust has identified a preferred option for accommodation and expects that accommodation will be available to enable the target start dates to be realised.

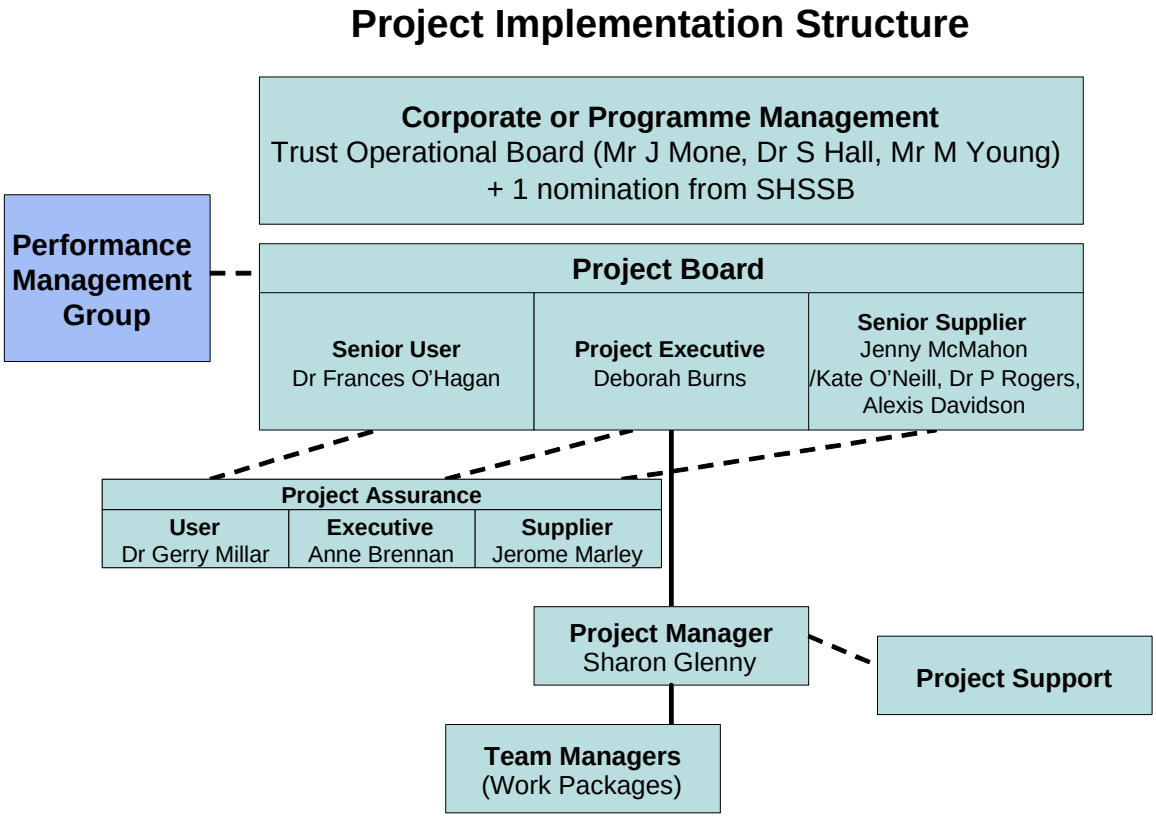
Tasks and timescales relating to the implementation of Phase C (Female Urology) will be determined over the coming months, however the Trust expects that Phase C could be operational by 1st September 2007. This date is indicative and is dependent upon the outcomes of further discussions with primary and community care representatives.

The current version of the Project Plan is included as Appendix I.

8.0 Project Structure

8.1 Project Implementation Structure

A Project Structure, based on PRINCE 2 methodology for Project Management is provided below and identifies the key stakeholders and interfaces throughout the project lifespan.



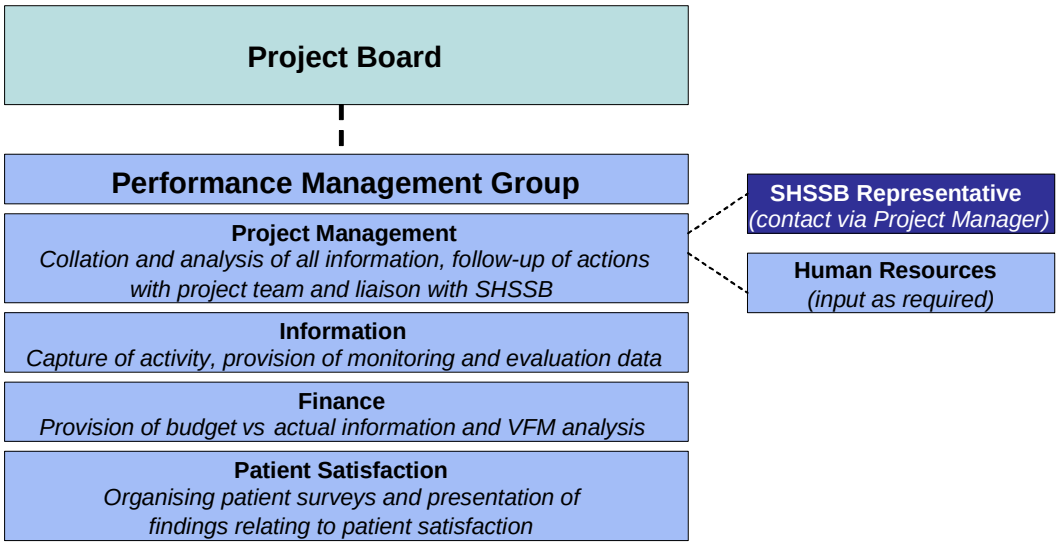
The following work packages are indicated for this project:

- Job Descriptions and Recruitment;
- Host Facilities and Capital Work;
- Referral Guidelines;
- Administration (including ERMS);
- Training, Accreditation and Audit;
- Communication Strategy;
- Care Pathways;
- Female Urology; and
- Accountability and Monitoring.

8.2 Performance Management Structure

The following Performance Management Structure will operate alongside the Project Implementation Structure, the Performance Management Group will provide information to the Project Implementation Structure via the Project Board.

Performance Management Structure



The following terms of reference are suggested for the Performance Management Structure, led by the Project Board:

- Provide a strategic focus to take the work forward;
- To ensure that the work is rooted in the wider reform and modernisation plan;
- To ensure that the work in ICATS is also connected to the wider reform of Urology Services;
- To develop critical success factors;
- To establish a performance management framework to ensure that the outcomes set for the programme in general and specific initiatives are delivered;
- To continuously review services to identify opportunities for rolling out the ICATS principles to as many areas of work as possible;
- To review service delivery in line with targets;
- Audit triage decisions;
- Identify outstanding training and competency requirements;
- Identify need for pathway/ protocol development and amendment;
- Review and monitor ICATS performance indicators e.g.:
  - Follow- up rates;

- Onward referral rates from nurses to consultants;
- Investigation waiting times;
- Average access times for patients to tier 2 assessment;
- Non attendance rates; and
- Patient satisfaction.

Appendix I
Project Plan v6

To be inserted

Report on Urology Theatre Team visit in reference to infusion pump system use in urology endoscopic interventions

Mr Young, consultant Urologist, Dr Morrow, consultant anaesthetist and Urology Sister S English attended an educational unit visit to a Berlin hospital along with David Hazlett, company Director, for the purposes of observing first-hand the specialized infusion pump system for fluid irrigation during endoscopic procedures. This system monitors precisely the amount of fluid being irrigated and controls the infusion pressure. It also monitors the fluid volume that returns out of the endoscope. Various alarm systems are given.

Seeing the technology in action along with the practical aspects and the usual few minor issues that occur during live surgical demonstrations, made this a worthwhile and productive visit.

It has been worthwhile waiting for the urology version of this machine to become available. Although the pump system itself is the same, the computer software to run the system for gynaecological cases is different to the urology settings. It is possible to install the software for both onto the same pump machine but this is at a significantly higher price.

On discussions within the team it would be suggested that one machine each be set solely for urology and gynaecology and the third machine be upgraded to both applications so that it could be used by either team. This would allow for two similar theatre teams to use the systems jointly or if one machine failed then the spare could be used.

The mechanism and the steps required to set up this pump system will require a reasonable period of time to train both the surgeons and the theatre staff. This may take a month or two to complete due to the time or year (ie summer months and the technical aspects). A change in surgical technique / approach is required.

Our suggestion is that a dedicated nurse should be allocated to look after the fluid management system in totality. This was an issue highlighted in the recent audit carried out in the urology theatre and is now backed by our observation during this visit. This would considerably improve the real time monitoring and functioning of the fluid input and output arrangements that require the manual and mathematical input.

The endoscopic procedures observed during this visit were bladder tumour resections and ureteroscopes. The team discussed the appropriateness of this particular pump system for the various urological endoscopic procedures.

Undoubtedly its use for TURP has a distinct advantage if it is thought that pressure regulation, as opposed to flow rate, is of major importance. If all the fluid output can be captured (ie minimizing floor spillage) then this system will accurately measure real-time input / output. Both pressure and matching input / output appear to some as the main issues. This however is not necessarily a consensus opinion and there is still debate on the later point. We did not observe it use for a TURP case on this visit and my concern would be if a high flow rate was required for whatever reason, then the system does not fully respond to this need. A higher infusion pressure setting would then probably be used and then this may counteract the desired effect of a low pressure for resection.

Its use for TUR of bladder tumours was observed and straight forward.

I see its use in ureteroscopy and basic cystoscopy as limited

Although saline is used for irrigation during PCNL renal surgery and volume measurement has not previously been an apparent issue, we feel this system could be used and of advantage.

In conclusion, this system is probably best suited for TURP and possible TURBT cases, if it is felt that monitoring of input irrigation pressure and close real-time monitoring of input/output is important

Report compiled by M Young

CRAIGAVON AREA HOSPITAL
68 LURGAN ROAD
PORTADOWN, BT63 5QQ

UROLOGY DEPARTMENT

CONSULTANT: Mr MRA Young, Consultant Urologist
SECRETARY: Miss Paulette Dignam
TELEPHONE: Personal Information redacted by the USI
FAX: Personal Information redacted by the USI
E-MAIL: Personal Information redacted by the USI

01st December 2008

MR PADDY LOUGHRAN
MEDICAL DIRECTOR
CRAIGAVON AREA HOSPTIAL

Dear Paddy

I am writing to you with regards to an administrative issue. You are fully aware of the timelines and deadlines for such issues as patients breaching. An integral part of the administration of this is the typing of letters and the administration that goes with their outcome. The Trust appears to have a lack of focus on the importance of secretarial and audio typist input into this subject. The specific example I am referring to from my service, is the turnover of audio typists. It appears that agencies or temporary staff are being used. A lot of time and effort is spent on teaching these staff members, only for them to leave the service for permanent posts or better paid jobs. This results in the whole process starting again. It is very difficult for staff morale to keep up the momentum for teaching, only for it to be a fruitless endeavour.

From a Trust perspective there is a significant risk for administrative errors having a potential effect on the patients' wellbeing as well as from the Trust perspective of patients breaching their target times. I do appreciate that the Trust appears to be investigating alternative methods of letter dictation (as defined by a recent email) but it only appears to be a preliminary investigation into methods. From past experience such projects often take a significant period of time to instigate especially if training and finance is involved.

In the interim I would like to request that the Trust endeavours to implement a better and more stable approach to a provision of audio typist support. We as clinicians have to consider such issues in our total patient management plan and if this is a weak link we may have to consider lessening the workload.

I would be grateful if you could give consideration to this important issue.

Many thanks.

Yours sincerely,

Mr M RA Young, MD FRCS (Urol)
Programme Director,

Urology, Northern Ireland
/pd

UROLOGY	Backlog - Number of charts with oldest date in brackets						
Consultant	Discharges awaiting Dictation	Discharges to be typed	Clinics to be dictated	Clinics to be typed	Results to be dictated	Results to be typed	Filing
Mr Aslam							
Mr Glackin	2 (Dec/Jan)	8 (26.01.17)	0	37 (25.01.17)	86 (Jan/Feb)	15 (31.01.17)	2 lever arch files
Mr Haynes	0	0	0	4 (Jan 17)	12 (Jan 17)	63 (Dec/Jan)	Nil recorded
Mr Jakob							
Mr O'Brien	11	0	0	20 (02.02.17)	20	0	6 lever arch files
Mr O'Donoghue	0	0	0	0	0	7 (02.02.17)	1 lever arch file
Mr Suresh							
Mr Young							
Sub Speciality Totals							

UROLOGY	Backlog - Number of charts with oldest date in brackets						
Consultant	**Discharges awaiting Dictation**	**Discharges to be typed**	**Clinics to be dictated**	**Clinics to be typed**	**Results to be dictated**	**Results to be typed**	**Filing**
Mr Alsam	0	0	0	0	5 (21.02.17)	0	1 lever arch file
Mr Brown	0	0	0	0	15 (20.02.17)	0	
Mr Suresh	0	0	0	0	4 (Jan 17)	0	
Mr Glackin	3 (Jan 17)	4 (10.02.17)	2 (06.02.17)	33 (03.02.17)	30 (Feb 17)	28 (10.02.17)	2 lever arch file blocks
Mr Haynes	0	0	0	8 (23.02.17)	25 (Mid Feb 17)	0	approx 50 sheets
Mr Jakob	0	0	0	0	37 (Jan/Feb)	0	
Mr O'Brien	0	0	0	0	0	0	6 lever arch files
Mr O'Donoghue	0	0	0	4 (17.02.17)	0	11 (15.02.17)	1 lever arch file
Mr Young							
Sub Speciality Totals							

UROLOGY	Backlog - Number of charts with oldest date in brackets						
Consultant	**Discharges awaiting Dictation**	**Discharges to be typed**	**Clinics to be dictated**	**Clinics to be typed**	**Results to be dictated**	**Results to be typed**	**Filing**
Mr Aslam							
Mr Glackin	0	8 (20.03.17)	0	19 (21.03.17)	18 (March)	6 (24.03.17)	2 1/4 lever arch files
Mr Haynes	0	0	0	34 (24.03.17)	5 (March 17)	40 (29.03.17)	ICATS & Mr Haynes - 80
Mr Jakob							
Mr O'Brien							
Mr O'Donoghue	0	0	0	0	0	0	1 lever arch file
Mr Suresh							
Mr Young							
Sub Speciality Totals							

UROLOGY	Backlog - Number of charts with oldest date in brackets						
Consultant	Discharges awaiting Dictation	Discharges to be typed	Clinics to be dictated	Clinics to be typed	Results to be dictated	Results to be typed	Filing
Mr Alsam							
Mr Jakob							
Mr Suresh							
Mr Glackin	2 (Mar/Apr 17)	8 (13.04.17)	2 (04.04.17)	11 (10.04.17)	100 (Various)	32 (06.04.17)	2 1/2 lever arch files
Mr Haynes	0	0	0	0	25 (April 17)	10 (April 17)	45 sheets
Mr O'Brien							
Mr O'Donoghue	0	0	0	0	0	0	1 lever arch file
Mr Young							
Sub Speciality Totals							

UROLOGY	Backlog - Number of charts with oldest date in brackets						
Consultant	**Discharges awaiting Dictation**	**Discharges to be typed**	**Clinics to be dictated**	**Clinics to be typed**	**Results to be dictated**	**Results to be typed**	**Filing**
Mr Alsam/Suresh							1 lever arch file
Mr Jakob	0	0	0	0	58 (May)	2 (23.05.17)	
Mr Glackin	10 (April/May 17)	13 (28.04.17)	1 (04.04.17)	35 (03.05.17)	21 (May 17)	19 (16.05.17)	3 lever arch files
Mr Haynes (& ICATS)	0	0	0	4 (16.05.17)	40 (May 17)	0	65 sheets
Mr O'Brien	0	0	0	6 (11.05.17)	4	0	Approx 6 lever arch files
Mr O'Donoghue	0	0	0	62 (10.05.17)	0	8 (16.05.17)	1 lever arch file
Mr Young							
Sub Speciality Totals	**10**	**13**	**1**	**107**	**119**	**27**	

UROLOGY	Backlog - Number of charts with oldest date in brackets						
Consultant	**Discharges awaiting Dictation**	**Discharges to be typed**	**Clinics to be dictated**	**Clinic letters to be typed**	**Results to be dictated**	**Results to be typed**	**Filing**
Mr Alsam/Suresh							1 lever arch file
Mr Jakob	0	2 (23.06.17)	0	23 (22.06.17)	20 (June)	8 (June)	
Mr Glackin	6 (May/June)	5 (14.06.17)	2 (06.06.17)	18 (13.06.17)	67 (May/June)	8 (14.06.17)	3 1/2 lever arch block files
Mr Haynes	0	7 (26.06.17)	0	0	0	0	60 sheets
Mr O'Brien	8 (03.05.17)	0	0	0	4	0	Approx 6 lever arch files
Mr O'Donoghue	0	0	0	59 (14.06.17)	0	20 (15.06.17)	1 lever arch file
Mr Young							
Sub Speciality Totals	**14**	**14**	**2**	**100 (13.06.17)**	**91**	**36**	

	A	B	C	D	E	F	G	H
1								
2								
3	**UROLOGY**	**Backlog - Number of charts with oldest date in brackets**						
4	**Consultant**	**Discharges awaiting Dictation**	**Discharges to be typed**	**Clinics to be dictated**	**Clinic letters to be typed**	**Results to be dictated**	**Results to be typed**	**Filing**
5	**Mr Alsam - No longer here**							1 lever arch file
6	**Mr Jakob**	0	9 (21.07.17)	0	14 (19.07.17)	20 (21.07.17)	16 (18.07.17)	
7	**Mr Suresh - No longer here**							
8	**Mr Glackin**	23 (11.07.17)	6 (june/July)	4 (04.04.17)	18 (11.07.17)	47 (July 17)	30 (13.07.17)	3 1/2 file blocks
9	**Mr Haynes**	0	0	0	3 (20.07.17)	8 (July 17)	0	50 Sheets
10	**Mr O'Brien**	9 (27.06.17)	0	0	0	14	0	6 lever arch files
11	**Mr O'Donoghue**	0	0	0	0	0	0	1 lever arch file
12	**Mr Young**	30 (Nov 16)	0	0	0	12 (May 17)	0	Approx 1 1/2 box files
13								
14	**Sub Speciality Totals**	**62**	**15**	**4**	**35**	**101**	**46**	

UROLOGY	Backlog - Number of charts with oldest date in brackets						
Consultant	**Discharges awaiting Dictation**	**Discharges to be typed**	**Clinics to be dictated**	**Clinic letters to be typed**	**Results to be dictated**	**Results to be typed**	**Filing**
Mr Alsam	Left						1 lever arch file
Mr Jakob	0	0	0	11 (31.08.17)	0	2 (28.08.17)	
Mr Suresh							
Mr Glackin	2 (July 17)	3 (25.08.17)	6 (04.04.17)	0	75	18 (24.08.17)	2 3/4 lever arch files
Mr Haynes	0	0	0	0	10 (Aug 17)	0	40 sheets
Mr O'Brien	10 (24.08.17)	1 (02.09.17)	0	0	35	0	1 small file & Monica backlog
Mr O'Donoghue	0	0	0	0	0	4 (22.08.17)	1 lever arch file
Mr Young	38 (Nov 16)	0	0	0	31 (July 17)	0	Approx 1 1/2 lever arch files
Sub Speciality Totals	**50**	**4**	**6**	**11**	**151**	**24**	

UROLOGY	Backlog - Number of charts with oldest date in brackets						
Consultant	**Discharges awaiting Dictation**	**Discharges to be typed**	**Clinics to be dictated**	**Clinic letters to be typed**	**Results to be dictated**	**Results to be typed**	**Filing**
Mr Jakob	0	0	0	12 (02.10.17)	35 (25.09.17)	5 (18.09.17)	1 lever arch file
Mr Suresh							
Mr Glackin	1 (Sept)	7 (10.09.17)	2 (06.06.17)	28 (12.09.17)	8 (11.09.17)	7 (22.09.17)	2 1/4 lever arch file
Mr Haynes	0	0	0	0	7 (26.09.17)	0	60 documents
Mr O'Brien	13 (27.06.16)	0	0	0	6	0	6 lever arch files
Mr O'Donoghue	0	0	0	0	0	7 (21.09.17)	1 lever arch file
Mr Young	11 (Jan 17)	17	0	2 (28.09.17)	17 (July 17)	0	1 1/2 lever arch files
Sub Speciality Totals	**25**	**24**	**2**	**42**	**67**	**19**	

UROLOGY	Backlog - Number of charts with oldest date in brackets						
Consultant	**Discharges awaiting Dictation**	**Discharges to be typed**	**Clinics to be dictated**	**Clinic letters to be typed**	**Results to be dictated**	**Results to be typed**	**Filing**
Mr Jakob	0	0	0	6 (25.10.17)	34 (25.09.17)	5 (23.10.17)	
Mr Suresh							
Mr Glackin	4 (Oct 17)	6 (24.10.17)	2 (06.06.17)	1 (30.10.17)	81 (16.10.17)	0	2 1/2 Lever arch files
Mr Haynes	0	0	0	0	2 (29.10.17)	26 (30.10.17)	70 sheets
Mr O'Brien	13 (27.06.16)	0	0	0	3	0	Approx 6 lever arch files
Mr O'Donoghue	0	0	0	14 (24.10.17)	0	21 (24.10.17)	1 lever arch file
Mr Young	20 (Jan 17)	0	0	2 (02.11.17)	14 Cons, 11 Reg, July 17	0	1 1/2
Sub Speciality Totals	**37**	**6**	**2**	**23**	**145**	**52**	

UROLOGY	Backlog - Number of charts with oldest date in brackets						
Consultant	**Discharges awaiting Dictation**	**Discharges to be typed**	**Clinics to be dictated**	**Clinic letters to be typed**	**Results to be dictated**	**Results to be typed**	**Filing**
Mr Jakob	0	0	0	3 (29.11.17)	11 (27.11.17)	35 (20.11.17)	1 lever arch file
Mr Suresh							
Mr Glackin	3 (Nov)	3 (24.11.17)	3 (06.06.17)	2 (21.11.17)	80 (Oct)	7 (15.11.17)	3 lever arch files
Mr Haynes	0	10 (22.11.17)	0	0	1 (27.11.17)	23 (23.11.17)	60 sheets
Mr O'Brien	12 (27.06.16)	0	0	0	2	0	Approx 6 lever arch files
Mr O'Donoghue	0	0	0	14 (22.11.17)	0	11 (23.11.17)	1 lever arch file
Mr Young	3 (Feb 17)	0	0	36 (27.11.17)	15 MY, 17 Reg, July 17	0	1 1/2 lever arch files
Sub Speciality Totals	**18**	**13**	**3**	**55**	**126**	**76**	

Received from Michael Young on 01/09/22. Annotated by Urology Services Inquiry

UROLOGY	Backlog - Number of charts with oldest date in brackets						
Consultant	Discharges awaiting Dictation	Discharges to be typed	Clinics to be dictated	Clinic letters to be typed	Results to be dictated	Results to be typed	Filing
Mr Jakob							
Mr Suresh							
Mr Glackin							
Mr Haynes							
Mr O'Brien							
Mr O'Donoghue							
Mr Young							
Sub Speciality Totals							

UROLOGY	Backlog - Number of charts with oldest date in brackets						
Consultant	**Discharges awaiting Dictation**	**Discharges to be typed**	**Clinics to be dictated**	**Clinic letters to be typed**	**Results to be dictated**	**Results to be typed**	**Filing**
Mr Jakob	0	0		3 clinics (03.01.17	20 (01.1.17)	20 (25.12.17)	1 lever arch file
Mr Suresh	0	0					
Mr Glackin	2	2	2 charts 06.06.17	21 (into jan)	37	8 (26.12.17)	2.5 lever arch files
Mr Haynes	0	10 (29.12.17	0	0	0	22 (28.12.17)	80 sheets
Mr O'Brien	12	0	0	7 clinics (29.12.17)	6	0	6 lever arch files
Mr O'Donoghue	0	0		17	0	13 (19.12.17)	lever arch file
Mr Young	Secretary on AL						
Sub Speciality Totals	**22**	**10**	**2**	**approx 100**	**63**	**63**	

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UROLOGY	Backlog - Number of charts with oldest date in brackets						
Consultant	Discharges awaiting Dictation	Discharges to be typed	Clinics (no of charts) to be dictated	Clinic letters to be typed	Results to be dictated	Results to be typed	Filing
Mr Jakob	0	0	0	0	0	0	lever arch file
Mr Suresh	0	4		14 (05.02.18)	15 (05.02.18)	6	
Mr Glackin	0	12	1	1	84 (12.01.18)	9 (31.01.18)	lever arch file
Mr Haynes	0	0	0	7 (25.1.18)	2 (29.01.18)	29 (04.02.18)	lever arch file
Mr O'Brien	12	0	0	0	6		6 lever arch files
Mr O'Donoghue	0	0	0	22 (31.01.18)	0	16 (01.02.18)	1 lever arch file
Mr Young							
Sub Speciality Totals							

UROLOGY	Backlog - Number of charts with oldest date in brackets						
Consultant	Discharges awaiting Dictation	Discharges to be typed	Clinics to be dictated	Clinic letters to be typed	Results to be dictated	Results to be typed	Filing
Mr Jakob	0	3	0	15	15	19	1 file
Mr Suresh							
Mr Glackin	6	0	10	67	2	12	1 file
Mr Haynes	0	0	0	5	0	9	1 file
Mr O'Brien	21	0	0	0	8	0	6 files
Mr O'Donoghue	0	0	0	48	0	3	1 file
Mr Young	6	0	0	0	6	0	1.5
Sub Speciality Totals	**33**	**3**	**10**	**130**	**31**	**40**	

(all within march)

Received from Michael Young on 01/09/22. Annotated by Urology Services Inquiry

UROLOGY	Backlog - Number of charts with oldest date in brackets						
Consultant	**Discharges awaiting Dictation**	**Discharges to be typed**	**Clinics LETTERS to be dictated**	**Clinic letters to be typed**	**Results to be dictated**	**Results to be typed**	**Filing**
Mr Jakob	0	10 (13.04.18)	0	15 (12.04.18)	0	40 (09.04.18)	2 lever arch files
Mr Suresh							
Mr Glackin	3	10	15 (28.03.18)	1	98 (02.04.18)	3	
Mr Haynes	0	0	0	0	10 (05.04.18)	15 (15/04/18)	70 sheets
Mr O'Brien	30 (06.04.18)	0	0	57 (27.03.18)	10	0	6 lever arch files
Mr O'Donoghue	0	0	0	57 (10.04.18)	0	10 (12.04.18)	1 lever arch file
Mr Young	9	0	1	0	39 (March/April)	0	2 BOXES
Sub Speciality Totals	**42**	**20**	**16**	**129**	**157**	**65**	

UROLOGY	Backlog - Number of charts with oldest date in brackets						
Consultant	Discharges awaiting Dictation	Discharges to be typed	Clinics letters to be dictated	Clinic letters to be typed	Results to be dictated	Results to be typed	Filing
Mr Jakob	0	2	0	3	30 (23.04.18)	0	
Mr Glackin	4	6	3	15 (25.04)	8	14	2 lever arch
Mr Haynes	0	0	0	6 (26.04.18)	12 (16.04.18)	32 (27.4.18)	
Mr O'Brien	9 (01.18)	0	0	1 (27.04.18)	14 (Reg 2017)	28	2 boxes
Mr O'Donoghue	0	0	0	26	0	12	1 lever arch
Mr Young	no sec response						
Sub Speciality Totals	**13**	**8**	**3**	**37**	**56**	**86**	

UROLOGY	Backlog - Number of charts with oldest date in brackets						
Consultant	Discharges awaiting Dictation	Discharges to be typed	Clinics (charts) to be dictated	Clinic letters to be typed	Results to be dictated	Results to be typed	Filing
Mr Jakob	0	3	0	19	16	22	1 file
Mr Glackin	1	10	4	21 (25.05)	84 (14.05)	13	1 box
Mr Haynes							
Mr O'Brien	20	17	54 (10.04.18)	12	8	0	6 files
Mr O'Donoghue	0	0	0	0	0	6	1 lever arch file
Mr Young	15 (Jan 18)	0	0	0	38	0	2 boxes
Sub Speciality Totals							

UROLOGY	Backlog - Number of charts with oldest date in brackets							
Consultant	Discharges awaiting Dictation	Discharges to be typed	Clinic letters to be dictated	Clinic letters to be typed	oldest date	Results to be dictated	Results to be typed	Filing
Mr Jakob	10	10	0	0		40	14	1 file
Mr Glackin	1	1	3	7	27.06	84	0	2 files
Mr Haynes	0	0	0	6	29.06.18	44	0	
Mr O'Brien								6 files
Mr O'Donoghue	0	0	0	6		0	23	1 file
Mr Young	0	0	0	0		38	38	2 boxes
Sub Speciality Totals	**11**	**11**	**3**	**19**		**206**	**75**	

UROLOGY	Backlog - Number of charts with oldest date in brackets								
Consultant	Discharges awaiting Dictation	Discharges to be typed	Clinic letters to be dictated	oldest date of clinic letters to be dictated	Clinic letters to be typed	oldest date	Results to be dictated	Results to be typed	Filing
Mr Jakob	7	7	0		2	06.08.18	60	60	1 file
Mr Glackin	10	13	9	july	0		44	3	2 files
Mr Haynes	0	0	0		23	02.08.18	8	70	
Mr O'Brien	31		44	08.05.18	17	06.08.18	10	0	6 files
Mr O'Donoghue	0	0	0		3		0	47	1 file
Mr Young	0	0	0		12	01.08.18	0	4	2 boxes
Sub Speciality Totals	**48**	**20**	**53**		**57**		**122**	**184**	

UROLOGY	Backlog - Number of charts with oldest date in brackets								
Consultant	Discharges awaiting Dictation	Discharges to be typed	Clinic letters to be dictated	oldest date of clinic letters to be dictated	Clinic letters to be typed	oldest date	Results to be dictated	Results to be typed	Filing
Mr Jakob	0	8	0		10	03.09.18	10	0	2 files
Mr Glackin	4	19	4	06.06.18	21	23.08.18	49	29	2 files
Mr Haynes	0	9	0		6	30.8.18	15	12	85 sheets
Mr O'Brien	17				81	01.06.18	5		6 files
Mr O'Donoghue					55	28.08.18	14	0	2 files
Mr Young	11	0	2	24.08.18	0		44	0	2 files
Sub Speciality Totals	**32**	**36**	**6**		**173**		**137**	**41**	

UROLOGY	Backlog - Number of charts with oldest date in brackets								
Consultant	Discharges awaiting Dictation	Discharges to be typed	Clinic letters to be dictated	oldest date of clinic letters to be dictated	Clinic letters to be typed	oldest date	Results to be dictated	Results to be typed	Filing
Mr Jakob					18	25.09.18	30	0	3 files
Mr Glackin	5	6	7	06/06/2018 (1 letter)	11	26.09.18	29	5	1.5 files
Mr Haynes	0	0	19	26.09.18	0		55	0	115 sheets
Mr O'Brien	17	0	91	15.06.18	0				6 files
Mr O'Donoghue					15	26.09.18	12	0	2 files
Mr Young	12	0	0	0	2	27.09.18	35	0	2.5 files
Sub Speciality Totals	**34**	**6**	**117**		**46**		**161**	**5**	

UROLOGY	Backlog - Number of charts with oldest date in brackets											
Consultant	Discharges awaiting Dictation	oldest date	Discharges to be typed	Clinic letters to be dictated	oldest date of clinic letters to be dictated	Clinic letters to be typed	oldest date	Results to be dictated	oldest date	Results to be typed	oldest date	Filing
Mr Jakob	0	0	0	0		0		22	05.11.18	0		3 files
Mr Glackin	22	26.10.18	2	3	23.10.18	30	23.10.18	0		28	18.10.18	1.75 files
Mr Haynes	0		0	0		2	31.10.18	11	11.10.18	56	01.11.18	150 sheets
Mr O'Brien	17	27.06.16 GP has hard copy	25	0		8	02.11.18	7	6.2018	0		6 files all onoclogy filed
Mr O'Donoghue			2	0		38	29.10.18	28	11.10.18	18.10.18	01.11.18	2 files
Mr Young	12	Mar-18	0	0		26	01.11.18	10	october	0		3 files
Sub Speciality Totals	51		29	3		104		78		84		

UROLOGY	Backlog - Number of charts with oldest date in brackets											
Consultant	Discharges awaiting Dictation	oldest date	Discharges to be typed	Clinic letters to be dictated	oldest date of clinic letters to be dictated	Clinic letters to be typed	oldest date	Results to be dictated	oldest date	Results to be typed	oldest date	Filing
Mr Jakob	0		5	0		0		5	03.12.18	34	19.11.18	3 files
Mr Glackin	8	oct/nov	0	3	19.09.18	3	28.11.18	25	05.11.18	10	28.11.18	2 files
Mr Haynes	0		20	0		12	26.11.18	6	19.11.18	14	02.12.18	175 sheets
Mr O'Brien	13	27.06.16 gp has the hard copy	5	10	30.11.18	10	27.11.18	13		10		
Mr O'Donoghue	0	0	0	0	0	0	0	0	0	0	0	2 files
Mr Young	12		9	0		26		40		55		3 files
Sub Speciality Totals	33		39	13		51		89		123		

Received from Michael Young on 01/09/22. Annotated by Urology Services Inquiry

UROLOGY	Backlog - Number of charts with oldest date in brackets												
Consultant	Discharges awaiting Dictation	oldest date	Discharges to be typed	oldest date	Clinic letters to be dictated	oldest date of clinic letters to be dictated	Clinic letters to be typed	oldest date	Results to be dictated	oldest date	Results to be typed	oldest date	Filing
Mr Jakob	0		0		0		3	03.01.19	30	31.12.18	29	05.01.19	4 files
Mr Glackin	2	Nov-18	19	21.12.18	2	19.09.18	8	31.12.18	7	24.12.18	32	27.12.18	2 files
Mr Haynes	0		10	02.01.19	0		24	02.01.19	6	24.12.18	75	27.12.18	240 sheets
Mr O'Brien	15	27.06.16 but the handwritten discharge in the chart and GP has	10		nothing on report		13	12 of these are triage letters 05.01.19	10				6 files
Mr O'Donoghue	0		0		0		10	03.01.19	60	14.11.2018	24	03.01.19	3 files
Mr Young	0	-	0				11	04.01.19	32	december	27		3 charts
Sub Speciality Totals	17		39		2		69		145		187		

UROLOGY	Backlog - Number of charts with oldest date in brackets												
Consultant	Discharges awaiting Dictation	oldest date	Discharges to be typed	oldest date	Clinic letters to be dictated	oldest date of clinic letters to be dictated	Clinic letters to be typed	oldest date	Results to be dictated	oldest date	Results to be typed	oldest date	Filing
Mr Jakob	0	0	0	0	0	0	0	0	12	31.12.18	0	0	2 files
Mr Glackin	14	Nov-18	20	25.01.19	1	22.01.19	1	30.01.19	32	24.12.18	19	30.01.19	1.75
Mr Haynes	0	0	9	30.01.19	0	0	6	30.01.19	3	28.01.19	45	01.02.19	1 file
Mr O'Brien	14	27.06.16 but the handwritten discharge in the chart and GP has	5	03.02.19			16	02.02.19	6	02.02.19	2		6 files
Mr O'Donoghue	0	0	0	0	0	0	0	0	3	04.01.19	33	31.01.19	3 files
Mr Young	0	-	0	0	0	0	0	0	41		17	jan	3 files
Sub Speciality Totals	**28**		**34**		**1**		**23**		**97**		**116**		

Received from Michael Young on 01/09/22. Annotated by Urology Services Inquiry

UROLOGY	Backlog - Number of charts with oldest date in brackets												
Consultant	Discharges awaiting Dictation	oldest date	Discharges to be typed	oldest date	Clinic letters to be dictated	oldest date of clinic letters to be dictated	Clinic letters to be typed	oldest date	Results to be dictated	oldest date	Results to be typed	oldest date	Filing
Mr Tyson	0		0		0		6	25.03.19	14	February	6	25.03.19	2 lever arch files
Mr Glackin	1	Nov	4	26.03.19	0		27	26.03.19	28	11.02.19	15	26.03.19	2 lever arch files
Mr Haynes	0		5	25.03.19	0		22	26.03.19	37	12.03.19	23	23.03.19	1 lever arch file
Mr O'Brien	18	27.06.16	0		0		39	08.03.19	15	-	0		approx 6 lever arch files
Mr O'Donoghue	0		0		0		20	27.03.19	68	18.02.18	9	27.03.19	3 lever arch files
Mr Young	3	-	0	-	0		14	29.03.19	37	-	9	Feb-19	
Sub Speciality Totals	**22**		**9**		**0**		**128**		**199**		**62**		

Received from Michael Young on 01/09/22. Annotated by Urology Services Inquiry

UROLOGY	Backlog - Number of charts with oldest date in brackets												
Consultant	Discharges awaiting Dictation	oldest date	Discharges to be typed	oldest date	Clinic letters to be dictated	oldest date of clinic letters to be dictated	Clinic letters to be typed	oldest date	Results to be dictated	oldest date	Results to be typed	oldest date	Filing
Mr Tyson	0	-	6	24.04.19	0	-	0	-	14	15.04.19	5	25.04.19	
Mr Glackin	3	Mar-19	0	-	3	25.03.19	30	15.04.19	22	08.04.19	1	18.04.19	2 lever arch files
Mr Haynes	0	-	0	-	0	-	27	16.04.19	9	18.04.19	15	19.04.19	
Mr O'Brien	15	27.06.16	0	-	0	-	50	03.04.19	6	-	2	13.04.19	6 files
Mr O'Donoghue	0	-	0	-	0	-	0	-	26	11.04.19	0	-	3 files
Mr Young	2	Jan-19	0	-	0	-	24	19.04.19	23	-	10	-	4 box files
Sub Speciality Totals	20		6		3		131		100		33		

UROLOGY	Backlog - Number of charts with oldest date in brackets											
Consultant	Discharges awaiting Dictation	oldest date	Discharges to be typed	oldest date	Clinic letters to be dictated	Clinic letters to be typed	oldest date	Results to be dictated	oldest date	Results to be typed	oldest date	Filing
Mr Tyson	0		0		0	10	29.05.19	10	30.05.19	42	24.05.19	3 files
Mr Glackin	6	28.05.19	9	March-May	5	28	23.05.19	17	20.05.19	21	28.05.19	2 files
Mr Haynes	0	-	0	-	0	31	28.05.19	36	20.05.19	13	30.05.19	2 lever arch files
Mr O'Brien	18	27.06.19	0	-	38 - 24.05.19	0	-	0	-	6	-	6 files
Mr O'Donoghue	0	-	0	-	0	25	29.05.19	0	-	2	30.05.19	3 files
Mr Young	6	-	0	-	0	15	30.05.19	25	-	0	-	4.5 files
Sub Speciality Totals	30		9		5	109		88		84		

UROLOGY	Backlog - Number of charts with oldest date in brackets											
Consultant	Discharges awaiting Dictation	oldest date	Discharges to be typed	oldest date	Clinic letters to be dictated	Clinic letters to be typed	oldest date	Results to be dictated	oldest date	Results to be typed	oldest date	Filing
Mr Tyson	0	-	0	-	0	2	26.06.19	40	24.06.19	54	24.05.19	3 files
Mr Glackin	7	Mar-19	0	-	1 - 04.04.19	0	-	31	03.06.19	0	-	2 files
Mr Haynes	0	-	0	-	0	0	-	19	10.06.19	20	26.06.19	1.5 files
Mr O'Brien	18	27.06.16	0	-	43 - 24.05.19	0	-	10	-	0	-	6 files
Mr O'Donoghue	0	-	0	-	0	12	25.06.19	11	01.05.19	12	24.06.19	3 files
Mr Young	6	-	0	-	0	0	-	17 (MY) 7 (Reg)	May-19	0	-	2.5 files
Sub Speciality Totals	31		0		0	14		111		86		

UROLOGY	Backlog - Number of charts with oldest date in brackets												
Consultant	Discharges awaiting Dictation	oldest date	Discharges to be typed	oldest date	Clinic letters to be dictated	oldest date	Clinic letters to be typed	oldest date	Results to be dictated	oldest date	Results to be typed	oldest date	Filing
Mr Tyson/ solt	0	-	3	26.07.19	0	-	9	30.07.19	20	29.07.19	4	31.07.19	3 lever arch files
Mr Glackin	8	Mar-19	12	05.07.19	2	-	29	22.07.19	21	10.06.19	61	10.07.19	2 lever arch files
Mr Haynes	0	-	3	17.07.19	0	-	37	22.07.19	15	22.07.19	90	17.07.19	1.5 lever arch files
Mr O'Brien	34	27.06.16	0	-	60	10.06.19	0	-	7	Dec-18	0	-	6 lever arch files
Mr O'Donoghue	0	-	0	-	0	-	47	17.07.19	65	15.05.19	2	18.07.19	3 lever arch files
Mr Young	6	-	0	-	0	-	15	26.07.19	11	-	0	Jan-00	2.5 box files
Sub Speciality Totals	48		18		62		137		139		157		

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UROLOGY	Backlog - Number of charts with oldest date in brackets												
Consultant	Discharges awaiting Dictation	oldest date	Discharges to be typed	oldest date	Clinic letters to be dictated	oldest date	Clinic letters to be typed	oldest date	Results to be dictated	oldest date	Results to be typed	oldest date	Filing
Mr Tyson/ solt	0	-	0	-	0	-	0	-	25	19.08.19	23	26.08.19	3 lever arch files
Mr Glackin	11	Mar-19	7	19.08.19	0	-	28	19.08.19	6	29.07.19	64	19.08.19	2 lever arch
Mr Haynes	0	-	0	-	0	-	2	19.08.19	24	12.08.19	19	29.08.19	2.5 lever arch files
Mr O'Brien	25	27.06.16	0	-	49	16.08.19	0	-	11		7		6 files
Mr O'Donoghue	0	-	0	-	1	20.08.19	36	09.08.19	61	04.07.19	26	07.08.19	3 lever arch files
Mr Young	9	-	0	-	0	-	25	28.08.19	21	Aug-19	0	-	3 file boxes
Sub Speciality Totals	45		7		50		91		148		139		

Received from Michael Young on 01/09/22. Annotated by Urology Services Inquiry

UROLOGY	Backlog - Number of charts with oldest date in brackets												
Consultant	Discharges awaiting Dictation	oldest date	Discharges to be typed	oldest date	Clinic letters to be dictated	oldest date	Clinic letters to be typed	oldest date	Results to be dictated	oldest date	Results to be typed	oldest date	Filing
Mr Tyson/ solt	0	-	0	-	0	-	0	-	45	25.09.19	45	25.09.19	4 lever arch files
Mr Glackin	8	Mar-19	9	20.09.19	0	-	47	18.09.19	25	23.09.19	19	18.09.19	2.5 lever arch files
Mr Haynes	0	-	23	20.09.19	0	-	19	17.09.19	10	16.09.19	41	23.09.19	3 lever arch files
Mr O'Brien	30		0	-	22	23.09.19	54	20.08.19	11	-	6	-	6 lever arch files
Mr O'Donoghue	0	-	0	-	0	-	61	17.09.19	26	01.08.19	15	16.09.19	4 lever arch files
Mr Young	10	Mar-19	0	-	0	-	10	07.10.19	28	Aug-19	7	Aug-19	3.5 folscap boxes
Sub Speciality Totals	**48**		**32**		**22**		**191**		**145**		**133**		

Received from Michael Young on 01/09/22. Annotated by Urology Services Inquiry

UROLOGY	Backlog - Number of charts with oldest date in brackets												
Consultant	Discharges awaiting Dictation	oldest date	Discharges to be typed	oldest date	Clinic letters to be dictated	oldest date	Clinic letters to be typed	oldest date	Results to be dictated	oldest date	Results to be typed	oldest date	Filing
Mr Tyson/ solt													
Mr Glackin	1	Aug-19	16	28.10.19	1	22.10.19	3	29.10.19	13	07.10.19	21	23.10.19	2.5 lever arch files
Mr Haynes	0	-	0	-	0	-	17	24.10.19	11	21.10.19	15	30.10.19	4 lever arch files
Mr O'Brien	35	27.06.17	0	-	45	23.09.19	11	20.09.19	21		0	-	
Mr O'Donoghue	0	-	0	-	0	-	43	15.10.19	19	16.08.19	78	15.10.19	4 lever arch files
Mr Young	8	-	0	-	0	-	29	24.10.19	32	-	0	-	3 box files
Sub Speciality Totals	44		16		46		103		96		114		

UROLOGY	Backlog - Number of charts with oldest date in brackets												
Consultant	Discharges awaiting Dictation	oldest date	Discharges to be typed	oldest date	Clinic letters to be dictated	oldest date	Clinic letters to be typed	oldest date	Results to be dictated	oldest date	Results to be typed	oldest date	Filing
Mr Tyson/ solt	0	-	0	-	0	-	0	-	0	-	0	-	
Mr Glackin	6	Nov-19	1	22/11/2019	-	-	5	22/11/2019	46	25/11/2019	12	22/11/2019	1.5 lever arch files
Mr Haynes	-	-	-	0	-	-	23	25/11/2019	58	04/11/2019	2	25/11/2019	3.5 lever arch files
Mr O'Brien	20	02/05/2019	-	-	42	05/11/2019	6	01/11/2019	10	Oct-19	2		6 lever arch files
Mr O'Donoghue	-	-	-	-	-	-	-	-	22	14/11/2019	17	18/11/2019	6 lever arch files
Mr Young	7	Mar-19	0	-	0	-	0	-	35	Sep-19	0	-	4.5 lever arch files
Sub Speciality Totals	33		1		42		34		171		33		

UROLOGY	Backlog - Number of charts with oldest date in brackets												
Consultant	Discharges awaiting Dictation	oldest date	Discharges to be typed	oldest date	Clinic letters to be dictated	oldest date	Clinic letters to be typed	oldest date	Results to be dictated	oldest date	Results to be typed	oldest date	Filing
Mr Tyson/ solt	0	0	0	0	0	0	0	0	3	30/12/2019	10	06/01/2020	4 lever arch files
Mr Glackin	8	Nov-19	16	13/12/2019	-	-	25	11/12/2019	10	02/12/2019	15	17/12/2019	1 3/4 lever arch
Mr Haynes	-	-	5	23/12/2019	-	-	18	16/12/2019	28	22/12/2019	71	21/12/2019	4 lever arch files - virtual letters
Mr O'Brien	23	18/09/2019	-	-	68	09/12/2019	33	08/11/2019	13	Oct-19	4		6 lever arch files
Mr O'Donoghue	-	-	-	-	-	-	26	17/12/2019	39	27/11/2019	24	17/12/2019	6 lever arch files
Mr Young	8	Mar-19	0	0	0	0	12	03/01/2019	10	Nov-19	30	Sep-19	5 Folscap boxes
Sub Speciality Totals	39		21		68		114		103		154		

Stinson, Emma M

From: Young, Michael
Sent: 24 July 2022 17:34
To: Stinson, Emma M
Cc: Young, Michael
Subject: inquiry

Can this be put in my folder Q23

From: Young, Michael [redacted]
Sent: 10 September 2020 22:17
To: Robinson, Katherine [redacted]; Corrigan, Martina [redacted]
Subject: RE: stc administration

Fabulous
I take it this is the complete package and will discuss with Teresa when she returns soon

Thank you

MY

From: Robinson, Katherine
Sent: 21 August 2020 15:41
To: Young, Michael; Corrigan, Martina
Subject: RE: stc administration

Teresa Loughran has agreed to take this on wef 1/9/20. I trust this meets with your approval.

Regards

K

From: Young, Michael
Sent: 19 August 2020 11:58
To: Corrigan, Martina; Robinson, Katherine
Subject: stc administration

Could we have a meeting with reference to the STC administration fairly soon please.

Leanne has carried out an excellent job and set this up well with regard to the research and running of the weekly meeting.
It's clear from everything that has gone on in the last 2 years that the administration for the STC in its totality is quite substantive and possibly more than in fact has been recognised.

Also Leanne's post was paid for via research monies.

For this to continue we need a substantive post and more if we are to take on regional work. However till that service arrangement is fully defined we certainly need to have an efficient service already working.
Therefore a funded system is needed.

Can we meet soon to discuss?

Enclosed is a document that Laura had drafted before

MY

CRAIGAVON AREA HOSPITAL GROUP TRUST

Caring Through Commitment

Proposal for the development of Urology Nurse Specialist Led Clinical Services at Craigavon Area Hospital Group Trust

Directorate of Planning & Contracts
Date: Monday, 06 June 2005
Author: Anne Brennan

Proposal for the development of Urology Nurse Specialist Led Clinical Services at Craigavon Area Hospital

Surgical Directorate

1.0 Introduction

This current paper details the proposed organisation and planned activity associated with the appointment of two Urology Nurse Specialists and the development of associated clinics at Craigavon Area Hospital Group Trust.

2.0 The key areas where specialist nursing could impact?

- New Outpatient Referrals
- General Urology Review Patients
- Uro-Oncology Patients
- Current Outpatient Waiting Lists

3.0 Current Key Issues:

3.1 New Outpatient Referrals:

- Service receives on average 220 new outpatient referrals per month, this has increased from an average of 194 per month in 2003/2004
- Service currently sees approximately 570 new patients per annum
- Outpatients is the only access point to service outside of emergency admissions
- Pressure of review patients is impacting on the ability to see new patients
- 24% patients waiting over 24+ for 1st appointment

If we had a 'perfect' Urology service & dealt with OP referrals as per BAUS guidelines capacity would be at max 1,260 per annum (based on 3 consultants) V current referrals total 2,640 per annum

3.2 Outpatient Reviews:

- Current new:review ratio is 1:9, BAUS recommends 1:2 [with junior doctor support]
- Reviews totalled 3,800 in 2003/2004 with a 1:7 new: review ratio and YTD 2004/2005, excluding ACH are 2,725 with a new:review ratio of 1:9
- Reviews are generated through outpatients but also through emergency admissions, intra hospital transfers and inter hospital transfers
- Current new: review ratio is having negative impact on ability to see new patients
- There are no other safe channels for review other than referral back to GP under current conditions, this is not always possible/feasible due to complexity of casemix and age profiles.

3.3 Uro-Oncology Workload

- In England, Prostatic cancer is the most commonly diagnosed cancer in men and the second most common cause of death from Cancer in men [after lung cancer] [1]
- CAH Service is provided via a combination of outpatient visits, extra out of hours visits with consultants and ad-hoc clinics. There is no dedicated clinic at this time
- There is no dedicated TRUS Biopsy session and patients are currently added to Ultrasound lists in the Radiology Department
- Urology review estimated 150 cases of prostatic cancer and 60 cases of bladder cancer per annum for CAH
- Urology Review estimates that approximately 600 patients per annum would require some form of prostate investigation
- Research has demonstrated that these figures will rise as the population age profile of men within the SHSSB rise
- Often provide end stage palliative care for patients
- Increased life expectancy has resulting in a growing cohort of ‘stable’ patients who require ongoing specialist care. Five year survival prostate rates improved from around 42% in the late 1980’s to 68% in the late 1990’s.

1. Making Progress on Prostate Cancer – NHS Nov 2004

3.4 Outpatient Waiting Lists:

- 1,300 outpatients on list requiring 1st appointment
- 25% waiting 24+ months

- 70% waiting in excess of 6 months
- 99 GP Practices have referred to the Urology Service
- 35% of referrals emanate from 8 GP practices
- Estimate based on Armagh GP referral patterns pilot demonstrates that ~33% of these patients may have LUTS/Prostatic Symptoms
- Draft PFA Targets unachievable
- Increasing numbers of long waiters converting into emergency admissions/cases

4.0 How we think can specialist nurse can help

4.1 New Patients:

4.1.1 Immediate Objectives:

- Establishment of Nurse Led LUTS Assessment Clinic & follow up
- Establishment of Prostatic Symptom Clinic
- Freeing up of Consultant time to see more new patients in a more timely manner through the establishment of Nurse Led clinics
- Provide patients with time to consider decisions regarding their treatment for prostatic cancer[2]
- Making best use of 1st consultation with Consultant by advising/educating GPs

4.2 Review Patients:

4.2.1 Immediate Objectives

- Adopting the recommendations of Urology Strategy - Modernisation recommendations[3] to ensure that all patients are reviewed by the most appropriate member of the multidisciplinary team.
- Undertaking review of Nurse Led LUTS & Prostatic clinic
- Establishment of TRUS Biospy Service

4.2.2 Medium Term Objectives:

- Establishment of Nurse Led General Urology Review Clinic with clear discharge policies
- Establishment of Uro-Oncology Nurse Led Review Clinic

- Longer term - Development of telephone follow-up for appropriate patients

2,3 NHS Modernisation Agency – Urology Strategy for Spread & Sustainability

4.3 Uro-Oncology Patients:

4.3.1 Immediate Objectives:

- Handling a proportion of the diagnostic workload via the Prostatic Symptom clinic
- Undertaking a review of the Nurse Led Prostatic clinic, freeing up Consultant time through the establishment of a Uro-Oncology Nurse Led Service

4.3.2 Medium Term Objectives:

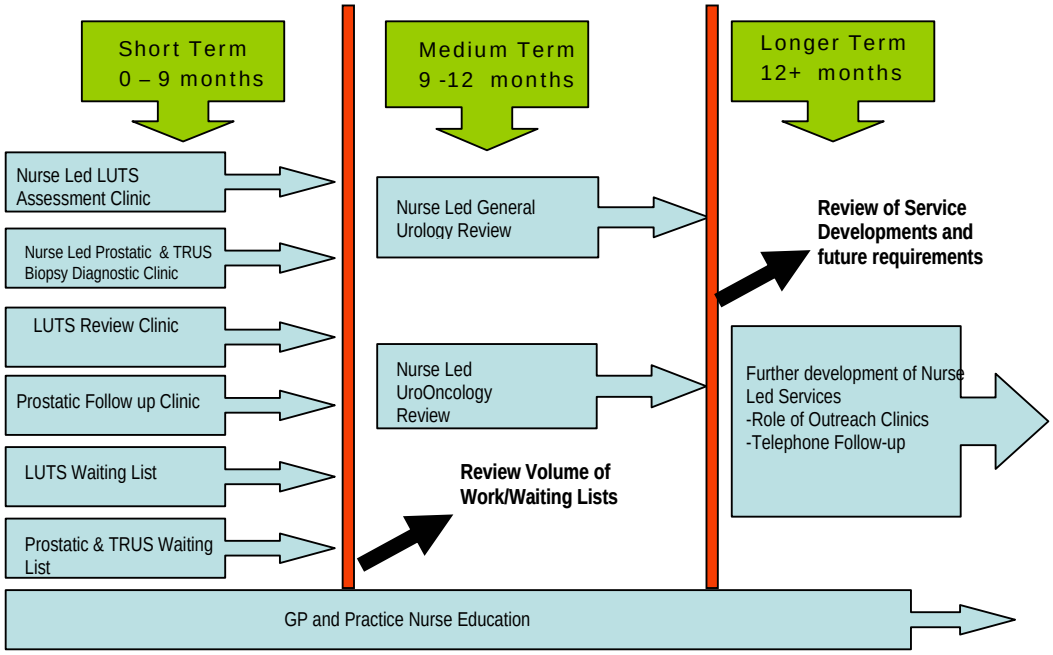
- Ongoing review/care of “stable” oncology patients under appropriate protocols, freeing up consultant time

4.4 Outpatients Waiting List

4.4.1 Immediate Objectives:

- Undertaking additional clinics to handle existing waiting lists

5.0 Timeline for Implementation



6.0 Proposal for the appointment of two Urology Nurse Specialists & associated development of clinical services

The Trust is seeking SH&SSB approval to appoint two Urology Nurse Specialists to develop the following in a phased manner

- Nurse Led LUTS Assessment Clinic & Follow up Review Service
- Nurse Led Prostatic Diagnostic Clinic & Biopsy Service and Follow up Review Service
- Nurse Led LUTS Waiting List Initiative
- Nurse Led Prostatic & TRUS Waiting List Initiative
- Nurse Led General Urology Review Service
- Nurse Led Uro-Oncology Review Service

7.0 Nurse Led LUTS Assessment Clinic & Follow up Reviews

7.1 Anticipated Throughput (per month)

- 8 X Assessment clinics [All day Monday CAH Site]
- 4 X Review Clinic [Tuesday PM CAH Site]
- 32 new patients per month
- 32 Review patients per month

7.2 Projected Demand (per month)

- 220 new referrals
- 33% LUTS/Prostatic Related [72 patients]
- 48 of these suitable for LUTS Assessment clinic

7.3 Modernisation Impact:

- Introduction of LUTS Clinic increases current new patient capacity by 60% alone
- Provides an ability to meet increased needs of demand for services
- Reduction of pressure of referrals to consultant
- Removal of 352 new patients slots per annum from outpatients & 352 Review slots
- More time available for patients & an ability to assess patient satisfaction
- Health Promotion opportunities

8.0 Nurse Led Prostatic Diagnostic Clinic & TRUS Biopsy and Follow up Review Service

8.1 Anticipated Throughput (per month)

- 4 X Symptom Clinics seeing 16 new patients *[as per Belfast City Hospital guidelines, 45mins – 1 hour per patient]*
- 8 X Review Clinics seeing 52 review patients [1 clinic X 5 patients [Trus Biopsy Review]/1 clinic X 8 patients]
- Will oversee TRUS Biopsies, providing patient support and education [184 TRUS Biopsies per annum]

8.2 Projected Demand (per month)

- 184 new referrals
- 33% LUTS/Prostatic Related [72 patients]
- 24 of these suitable for Prostatic Diagnostic clinic

8.3 Modernisation Impact:

- Establishment of rapid assessment clinic reducing the number of visits to diagnosis, currently could take up to 5 visits before diagnosis
- Removal of 184 new patients slots from outpatients & 598 Review slots per annum
- Work with primary care via Dr. Millar to ensure that the right patients are referred through the urgent route through development of referrals proforma templates and GP education
- Ensure patients are counselled appropriately

9.0 Nurse Led LUTS Waiting List Initiative

9.1 Anticipated Throughput (per month)

- 4 X Waiting List Assessment clinics seeing 16 new patients
- 4 X Waiting List Review Clinic seeing 32 review patients

9.2 Projected Demand

- Current waiting list estimated at 291 patients awaiting first assessment

9.3 Modernisation Impact:

- Yearly – 184 new patients /368 review patients per annum from waiting list
- Clearance within 18 months

10.0 Nurse Led Prostatic Waiting List Initiative

10.1 Anticipated Throughput (per month)

- 4 X Waiting List Symptom Clinics seeing 16 new patients
- 4 X Prostatic Review Clinics seeing 32 review patients

10.2 Projected Demand:

- Currently waiting list estimated at 145 patients

10.3 Modernisation Impact:

- 184 new patients seen per annum from current waiting lists
- 368 Review patients per annum
- Clearance within 9 months

11.0 Nurse Led General Urology Review Service

11.1 Anticipated Throughput (per month)

- 4 X Review clinics [Year 1] seeing 32 patients
- Clear concise, strict discharge policy
- Combination of clinic/telephone review [Phased approach]

11.2 Projected Demand:

- Existing cohort of (new:review) patients 1:9 ratio
- Post operative patients/outpatients

11.3 Modernisation Impact:

- 368 Reviews from Consultants main outpatient service per annum
- Potential to offer outreach to Banbridge Polyclinic and Armagh Community Hospital sites

12.0 Nurse Led General Uro-Oncology Review Service

12.1 Anticipated Throughput (per month)

- 4 X Review clinics [Year 1] seeing 32 patients
- Designed for “stable”/counselling oncology patients
- No discharge policy possible

12.2 Projected Demand:

- Existing cohort of patients 1:9 ratio
- Estimate stable patients require 6 monthly review

12.3 Modernisation Impact:

- 368 Reviews from Consultants main outpatient service per annum

- Enables increase in duration of per-patient-review when conducted by specialist nurse
- Enables patient more discussion time
- Potential to offer at Banbridge Polyclinic and Armagh Community Hospital sites

13.0 Timetable of Proposed Activities

Monday AM	Nurse Led LUTS Assessment Clinic – Craigavon Area Hospital, Macmillan Unit	Nurse Led Prostatic Assessment Clinic – CAH, Macmillan Unit TRUS Biopsy Clinic – CAH, Macmillan Unit
Monday PM	Nurse Led LUTS Assessment Clinic – CAH, Macmillan Unit	TRUS Biopsy Review Clinic, CAH Macmillan Unit
Tuesday PM	Nurse Led LUTS Review – CAH Macmillan Unit	Nurse Led Prostatic Review – CAH, Macmillan Unit
Thursday AM	LUTS Waiting List Assessment Clinic, CAH, Stone Treatment Centre	Prostatic Waiting List Assessment Clinic CAH, Stone Treatment Centre
Thursday PM	Nurse Led General Review [Alternate weeks] 1st/3rd BBPC]	Nurse Led Uro-Oncology Review [alternate weeks] [2nd/4th Thursday]
Friday AM	LUTS Waiting List Review Clinic CAH, Stone Treatment Centre	Prostatic Waiting List Review Clinic CAH, Stone Treatment Centre
Friday PM	Nurse Led General Review [Alternate weeks] CAH, Outpatients Department [2nd/4th CAH]	Nurse Led Uro-Oncology Review [alternate weeks] CAH, Outpatients Department [1st/3rd]

14.0 Specialist Urology Nursing – Northern Ireland Analysis

Centre	Specialist Nurses / Nursing Roles	Consultants
Altnagelvin	4	2
Belfast City	3	6
Causeway	0	1+1 to be recruited
Craigavon	0	2+1 to be recruited
Ulster	1	1
Mater	0	1

15.0 So why do we need two Nurse Specialists?

- Workload – 2,600 referrals per annum
- Introduction of four new specialist clinics from scratch - nothing exists at present
- Implementation of massive change for GPs in terms of service delivery, one nurse will bring little or no impact for such immense change
- No compromise between establishment of LUTS/Prostatic possible – both are equally needed
- No back up/cross cover possible
- Services demand experienced personnel requiring higher grading.
- Service has already suffered from training lower grade staff who then move to higher grade posts elsewhere

16.0 Why cant these Nurses Process More Patients

- Reviewed services in other sites in Northern Ireland
- Have viewed the establishment of these clinics in light of the capacity of the service in terms of consultant manpower, theatres, beds and diagnostics --- given current capabilities this is the optimum number

17.0 Comparison of Consultant V Nurse Specialist

CAHGT - Financial Planning						
Nurse Led Specialist Clinics						
1 March 2005						
Comparison of Consultant v Nurse Specialist						
		Consultant	*Nurse Specialist*	*Difference*		*Note*
		£	£	£		
Hourly rate		37.89	17.87	20.02		*1, 3, 6, 7*
Sessional rate		132.62	62.54	70.08		*2*
Cost per new patient		33.15	15.63	17.52		*8*
Cost per review patient		16.58	7.82	8.76		*9*
Estimated number of new patients to be seen by nurse specialist				500		*4*
Estimated number of review patients to be seen by nurse specialist				2,000		*4*
Differential from nurse specialist seeing new patient				8,760		
Differential from nurse specialist seeing review patient				17,520		
Total differential per annum from employing a nurse specialist				**26,279**		*5, 6, 7*
Annual cost of H grade nurse specialist				**34,842**		*1, 6, 7*

19.0 Impact Summary

19.1 New Patients

- Capacity for 368 new LUTS Referrals to be seen by Nurse Specialist
- Capacity for 184 New Prostatic Assessments to be undertaken by Nurse Specialist
- Access for 552 new patients to access the Urology Service
- Doubling our current outpatient capacity to see new patients

19.2 Review Patients

- Undertaking review of new patients entering the service via Nurse Led Services
- Development of innovative discharge focused general Urology service – capacity of 368 patients per annum
- Development of Uro-Oncology Review service for ‘stable’ oncology patient cohort with a capacity of 368 patients per annum
- Frees consultants from review services: allows for more new patients and a movement toward BAUS new:review guidelines

- Potential to offer outreach to Banbridge Polyclinic and Armagh Community Hospital sites

19.3 Waiting Lists

- Identification of Persons suitable for nurse led LUTS/Prostatic services
- Capacity to clear waiting lists in 9 to 18 months [based on Armagh GP referral patterns]
- Ability to identify 'clinically urgent' patients on waiting lists and fast track them

20.0 Resource Requirements Summary

20.1 Summary Projected Activity

Clinic Description	New	Review	Total
Nurse Led LUTS Assessment	368	368	736
Nurse Led Prostatic Symptom clinic & Follow up	184	414	598
TRUS Biopsy Service	230	-	230
Nurse Led LUTS Waiting List Initiative	184	368	552
Nurse Led Prostatic Waiting List Initiative	145	290	435
TRUS Waiting List	145	-	145
Nurse Led General Urology Review	-	368	368
Nurse Led Uro-Oncology Review	-	368	368
Total Projected Annual Activity	**1256**	**2176**	**3,432**

20.2 Summary Resource Requirement by Clinic

Staff Description	Grade	Nurse Led LUTS Assessment	Nurse Led Prostatic Symptom clinic & Follow up	Nurse Led LUTS Waiting List Initiative	Nurse Led Prostatic Waiting List Initiative	Nurse Led General Urology Review	Nurse Led Uro-Oncology Review	Total
Specialist Nursing [1]	Grade H	0.50	0.55	0.30	0.25	0.20	0.20	**2.0**
Nursing Auxillary[2]	Grade A	0.235	0.125	0.125	0.125	-	-	**0.61**
Radiographer[3]	Senior 1	0.125	0.125	0.125	0.125	-	-	**0.50**
Radiology Clerical Support[4]	Grade II	0.062	0.062	0.062	0.062	-	-	**0.25**
Consultant Radiologist[5]	-	-	0.15		0.09	-	-	**0.24**
Secretarial Support[6]	Grade III	0.16	0.14	0.12	0.12	0.08	0.08	**0.70**
Reception	Grade II	0.02	0.03	-	-	-	-	**0.05**
Health Records[7]	Grade II	0.14	0.12	0.10	0.10	0.07	0.07	**0.60**
Portering[8]	Grade II	0.023	0.019	0.017	0.017	0.012	0.012	**0.10**
Facilities [9]	Domestic	From existing Resources	From existing Resources	0.025	0.025	From existing Resources	From existing Resources	**0.05**
Laboratory[10]	BMS 1	0.06	0.07	0.03	0.03	0.03	0.03	**0.25**
Pharmacy[11]	No Resources required	No Resources required	No Resources required	No Resources required	No Resources required	No Resources required	No Resources required	**0**

1. Specialist Nursing based on the following allocation between clinics:

    General Review 20%, LUTS Assessment & Review 50%, LUTS Waiting List 30%

    Prostatic Assessment/Review 55%, Uro-Oncology Review 20%, Prostatic Waiting List 25%

2. Nursing Auxiliary based on:

    3 sessions LUTS & Prostatic Assessment/Review, 2 sessions LUTS/Prostatic Waiting List Initiatives

    Existing outpatient staff nursing will undertake Review clinic workload from existing resources

3 Radiographer based on:

    5 sessions Prostatic & LUTS Assessment & Prostatic & LUTS Waiting List – Scanning and reporting of same.

4. Radiology Clerical Support based on:

    Reporting of above sessions

5. Consultant Radiologist

6. Secretarial Support based on:

    Activity relating to all 6 clinics

    Nurse Led LUTS 23%, Nurse Led Prostate 19%, Nurse Led LUTS Waiting List 17%, Nurse Led Prostate Waiting List 17%, General Urology Review 12%, Uro-Oncology Review 12%

7. Health Records based on:

    Activity relating to all clinics

    Nurse Led LUTS 23%, Nurse Led Prostate 19%, Nurse Led LUTS Waiting List 17%, Nurse Led Prostate Waiting List 17%, General Urology Review 12%, Uro-Oncology Review 12%