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
3 June 2005

			Notes	Assumptions
NON-RECURRING CAPITAL COSTS		**FYE £**		
TOTAL NON-RECURRING CAPITAL COSTS		**23,501**	3	
NON-RECURRING REVENUE COSTS				1
PAYROLL COSTS				
	WTE			
Nursing staff				
Nursing Grade A	0.25	3,494		
Sub-total	0.25	3,494		
Radiology				
Consultant radiologist	0.09	7,068		4
Senior I radiographer	0.25	8,116		
Sub-total	0.34	15,184		
Clerical				
Grade 2 radiology clerical support	0.12	1,781		
Sub-total	0.12	1,781		
Portering				
Grade 2 porter	0.03	464		
Sub-total	0.03	464		
Total Non-Recurring Payroll	**0.75**	**20,924**		
GOODS AND SERVICES				2
		Outpatients £	1, 2	
Area services (pharmacy, radiography, labs)		14,149		3
Medical & surgical/general disposables/sterile disp		3,061		
General/stationery/postage/telephone		62		
Portering		83		
Domestic services - cleaning		755	4	
Travelling/training/uniforms		3,150		
Total non-recurring goods & services		**21,261**		
TOTAL NON-RECURRING REVENUE COSTS		**42,185**		
TOTAL NON-RECURRING COSTS		**65,686**		

RECURRING REVENUE COSTS				1
PAYROLL COSTS			**Notes**	**Assumptions**
	WTE	**£**		
Nursing staff				
Nursing Grade H	2.00	71,933		
Nursing Grade A	0.36	5,032		
Sub-total	2.36	76,964		
Radiology				
Consultant radiologist	0.15	11,663		4
Senior I radiographer	0.25	8,116		
Sub-total	0.40	19,779		
Laboratories				
BMS 1	0.24	13,548		
Sub-total	0.24	13,548		
Clerical				
Grade 3 secretarial support	0.70	11,156		
Grade 2 health records	0.60	8,617		
Grade 2 reception	0.05	718		
Grade 2 radiology clerical support	0.12	1,781		
Sub-total	1.47	22,272		
Portering				
Grade 2 porter	0.07	902		
Sub-total	0.07	902		
Total Recurring Payroll	**4.54**	**133,465**		

		Notes	**Assumptions**
GOODS AND SERVICES			2
	Outpatients		
	£		
Area services (pharmacy, radiography, labs)	26,439		3
Medical & surgical/general disposables/sterile disp	4,850		
General/stationery/postage/telephone	146		
Portering	195		
General services (including travel/training/uniforms)	19,933		
Total recurring goods & services	**51,563**		
TOTAL RECURRING REVENUE COSTS	**185,028**		
TOTAL NON-RECURRING & RECURRING COSTS	**250,714**		

CAHGT - Financial Planning
Summary of Nurse Led Urology Clincs
3 June 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 for 2004/05 and 2.5% for 2005/06.
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
3 June 2005

Assumptions	Detail
1	Payroll is costed at mid point using the 2005/06 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.
4	Consultant is costed using the 2004/05 pay rates uplifted for inflation and excluding the impact of the new consultants' contract.

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

Appendix B Nurse Led Prostatic Assessment & Follow up

Appendix C: Nurse Led General Urology Review

Appendix D: Nurse Led Uro-Oncology Review

Appendix E: Nurse Led LUTS Waiting List

Appendix F: Nurse Led Prostatic Assessment & Follow Up [Waiting List]

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]	

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

Directorate of Planning & Contracts
Date: Monday, 06 June 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
3 June 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	17,983		
Nursing Grade A	0.24	3,285		
Sub-total	0.74	21,268		
Radiology				
Senior I radiographer	0.13	4,058		
	0.13	4,058		
Laboratories				
BMS 1	0.06	1,441		
	0.06	1,441		
Clerical				
Grade 3 secretarial support	0.16	2,550		
Grade 2 health records	0.14	2,011		
Grade 2 reception	0.02	287		
Grade 2 radiology clerical support	0.06	890		
Sub-total	0.38	5,738		
Portering				
Grade 2 porter	0.02	314		
Sub-total	0.02	314		
Total Recurring Payroll	**1.33**	**32,819**		

GOODS AND SERVICES			2
	Outpatients	1, 2	
	£		
Area services (pharmacy, radiography, labs)	10,551		3
Medical & surgical/general disposables/sterile disp	2,283		
General/stationery/postage/telephone	47		
Portering	62		
General services (including travel/training/uniforms)	4,923		
Total recurring goods & services	**17,865**		
TOTAL RECURRING REVENUE COSTS	**50,685**		
TOTAL NON-RECURRING & RECURRING COSTS	**59,219**		

CAHGT - Financial Planning
Nurse Led LUTS Assessment
3 June 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
3 June 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 for 2004/05 and 2.5% for 2005/06.
3	See appendix 1 for breakdown of non-recurring costs.

CAHGT - Financial Planning
Nurse Led LUTS Assessment
3 June 2005

Assumptions	Detail
1	Payroll is costed at mid point using the 2005/06 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

Directorate of Planning & Contracts
Date: Monday, 06 June 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

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	0.55
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
3 June 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	19,781		
Nursing Grade A	0.13	1,747		
Sub-total	0.68	21,529		
Radiology				
Consultant radiologist (TRUS)	0.15	11,663		4
Senior I radiographer	0.13	4,058		
	0.28	15,721		
Laboratories				
BMS 1	0.07	1,585		
	0.07	1,585		
Clerical				
Grade 3 secretarial support	0.14	2,231		
Grade 2 health records	0.12	1,723		
Grade 2 reception	0.03	431		
Grade 2 radiology clerical support	0.06	890		
Sub-total	0.35	5,276		
Portering				
Grade 2 porter	0.02	260		
Sub-total	0.02	260		
Total Recurring Payroll	**1.39**	**44,370**		

GOODS AND SERVICES			2
	Outpatients	1, 2	
	£		
Area services (pharmacy, radiography, labs)	11,870		3
Medical & surgical/general disposables/sterile disp	2,568		
General/stationery/postage/telephone	52		
Portering	70		
General services (including travel/training/uniforms)	6,656		
Total recurring goods & services	**21,216**		
TOTAL RECURRING REVENUE COSTS	**65,586**		
TOTAL NON-RECURRING & RECURRING COSTS	**80,553**		

CAHGT - Financial Planning
Nurse Led Prostate Clinic & Biopsy Service
3 June 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
3 June 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 for 2004/05 and 2.5% for 2005/06.
3	See appendix 1 for breakdown of non-recurring costs.

CAHGT - Financial Planning
Nurse Led Prostate Clinic & Biopsy Service
3 June 2005

Assumptions	Detail
1	Payroll is costed at mid point using the 2005/06 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.
4	Consultant is costed using the 2004/05 pay rates uplifted for inflation and excluding the impact of the new consultants' contract.

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

Directorate of Planning & Contracts
Date: Monday, 06 June 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
3 June 2005

			Notes	Assumptions
NON-RECURRING COSTS		**FYE £**		
TOTAL NON-RECURRING COSTS		**0**		
RECURRING COSTS				1
PAYROLL COSTS				
	WTE			
Nursing staff				
Nursing Grade H	0.20	7,193		
Sub-total	0.20	7,193		
Clerical				
Grade 3 secretarial support	0.08	1,275		
Grade 2 health records	0.07	1,005		
Sub-total	0.15	2,280		
Laboratories				
BMS 1	0.03	577		
Sub-total	0.03	577		
Portering				
Grade 2 porter	0.01	164		
Sub-total	0.01	164		
Total recurring payroll	**0.39**	**10,214**		
GOODS AND SERVICES				2
		Outpatients £	1, 2	
Area services (labs)		2,009		3
General/stationery/postage/telephone		23		
Portering		31		
General services (including travel/training/uniforms)		1,446		
Total recurring goods & services		**3,509**		
TOTAL RECURRING REVENUE COSTS		**13,723**		
TOTAL NON-RECURRING & RECURRING COSTS		**13,723**		

CAHGT - Financial Planning
Nurse Led General Urology Review
3 June 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 for 2004/05 and 2.5% for 2005/06.

CAHGT - Financial Planning
Nurse Led General Urology Review
3 June 2005

Assumptions	Detail
1	Payroll is costed using the 2005/06 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

Directorate of Planning & Contracts
Date: Monday, 06 June 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
3 June 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	7,193		
Sub-total	0.20	7,193		
Clerical				
Grade 3 secretarial support	0.08	1,275		
Grade 2 health records	0.07	1,005		
Sub-total	0.15	2,280		
Laboratories				
BMS 1	0.03	577		
	0.03	577		
Portering				
Grade 2 porter	0.01	164		
Sub-total	0.01	164		
Total Recurring Payroll	**0.39**	**10,214**		
GOODS AND SERVICES				2
		Outpatients £	1, 2	
Area services (pharmacy, radiography, labs)		2,009		3
General/stationery/postage/telephone		23		
Portering		31		
General services (including travel/training/uniforms)		1,532		
Total recurring goods & services		**3,595**		
TOTAL RECURRING REVENUE COSTS		**13,809**		
TOTAL NON-RECURRING & RECURRING COSTS		**13,809**		

CAHGT - Financial Planning
Nurse Led Uro-Oncology Review
3 June 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 for 2004/05 and 2.5% for 2005/06.

CAHGT - Financial Planning
Nurse Led Uro-Oncology Review
3 June 2005

Assumptions	Detail
1	Payroll is costed at mid point using the 2005/06 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

Directorate of Planning & Contracts
Date: Monday, 06 June 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

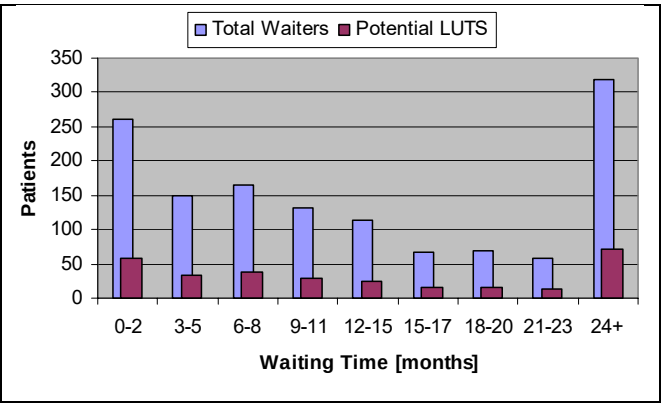
2.0 Background

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	0.30
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
3 June 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	1,747		
Sub-total	0.13	1,747		
Radiology				
Senior I radiographer	0.13	4,058		
	0.13	4,058		
Clerical				
Grade 2 radiology clerical support	0.06	890		
Sub-total	0.06	890		
Portering				
Grade 2 porter	0.02	232		
Sub-total	0.02	232		
Total Non-Recurring Payroll	**0.33**	**6,928**		

GOODS AND SERVICES			2
		Outpatients	1, 2
		£	
Area services (pharmacy, radiography, labs)		7,913	3
Medical & surgical/general disposables/sterile disp		1,712	
General/stationery/postage/telephone		35	
Portering		47	
Domestic services - cleaning		377	3
General services (including travel/training/uniforms)		1,051	
Total non-recurring goods & services		**11,135**	
TOTAL NON-RECURRING REVENUE COSTS		**18,063**	
TOTAL NON-RECURRING COSTS		**18,063**	
RECURRING REVENUE COSTS			1
PAYROLL COSTS			
	WTE		
Nursing staff			
Nursing Grade H	0.30	10,790	
Sub-total	0.30	10,790	
Clerical			
Grade 3 secretarial support	0.12	1,912	
Grade 2 health records	0.10	1,436	
Sub-total	0.22	3,349	
Laboratories			
BMS 1	0.03	8,648	
	0.03	8,648	
Total Recurring Payroll	**0.55**	**22,786**	
GOODS AND SERVICES			2
General services (including travel/training/uniforms)		3,418	
Total recurring goods & services		**3,418**	
TOTAL RECURRING REVENUE COSTS		**26,204**	
TOTAL NON-RECURRING & RECURRING COSTS		**44,267**	

CAHGT - Financial Planning
Nurse Led LUTS Waiting List Assessment & Review Service
3 June 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 for 2004/05 and 2.5% for 2005/06.
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
3 June 2005

Assumptions	Detail
1	Payroll is costed at mid point using the 2005/06 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

Directorate of Planning & Contracts
Date: Monday, 06 June 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.

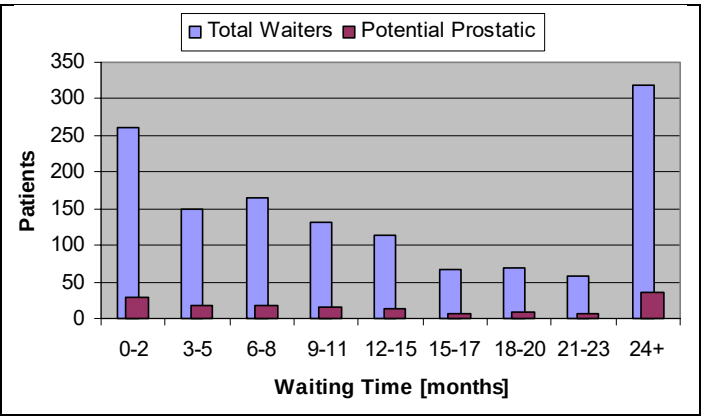
2.0 Background & Demand

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:

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
3 June 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	1,747		
Sub-total	0.13	1,747		
Radiology				
Consultant radiologist	0.09	7,068		4
Senior I radiographer	0.13	4,058		
	0.22	11,126		
Clerical				
Grade 2 radiology clerical support	0.06	890		
Sub-total	0.06	890		
Portering				
Grade 2 porter	0.02	232		
Sub-total	0.02	232		
Total non-recurring payroll	**0.42**	**13,996**		
GOODS AND SERVICES				2
		Outpatients £	1, 2	
Area services (pharmacy, radiography, labs)		6,236		3
Medical & surgical/general disposables/sterile disp		1,349		
General/stationery/postage/telephone		28		
Portering		37		
Domestic services - cleaning		377	3	
General services (including travel/training/uniforms)		2,099		
Total non-recurring goods & services		**10,126**		
TOTAL NON-RECURRING REVENUE COSTS		**24,122**		
TOTAL NON-RECURRING COSTS		**24,122**		
RECURRING REVENUE COSTS				1

PAYROLL COSTS			**Notes**	**Assumptions**
	WTE			
Nursing staff				
Nursing Grade H	0.25	8,992		
Sub-total	0.25	8,992		
Laboratories				
BMS 1	0.03	721		
	0.03	721		
Clerical				
Grade 3 secretarial support	0.12	1,912		
Grade 2 health records	0.10	1,436		
Sub-total	0.22	3,349		
Total recurring payroll	**0.50**	**13,061**		
GOODS AND SERVICES				2
General services (including travel/training/uniforms)		1,959		
Total recurring goods & services		**1,959**		
TOTAL RECURRING REVENUE COSTS		**15,020**		
TOTAL NON-RECURRING & RECURRING COSTS		**39,142**		

CAHGT - Financial Planning
Nurse Led Prostatic Assessment & Review & TRUS Biopsy Waiting List Initiative
3 June 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 for 2004/05 and 2.5% for 2005/06.
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
3 June 2005

Assumptions	Detail
1	Payroll is costed at mid point using the 2005/06 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.
4	Consultant is costed using the 2004/05 pay rates uplifted for inflation and excluding the impact of the new consultants' contract.

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

Urology Nurse Specialist 1: Weekly Commitment	
2.0 Sessions LUTS Assessment	
1.0 LUTS Review	
1.0 Administration of LUTS Service / GP Education and Advice	
1.0 Development of General Urology Nurse Led Review	
Year 1	*Year 2*
1.0 LUTS Waiting List Assessment 1.0 LUTS Waiting List Review	1.0 General Urology Review 1.0 LUTS Waiting List Assessment ***then*** 2.0 General Urology Review following clearance of LUTS waiting list migration
0.50 Administration of Urology Review Workload	
2.5 Support Professional Activities [Role development/MDT etc]	

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]	

Craigavon Area Hospital Group Trust

Consultant Job Plan Review Template

Prospective plan for 1 April 2007 until 31 March 2008

Personal details:

Name: **Mr M Young**	Contract:
Specialty/Directorate: **Urology**	☐ **Whole Time** ☐ Part Time

On-call availability supplement:

Rota Frequency: **1** in: 3

Rota Category ☐ **Category A** ☐ Category B ☐ N/A

Management Allowance: ☐ Medical Director ☐ Clinical Director ☐ **N/A**

Summary Of Programmed Activities:

Direct Patient Care:	**8.44** 's	
Supporting Professional Activities:	**2.5** PA's	
On-Call Allocation:	*Predictable* ☐ PA's	*Unpredictable* **1.57** PA's
Any Annualised Activity *(Reflecting any work undertaken outside the time included in the proposed job plan. Detailed information must be given):*	**0** PA's	***Details:***
TOTAL PA's: (Rounded to nearest 0.25)	**12.5** PA's	

Private Practice: *Please provide details of any private practice commitments and/or fee paying activity undertaken in normal working hours but which has not been included in the Job plan template:*

PLAN TEMPLATE - Average Weekly Programmed Activities

DAY	TIME	WORK ACTIVITY	LOCATION	HOURS		Total	Prem
				DCC	SPA		
Mon	8.30 - 10.00	Ward Round	CAH	1.5	0	9.75	0
	10.00 - 12.00	STC availability/ STC sessions/ Admin/ Urodynamic consultation	CAH	2	0		
	12.00 - 14.00	STC Clinic	CAH	2	0		
	14.00 - 15.00	Histopath MDT	CAH	1	0		
	15.00 - 17.00	New Prostate Clinic consultation (Variable??)	CAH	2	0		
	17.00 - 18.15	Pre Op Ward Round	CAH	1.25	0		
Tues	8.30 - 9.00	Pre Op Ward Round	CAH	0.5	0	9.75	0
	9.00 - 18.00	Theatre (Day Surgery 3rd week in month)	CAH	9	0		
	18.00 - 18.15	Post op Ward Round	CAH	0.25	0		
Wed	9.00 - 9.30	Ward Round	CAH	0.5	0	6	0
	9.30 - 13.00	STC Sessions / availability/ Admin	CAH	3.5	0		
	13.00 - 14.00	Patient Admin	CAH	1	0		
	14.00 - 15.00	*SpR Programme Director Workload*	CAH	0	1		
	PM	**Private Patients**	/	0	0		
Thurs	8.15 - 10.00	X Ray MDT	CAH	1.75	0	8.75	0
	10.00 - 12.30	Grand Round	CAH	2.5	0		
	12.30 - 16.00	Urology team meeting	CAH	0	3.5		
	16.00 - 17.00	Patient Admin	CAH	1	0		
Fri	8.30 - 9.00	SpR Programme Director / Admin/Teaching	CAH	0	0.5	9.5	0
	9.00 - 14.00	SPA Activities	CAH	0	5		
	14.00 - 17.00	Outpatients Clinic / Directorate meeting	CAH	3	0		
	17.00 - 18.00	Ward Round activities	CAH	1	0		
TOTAL HOURS				**33.75**	**10**	**43.75**	**0**
AVERAGE HOURS				**8.44**	**2.5**	10.938	**0**

Stinson, Emma M

From: Young, Michael
Sent: 10 August 2022 22:28
To: Stinson, Emma M
Subject: FW: s21 q29.17

upload

From: Shields, Katie [redacted]
Sent: 10 August 2022 12:41
To: Young, Michael [redacted]
Subject: RE: s21 q29.17

Hi Michael each complaint/inident/sai (all 3 in one report) report is sent to the Dr directly as per current process. It is a requirement that the Dr uploads and reflects upon in appraisal.

Katie

From: Young, Michael [redacted]
Sent: 10 August 2022 11:32
To: Shields, Katie [redacted]
Subject: s21 q29.17

Morning
A question

Are SAI reports sent to appraisers ? or is it just complaints

MY

Stinson, Emma M

From: Young, Michael
Sent: 10 August 2022 22:28
To: Stinson, Emma M
Subject: FW: s21 q29.17

upload

From: Corrigan, Martina [redacted]
Sent: 10 August 2022 13:41
To: Young, Michael [redacted]
Subject: RE: s21 q29.17

Not sure of dates but these have been about for the length of time I was in post since 2010 and were known as Root Cause Analysis before they changed to SAI.
Appraisers wouldn't have got these but they were all tabled and discussed at the M&M/Patient Safety meetings.

Many thanks

Martina
[redacted]

From: Young, Michael [redacted]
Sent: 10 August 2022 11:32
To: Corrigan, Martina [redacted]
Subject: s21 q29.17

When was the SAI system brought in?

And were appraisers sent these ?

MY

Chief Executives

Name & Dates in Post
Mr Colm Donaghy Apr 2007- Sept 2009
Mrs Mairead McAlinden Sept 2009 – March 2015
Mrs Paula Clarke Mar 2015-Mar 2016
Mr Francis Rice Apr 2016 – Mar 2018
Mr Stephen McNally Jan 17 – Jul 17 Nov 17 – Mar 2018
Mr Shane Devlin Mar 2018 – Jan 2022
Dr Maria O'Kane Jan 2022 - present

Medical Directors

Name & Dates in Post
Dr Paddy Loughran Apr 2007 – Jul 2011
Dr John Simpson Jun 2011 – Aug 2015
Dr Richard Wright Jul 2015 – Aug 2018
Dr Ahmed Khan Apr 2018 – Dec 2018
Dr Maria O'Kane Dec 2018 – May 2022

Directors of Acute Services

Name & Dates in Post
Ms Joy Youart Apr 2007 – Dec 2009
Dr Gillian Rankin 1st December 2009 (Interim Director of Acute Services) 01/03/2011 – 31/03/2013 – Director of Acute Services
Mrs Debbie Burns Mar 2013 – Aug 2015
Mrs Esther Gishkori Aug 2015 – Apr 2020
Mrs Melanie McClements

June 2019 – July 2022

Name & Dates in Post
Mr Simon Gibson Apr 2007 – Sep 2009
Mrs Heather Trouton Oct 2009 – Mar 2016
Mr Ronan Carroll Apr 2016 – present

Assistant Directors

Associate Medical Directors

Name
Mr Robin Brown CD for General Surgery in Daisy Hill but from Sept 2009-Dec 2013 also covered Urology
Mr Sam Hall Jan 2014 – Mar 2016
Mr Colin Weir Jun 2016 – Dec 2018
Mr Ted McNaboe Dec 2018 – Dec 2021

Name
Mr Eamon Mackle Jan 2008 – Apr 2016
Dr Charlie McAllister Apr 2016-Oct 2016
Mr Mark Haynes Oct 2017 – Jan 2022
Mr Ted McNaboe Acting AMD Jan 2022 -present

Clinical Directors

Consultant Urologists

Name
Mr Michael Young July 1998-May 2022
Mr Aidan O'Brien July 1992 – Jun 2020
Mr Mehmood Akhtar Sept 2007 – Apr 2012
Mr Anthony Glackin Aug 2012 - present
Mr Ajay Pahuja Nov 2012 – Jan 2014
Mr David Connolly Sep 2012 – Mar 2013
Mr Ram Suresh Dec 2013 – Oct 2016
Mr Mark Haynes May 2014 - present
Mr John O'Donoghue Aug 2014 - present
Mr Thomas Jacob Jan 2017 – Jan 2019
Mr Derek Hennessy Apr 2018 – May 2019
Mr Matthew Tyson Feb 2019 – present (note was on sabbatical from July 2019- Jan 2022

M. Young

2011

SIGN OFF

We confirm that the above information is an accurate record of the documentation provided by the appraisee and used in the appraisal process, and of the appraisee's position with regard to development action in the course of the past year.

Signed [Appraiser]	Personal Information redacted by the USI		
PRINT NAME	[redacted]		
GMC Number	2646042	Date	28/1/13

Signed [Appraisee]	Personal Information redacted by the USI		
PRINT NAME	M. Young		
GMC Number	2846385	Date	

3. Working relationships with colleagues

Commentary: No problems identified

Action Agreed: will carry on 360° as.

4. Relations with patients

Commentary: No problems identified

Action Agreed: will carry on patient satisfaction survey

5. Teaching and training

Commentary: ~~Not good~~
Educational supervision, Examiner QUB + RCSI, Teach + Lecture/Post-grad

Action Agreed:

SIGN OFF

We agree that the above is an accurate summary of the appraisal discussion and agreed action, and of the agreed personal development plan.

Signed [Appraiser]	Personal Information redacted by the USI		
PRINT NAME	[illegible]		
GMC Number	2646042	Date	28/1/13

Signed [Appraisee]	Personal Information redacted by the USI		
PRINT NAME	M. Young		
GMC Number	2546385	Date	28/1/13

Record here the names of any third parties who contributed to the appraisal and indicate the capacity in which they did so:

HEALTH DECLARATION

It is recommended that you sign the Health Statement attached. It is important that you discuss with your appraiser any areas of your health that are causing you concern. If you feel you are unable to sign this statement, please leave it unsigned. In deciding whether there are matters to raise, you should bear in mind the advice of the General Medical Council in Good Medical Practice. Paragraphs 77 to 79 of Good Medical Practice set out some of the health obligations that you should consider when signing a declaration. There are other types of obligations/information that you should also consider, for example, whether there are any formal or voluntary restrictions to your practice because of illness or a physical condition. This would include any conditions imposed by an employer or contractor of your services, any proceedings under the GMC's Health Procedures or Health Committee or similar proceedings of other professional regulatory or licensing bodies within the UK or abroad.

Professional obligations
The GMC's guidance 'Good Medical Practice and Serious communicable diseases' says that if a doctor has a serious condition which they could pass on to patients or colleagues they must have any necessary tests and act on the advice given to them by a suitably qualified colleague about necessary treatment and/or modifications to their clinical practice. Moreover, if their judgement or performance could be significantly affected by a condition, illness, physical disease or by taking medication, they must take and follow advice from a consultant in occupational health or another suitably qualified colleague on whether, and in what ways, they should modify their practice.

If you are able to sign both of the declarations set out below then you do not need to complete the rest of the pro-forma over the page. However, if you are not able to sign both of the declarations above then you will need to complete the full pro-forma below.)

I accept the professional obligations placed upon me in paragraphs 77 to 79 of *Good Medical Practice* and *Serious com[redacted]*

Signed [Appraisee]	Personal Information redacted by the USI		
PRINT NAME	M. Young		
GMC Number	2854 6385	Date	28-1-13

I can confirm I am registered with a General Practitioner

Signed [Appraisee]	Personal Information redacted by the USI		
PRINT NAME	M. Young		
GMC Number		Date	

ANNEX to HEALTH DECLARATION pro-forma
(need only be completed if declaration above cannot be completed)

Your own health
The GMC acknowledges that medicine can be a demanding profession and that doctors who become ill deserve help and support. Doctors also have to recognise that illness can impair their judgement and performance and thus put patients and colleagues at risk (this is particularly so in the case of psychiatric conditions, drug and alcohol abuse). The GMC therefore encourages doctors seek professional advice and consider whether, for health related reasons, they should modify their professional activities.

1. Do you have any illness or physical condition that has since your last appraisal/revalidation1 resulted in your restricting or changing your professional activities?

Yes☐ No☒

If yes, please give details of the changes in your professional activities which it is - or was - necessary for you
Make:

Regulatory and voluntary proceedings
2. Are you - or have you been since your last appraisal been the subject of any proceedings under the GMC's Health Procedures or Health Committee or similar proceedings of other professional regulatory or licensing bodies within the UK or abroad?

Yes ☐No☒

If yes, please give details:

3. Are you currently or since your last appraisal/revalidation been subject to medical supervision, voluntary or otherwise, and/or any restrictions voluntary or otherwise, imposed by your employer or
contractor resulting from any illness or physical condition within the UK or abroad?

Yes☐ No☒

If yes, please give details:

4. Have you reflected on the implications of your condition and or medication and sought appropriate professional advice?

Yes☐ No☐

If yes, please give details:

N/A

All the information in this declarati[redacted] knowledge.

Personal Information redacted by the USI

Signed [Appraisee]	[redacted]		
PRINT NAME	M. YOUNG		
GMC Number	2846385	Date	28/1/13

PERSONAL DEVELOPMENT PLAN

In this section the appraiser and appraisee should identify key development objectives for the year ahead, which relate to the appraisee's personal and/or professional development. This will include action identified in the summary above but may also include other development activity, for example, where this arises as part of discussions on objectives and job planning. Please indicate clearly the timescale within which these objectives should be met on the template provided here.

Consultants approaching retirement age may well wish to consider their retirement intentions and actions which could be taken to retain their contribution to the NHS.

The important areas to cover are:

- action to maintain skills and the level of service to patients
- action to develop or acquire new skills
- action to change or improve existing practice.

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

Southern Health and Social Care Trust
Quality Care - for you, with you

APPRAISAL DOCUMENTS

CONTENTS

FORM 1 - BACKGROUND DETAILS

- *This form should be completed by the appraisee in advance of the appraisal.*
- *The aim of Form 1 is to provide basic background information about you as an individual including brief details of your career and professional status.*
- *The form includes an optional section for any additional information.*

1.1	Full name	Michael Robert Andrew YOUNG
1.2	GMC Registered address (contact address if different)	Personal Information redacted by the USI
1.3	Main employer	Southern Trust Northern Ireland
1.4	Main place of work	Craigavon Area Hospital
1.5	Other employers/ places of work	Nil
1.6	Date of primary medical qualification	1983 MB BCh BAO
1.7	GMC registration number and type	2846385 Full
1.8	Start date of first substantive appointment in HSC as a trained doctor	August 1983
1.8	GMC Registration date and specialties	Urology 2Nd April 1998
1.9	Title of current post and date appointed	Consultant Urologist 1 st May 1998
1.10	For any specialist registration / qualification outside UK, please give date and specialty	
1.11	Please list any other specialties or sub-specialties in which you are registered	
1.12	Is your registration currently in question?	No
1.13	Date of last revalidation (if applicable)	
1.14	Please list all posts in which you have been employed in HSC and elsewhere in the last five years (including any honorary and/or part-time posts)	Southern Trust Health and social Care Northern Ireland

ANY ADDITIONAL INFORMATION

Consultant in urological surgery – general practice though job description specifies an interest in stone management.
Work involves outpatient clinics in the main hospital in Craigavon and at one outreach site at Banbridge (though a further clinic in Armagh, which had been a routine monthly clinic, has now been discontinued). In addition a regular specialised stone clinic is undertaken weekly. Inpatient management involves ward rounds and weekly operating sessions as well as a monthly day-surgery list. Other fixed commitments have included two specialised stone sessions (ESWL). Other areas covered include urodynamic sessions and administration. My lead Clinician role in Urology has continued to evolve with the changes within the Trust and the development of the service.
My job description generally has remained unchanged from previous appraisals though ad hoc additional theatre lists, clinics and urodynamic sessions have been undertaken to help meet targets.
Recent chances however have resulted in moving the out-reach clinics to a different time slot to accommodate the additional clinical session of urology uro-oncology MDT.
The External Regional Review of Urology services for Northern Ireland which are affecting the Southern Board, combined with the previous introduction of the ICATS services is now all coming into fruition with extra consultant appointments and changes to the population to be looked after.

I am a member of the following medical associations:

Fellow of the Royal College Surgeons in Ireland
British Association of Urological Surgeons
BAUS subsection of Endourology
British Medical Association

Medical Defence Union

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

FORM 2 - CURRENT MEDICAL ACTIVITIES

- *This form should be completed by the appraisee in advance of the appraisal.*
- *The aim of Form 2 is to provide an opportunity to describe your current post(s) in the HSC, in other public sector bodies, or in the private sector, including titles and grades of any posts currently held or held in the past year.*
- *Information should cover your practice at all locations since your last appraisal or during the last 12 months whichever is longer.*
- *You may wish to comment in addition on factors which affect the provision of good health care.*

2.1 Please give a short description of your work, including the different types of activity you undertake	I am a Consultant urologist with an interest in stone management. Work involves a general outpatient clinic at the main hospital in Craigavon and at Banbridge outreach polyclinic. In addition I have a weekly specialised stone clinic. Other specialist areas include a session of urodynamics combined with oncology assessment clinics. I run the Stone Treatment Centre with a team of nurses and Radiographers to provide a twice weekly ESWL service. Inpatient management involves ward rounds and weekly operating sessions as well as a monthly general anaesthetic day-surgery list. A supervisory role covers flexible cystoscopy lists performed by our SpRs and Specialty Doctors. Ad hoc additional theatre lists, clinics and urodynamic sessions have been undertaken to help meet Health Dept targets. I have a weekly Private Practice clinic held at the Hillsborough Private Clinic with a monthly theatre and clinic session at the Ulster Independent Clinic The lead Clinician in Urology role has continued to evolve with the changes within the Trust and the development of the service. I am also the Educational supervisor for our two SpR trainees in urology
2.2 List your main sub-specialist skills and commitments / special interests	- Director of Stone Treatment Centre. - Provide Percutaneous nephrolithotomy minimally invasive renal stone surgery service - Laparoscopic urological procedures - Urodynamic.

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

2.3 Please give details of any emergency, on-call and out of hours responsibilities	Participate in the Craigavon hospital Consultant Urologist Rota. This provides for after hours and weekend ward rounds and emergency theatre requirements. This was on a 1:2 rota when first employed, changed to 1:3 in 2006 and more recently to 1:4 / 1:5 in 2012
2.4 Please give details of out-patient work if applicable	Out-patient activity is solely urological. This currently averages three clinics per week and once a month at four a week. Clinic type include one stone clinic, one to two general clinics and a specialized clinic for urodynamics and oncology patients
2.5 Details of any other clinical work	Urological surgery is performed on day case and inpatients. ESWL stone therapy is provided in the Stone Treatment Centre under my stewartship.
2.6 In which non-HSC hospitals and clinics do you enjoy practising privileges or have admitting rights? Please give details including: ▪ Number and type of cases. ▪ Any audit or outcome data for the private practice. ▪ Details of any adverse events, critical incidents. ▪ Details of any investigations into the conduct of your clinical practice or working relationships with colleagues	Private Practice privileges are at the Hillsborough Private clinic where outpatient consultation and local anaesthetic endoscopy is performed. The majority of the endoscopy has been part of Contract work for the clinic on behalf of waiting list target workload for other Trusts. Feedback is given by the Clinic to the relevant Trust. Monthly clinic and inpatient surgery is performed at the Ulster Independent Clinic. I am unaware of any adverse incident on either site.
2.7 List any non-clinical work that you undertake which relates to teaching	Partake in the Regional Urology Teaching Forum for SpRs. I am an Educational supervisor for both our SpRs in Craigavon and am a post Urology Programme Director for Urology in Northern Ireland I am both an undergraduate and post graduate examiner
2.7.1 List any non-clinical work that you undertake which relates to management	Lead Clinician for Urology in southern Trust
2.7.2 List any non-clinical work that you undertake which relates to research	Past mentor for M.D fellowship within Trust. However there is no current Fellow.

2.7.3 List any work you undertake for regional, national or international organisations.	Member of Regional Urology review team and its sub-committees.
2.7.4 Please list any other activity that requires you to be a registered medical practitioner	Member of the MDU

CURRENT JOB PLAN

If you have a current job plan, please attach it. If you do not have a current job plan, please summarise your current workload and commitments in the space below:

See folder Job plan sept 2011 to sept 2012 = No change in this document but new five consultant team plan is in the process of being 'signed off' after imminent discussions

ADDITIONAL INFORMATION

Please use to record issues which impact upon delivery of patient care.

Enclosed
Letter from Matron Ulster Independent Clinic
Hillsborough Private Clinic
NIMDTA Educational Supervisor for Urology SpR

Reflective Template

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

FORM 3 - SUPPORTING INFORMATION & SUMMARY OF APPRAISAL DISCUSSION

DOMAIN 1 - Knowledge, Skills and Performance

Attribute: 1.1 Maintain your professional performance
Attribute: 1.2 Apply knowledge and experience to practice
Attribute: 1.3 Ensure that all documentation (including clinical records) formally recording your work is clear, accurate and legible.

	List of Supporting Information	Applicable Date
1	Job Plan Sept 11 to sept 12	
2	Proposed job plan 2013	
3	CHKS report Oct 2011 to sept 2012	
4	Letter re Mentor support for Postgraduate Diploma in Urology for GPWSI	
5	ISCP training update Nov 2012	
6	MRCS Examiners Training Course Feb. 2010	
7	Training Programme for Medical Teachers	
8	NIMDTA – Urology Training Committee agenda Dec.2011 Core Surgery Interviews	
9	3Rd Year examinations MBC June 2011 and 2012 Final Year examinations 2012	
10	Urology teaching by SPR Craigavon to students	
11	ARCP Urology Training Committee membership Teaching feedback from Programme Director email	16/5/13
12	Training Passport	
13	Blood Tranfusion Documentation 15.5.13	
14	Hyponatriaemia and peripheral line courses	
15	Research project passed by Ethical committee and associated letter	
16	Study leave record from Trust	
17	Celtic Urology Network Meeting Jan.2012	
18	CPD record Meetings attended EAU 2012 (AUA 2009 BAUS 2008 certificates not previously enclosed)	
19	Publications and presentations	
20	New Therapy for BPH Advisory Board – Northern Ireland (meeting of Consultants in N.I sponsored by GSK)	
21	Last years appraisal (2011) form 4	
22	Structured reflective template	

Discussion

Has carried out sufficient CPD / training etc for appraisal

Actions Agreed

Summary of CPD – internal and external to be collated

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

DOMAIN 2 - Safety and Quality

Attribute: 2.1 Contribute to and comply with systems to protect patients
Attribute: 2.2 Respond to risks to safety
Attribute: 2.3 Protect patients and colleagues from any risk posed by your health

	List of Supporting Information	Applicable Date
1	M&M 2011	
2	M&M 2012 and covering explanatory email	
3	Shortfall in Junior staff –explanation of why research project not started	
4		
5	Safety issue letter to Trust in response to Dr Carolyn Harper xray reporting	
6	Case Conference documentation Re complex case relating to recurrant septicaemia Correspondence from terteriary opinion Patient Passport request	16/3/13
7	Complaints / incidents Reflective template	
8	Haematuria Audit june 2012 Haematospermia audit 2012 Reflective templates	
9	Medical card and vaccination ref domain 4	

Discussion

M&M 2012 = 4/12 meetings attended but only 11 meetings per year held. Also of particular notes was the attendance at two Regional Urology Audit meetings /M&M = Therefore 6/11 meetings which is similar to all previous years.

Actions Agreed

In future will forward copy of regional urology meetings as evidence