From: David McCormick
To: David McCormick
Subject: FW: Post Project Evaluation
Date: 04 November 2022 16:40:33
Attachments: Urology Review PPE.docx
Urology Review Recommendations Progress 2019 (3).doc
Updated Urology Presentation.ppt
Urology Meeting Action Points.doc
Urology Eastern Plan Belfast PYE and FYE updated.xls
AC1819.199 - Urology NL IPDC - DMcC.XLSX
AC1819.199 - Urology NL OP - DMcC.XLSX
Team East Implementation Plan Final Draft Oct 2010.doc
Team South Implementation Plan v0.3 Revised 09 Nov 10.doc

---------- Forwarded message ----------
From: David McCormick <Personal Information redacted by the USI>
Date: 12 Mar 2019 09:23
Subject: FW: Urology Review Project Implementation Board Meeting 1 July 2010
To: joan.hardy Personal Information redacted by the USI
Cc: Lisa McWilliams <Personal Information redacted by the USI>

Joan,

Please find attached the completed PPE for the 2009 Urology Review.

It should be noted that the Urology Review was not an IPT/business case and theefor did not state spcific timelines for each rcommendation. Indeed some of the rcommendations continu to be validate today and theefor thee would not be an agred completion date.

The review made 26 rcommendations and I have given a written udate and RAG rating for each of these. I have also attached some suporting information which rflect the rpoted position for each rcommendation.

Please feel free to call me if you have any quries.

David

David McCormick

Acting Assistant Dirctor of Scheduled Ca

PMSID

Health and Social Car Board

12-22 Linehall Stret

Belfast

Telehone Personal Information redacted by the USI

POST PROJECT EVALUATION

Name of organisation	**DoH**
Project Title	**Review of Adult Urology 2009**
Total Cost	**£3.5m**
Start date	**Not stated in Review Document**
Completion date	**Not stated in Review Document**
PPE Due Date (Per associated Business case)	**Not stated in Review Document**
PPE Completed by	**N/A**
Signature and date	**N/A**

SECTION 1: INTRODUCTION

Background (a brief description of the project and its objectives)

A regional review of (Adult) Urology Services was undertaken in response to service concerns regarding the ability to manage growing demand, meet cancer and elective waiting times, maintain quality standards and provide high quality elective and emergency services. The review made 26 recommendations which were required to be implemented as part of a new 3 team model The proposed three teams were as follows:

- Team East comprising of the catchment area of Belfast HSCT, SET and the southern sector of the Northern HSCT. Team increasing from 11 consultants to 12 consultants.
- Team Northwest comprising of the catchment area of northern sector of the Northern HSCT and the catchment area of Altnagelvin hospital and Tyrone County Hospital in the Western HSCT. Team increasing from 5 consultants to 6 consultants.
- Team South comprising of the catchment area of the Southern HSCT and the Erne Hospital catchment in the Western HSCT. Team increasing from 3 consultants to 5 consultants.

Please give details of commencement of scheme, when staff were appointed and when full capacity was achieved.

Team East
Funding of £1.169m was agreed to cover the FYE cost of the new consultant and support staff (£637k had been allocated previously in 2008/09 to allow the recruitment of 2 new consultants). Part year effect funding and in-year activity volumes were agreed to reflect the phased recruitment of staff. The funding was allocated based on the following start dates in BHSCT:

1 WTE consultant appointment January 2012.
0.5 WTE specialty dr - January 2012
1 WTE specialty dr -1st January 2012
Theatre nurses, imaging, anaesthetic support - 1st November 2011
Team East Co-ordinator - 1st April 2011

Funding for the specialist nurse post in SET was based on a start date of January 2012.

Team South
Funding of £1.233m was agreed to cover the FYE cost of the 2 new consultants and support staff. Part year effect funding and in-year activity volumes were agreed to reflect the phased recruitment of staff.

The Southern Trust appointed the first consultant post and associated support staff in February 2012 but was not able to fill the second consultant post until 2014. The 5 Consultant team was never in place during 2013/14, although the Trust did use a locum Consultant during this time.

Team North
Funding of £0.566m was agreed to cover the FYE cost of the new consultant and support staff. FYE was agreed and part year funding for 2011/12 was been confirmed. Part year effect funding and in-year activity volumes were agreed to reflect the phased recruitment of staff.

The Team had advised that a suitable permanent appointment would not be available for approximately a year and therefore the HSCB approved the appointment of an additional Locum Consultant who started in October 2011.

The HSCB used the British Association of Urological Services (BAUS) workforce guidance to calculate the assumed FYE activity throughput for each team across outpatients, day cases and inpatients (an example of the agreed FYE and CYE activity volumes is attached)

SECTION 2: ACHEIVEMENT OF OBJECTIVES

Did this Investment meet objectives given in Business Case? Please give details.		
Objectives	Were they achieved?	How were they achieved?

See the 26 recommendations attached.	The majority of the recommendations have been achieved. A small number are currently being progressed and other actions will be ongoing.	*See detailed report*

SECTION 3: COSTS – PLANNED VERSUS ACTUAL

Costs planned in original Business Case	Actual Costs (Please comment on variances etc.)
£3.5m	£3.5m

Were actual costs equal to planned costs? If no, please provide reasons for the variance.
Yes

SECTION 4: TIMING PROFILE – PLANNED VERSUS ACTUAL

Timing profile planned in original Business Case – e.g. start date, milestones, completion dates etc	Actual Timing Profile (Please comment on variances etc.)
The urology review did not set out defined timescales and milestons. The actions and associated timescales were agreed through the Urology Review Project Implementation Board – see attached minutes of first meeting which detailed timescales for various actions.	

Did actual timing profile meet planned timing profile? If no, please provide reasons for the variance.
The main delay related to the challenges recruiting new consultants. This had a direct impact on the deliverability of the agreed activity volumes for all the teams.

SECTION 5: VALUE FOR MONEY

What methodology was used to assess quality and value for money of service provided? What were the conclusions?
A Urology Review Project Implementation Board was established consisting of clinical representation from all Trusts to oversee the implementation of the review and ensure that it delivered the expected outcomes. The Terms of reference of the Project Implementation Board were as follows: - Ensure the Implementation of a urology service is designed to meet the needs of patients - Recommend to the Board how the £3.5m available funding should be allocated - Establish Performance Indicators to confirm the implementation of the Urology Review recommendations. - Recommend the Service and Budget Agreement Standards, Volumes, Outcomes and Patient Pathways for each of the teams. - Advise the Board on the recommended timescale for the phased implementation of the additional funding. The Project Implementation Board met throughout 2010/11 to ensure that the key actions were delivered, this included the development of patient outcome indicators and key improvement indicators (see attached power point presentation). Increasing in-house capacity has helped reduce the reliance on additional WLI and IS usage which has reduced costs and improved VFM.

SECTION 6: RECOMMENDATIONS AND LESSONS LEARNED

What problems were encountered during implementation of the project, and how were such resolved?
The main problems pertained to the vulnerability of the consultant teams where sick leave, vacancies and recruitment challenges impacted on service provision. This was clearly evidenced in the Northern Trust where a consultant retirement and a consultant on long term sick leave, coupled with the inability to recruit locum staff, had a major impact on service delivery and waiting lists.

What was learned, how has this been disseminated, and to whom? Please provide supporting evidence.

It was clear that there was a need to reduce the reliance on consultant urologists and expand the skill mix of the wider team. This was discussed in detail at the regional urology group and examples of nurse led urology services were shared with each of the teams. Since this time there has been a steady increase in the volume of nurse led activity and this is evidenced by the attached activity.

UROLOGY REVIEW SUMMARY OF RECOMMENDATIONS

Section 2 – Introduction and Context

	Recommendation	Update
1 P8	Unless Urological procedures (particularly operative 'M' code) constitute a substantial proportion of a surgeon's practice, (s)he should cease undertaking any such procedures. Any Surgeon continuing to provide such Urology services should do so within a formal link to a Urology Unit/Team.	Complete - Since the completion of the review there has been a significant reduction in the level of "M" code work undertaken by General Surgeons. Patients who require m code procedures are now referred to their local urology team.
2 P9	Trusts should plan and consider the implications of any impending retirements in General Surgery, particularly with regard to the transfer of "N" Code work and the associated resources to the Urology Team.	Complete - The majority of N code work relates to vasectomies and this work is increasingly being undertaken by specialist GPs which has minimised the impact on the urology workforce.
3 P10	A separate review of urinary continence services should be undertaken, with a view to developing an integrated service model in line with NICE Guidance.	Ongoing - a scoping paper for community specialist continence services under the auspices of the older peoples framework has been completed. Work is ongoing to develop standardised urinary continence services and recent developments include the establishment of a regional sacral nerve stimulation service for urinary incontinence patients.

Section 3 – Current Service Profile

	Recommendation	Update
4 P15	Trusts must review the process for internal Consultant to Consultant referrals to Urology to ensure that there are no undue delays in the system.	Complete – The introduction of CCG has meant that the redirection of referrals can be actioned immediately therefore reducing delays.

5 P15	Northern Ireland Cancer Network (NICaN) Urology Group in conjunction with Urology Teams and Primary Care should develop and implement (by September 2009) agreed referral guidelines and pathways for suspected Urological Cancers.	Complete - The NICaN Standard Working Policy for Urological Cancer MDTs was formally signed off at the NICaN Urology Group on 8 October 2009. These have now been superseded by the NICaN Urology Clinical Management Guidelines (2016) which clearly outline guidelines for the referral, diagnosis, treatment and management of urological cancers. NICaN Referral Guidelines for Suspect Cancer were completed in May 2007 and revised in 2012. The urology CRG has recently proposed changes to the referral guidelines for prostate cancer. These proposals are currently being considered by a range of stakeholder groups (e.g. NICaN Board, NIGPC, HSCB SMT).
6 P17	Deployment of new Consultant posts (both vacancies and additional posts arising from this review) should take into account areas of special interest that are deemed to be required in the service configuration model.	Ongoing - Each team takes into account the demand for both core and special interest urology, in the recruitment of new urology consultants. However the ability to recruit consultants, with the relevant sub specialty interest, is subject to the availability of suitable candidates.
7 P17	Urologists, in collaboration with General Surgery and A&E colleagues, should develop and implement clear protocols and care pathways for Urology patients requiring admission to an acute hospital which does not have an acute Urology Unit.	Complete - The Board has developed Regional Pathways for the following conditions: ○ Diagnosis and Management of an acutely obstructed kidney with sepsis ○ Diagnosis and Management of Acute Urinary Retention ○ Diagnosis and Management of Suspected Renal Colic ○ Haematuria ○ Lower Urinary Tract System (LUTS) male only ○ Prostate ○ Testicular Cancer

		The teams have established appropriate arrangements to manage urology patients admitted under general surgery without urology units. This is done through the surgeon of the week 9.00-5.00 and by the on-call consultant out of hours.
8 P17	Urologists, in collaboration with A&E colleagues, should develop and implement protocols/care pathways for those patients requiring direct transfer and admission to an acute Urology Unit.	Complete -The teams have developed pathways with A&E colleagues, including the details of the expected standards for the urological input and the timely transfer and admission to an acute Urology Unit.
9 P18	Trusts should ensure arrangements are in place to proactively manage and provide equitable care to those patients admitted under General Surgery in hospitals without Urology Units (e.g. Antrim, Daisy Hill, Erne). Arrangements should include 7 day week notification of admissions to the appropriate Urology Unit and provision of urology advice/care by telephone, electronically or in person, also 7 days a week.	Complete - The teams have established appropriate arrangements to manage urology patients admitted under general surgery without urology units. This is done through the surgeon of the week 9.00-5.00 and by the on-call consultant out of hours.
10 P20	In undertaking the ICATS review, there must be full engagement with secondary care Urology teams, current ICATS teams, as well as General Practitioners and LCGs. In considering areas of Urology suitable for further development they should look towards erectile dysfunction, benign prostatic disease, LUTS and continence services. The review should also take into account developments elsewhere within the UK and in particular developments within PCTs in relation to shifting care closer to home.	Ongoing – Changes to staff and associated skillmix has meant that the ICATS teams are now integrated into the core urology service. The Board continues to work with the Trusts to ensure the effective use of the wider clinical team across the patient pathway. This work has helped support the following improvements: ○ Primary care led vasectomy services ○ Direct to scope ○ One stop LUTs clinics ○ Nurse led LUTs follow-up clinics ○ Nurse led telephone reviews ○ Nurse led scope services

Section 4 – Capacity, Demand and Activity

	Recommendation	Update
11 P23	Trusts (Urology departments) will be required to evidence (in their implementation plans) delivery of the key elements of the Elective Reform Programme.	Ongoing - The team Implementation Plans included the key elements of the Elective Reform Programme including; Pre Operative Assessment Admission on the day of surgery Day surgery rates by Consultant Average LOS by procedure Number and % of cancelled operations for both clinical and non clinical reasons The Board continues to monitor these areas of improvement. Regular monitoring information is provided on pre-operative LOS, Day case rates, OP DNAs and New/Review ratios.

Section 5 – Performance Measures

	Recommendation	Update
12 P27	Trust Urology Teams must as a matter of urgency redesign and enhance capacity to provide single visit outpatient and assessment (diagnostic) services for suspected urological cancer patients.	Ongoing - The Teams have introduced one-stop clinics for Prostate Red Flags and Haematuria Red Flags and both these clinics are working well. A new process has been put in place to e-triage all referrals so that patients can be sent direct for scope where clinically appropriate.
13 P13	Trusts should implement the key elements of the elective reform programme with regard to admission on the day of surgery, pre-operative assessment and increasing day surgery rates.	Ongoing - All patients are admitted on day of surgery except where they have been identified by the Consultant or Anaesthetist as needing to be admitted the day before. All patients that can be done as a day case are identified at the outpatient clinic and recorded as being able to be done as a day case. Changes in clinical practice will mean that admission of day of surgery and day case rates will continue to improve.

14 P29	Trusts should participate in a benchmarking exercise of a set number of elective (procedure codes) and non-elective (diagnostic codes) patients by Consultant and by hospital with a view to agreeing a target length of stay for these groups of patients.	Ongoing -Trust undertake regular benchmarking of their performance and the HSCB also run monthly performance reports looking at pre-operative LOS, day surgery rates etc.
15 P30	Trusts will be required to include in their implementation plans, an action plan for increasing the percentage of elective operations undertaken as day surgery, redesigning their day surgery theatre facilities and should work with Urology Team in other Trusts to agree procedures for which day care will be the norm for elective surgery.	Ongoing - This is ongoing work and will be enhanced further through the development of the urology elective care and treatment centre
16 P31	Trusts should review their outpatient review practice, redesign other methods/staff (telephone follow-up/nurse) where appropriate and subject to casemix/complexity issues reduce new:review ratios to the level of peer colleagues.	Complete - Clinic templates have been changed to reflect the agreed SBA levels and all consultants are working to these levels. Across the region improvements have been made on the way the service is delivered including the expansion of CNS led clinics (stone clinic, LUTs clinic), telephone review clinics and dedicated Emergency Department slots.

17 P32	Trusts must modernise and redesign outpatient clinic templates and admin/booking processes to ensure they maximise their capacity for new and review patients and to prevent backlogs occurring in the future.	Complete - Trusts are increasing using e triage to allow for the timely triage of referrals and to ensure that patients are being seen by the most appropriate clinician. Where clinically appropriate patients are being listed directly for surgery which is freeing up outpatient capacity.

Section 7 – Urological Cancers

	Recommendation	**Update**
18 P37	The NICaN Group in conjunction with each Trust and Commissioners should develop and implement a clear action plan with timelines for the implementation of the new arrangements/enhanced services in working towards compliance with IOG.	Ongoing - Urology MDTs were subject to formal peer review visits by the National Quality Surveillance Team in 2015/16. The peer review standards are based on IOG. At that time Peer review highlighted three key issues: • Inadequate time for the Specialist MDT – during 2018/19 the commissioner invested in the establishment of a new MDT within SET. This has removed circa 25 cases per annum form the SMDT and has alleviated the pressure on the specialist meeting. • The need to centralise nephron sparing surgery to the Specialist MDT - since peer review the number of sites at which nephron sparing surgery is undertaken has reduced from 5 to 3 with all cases being discussed at the Specialist MDM in Belfast. Plans are underway to move all nephron sparing surgery into Belfast Trust during 2019/20.

		• Delays in appointments for routine and urgent referrals – the Urology PIG has been established to take forward service improvement initiatives aimed at reducing elective waiting times. The newly established North West team underwent review during 2018/19 – no significant issues were raised. The newly established team in SET will be subject to formal review in 2019/20.
19 P38	By March 2010, at the latest, all radical pelvic surgery should be undertaken on a single site, in BCH, by a specialist team of surgeons. The transfer of this work should be phased to enable BCH to appoint appropriate staff and ensure infrastructure and systems are in place. A phased implementation plan should be agreed with all parties.	Complete - NICaN has formally issued the Urology MDM Working Policy, October 2009. All radical pelvic operations were transferred to the Belfast City Hospital in 2010. Since then, issues with availability of local operators trained in laproscopic radical prostatectomy necessitated the movement of this surgery to Addenbrookes. 2018/19 investment in the development of robotic assisted radical prostatectomy within Belfast Trust means that this surgery will be returned to Belfast Trust on an incremental basis between 2018/19 and 2020/21.
20 P38	Trusts should ensure that surgeons carrying out small numbers (<5 per annum) of either radical pelvic operation, make arrangements to pass this work on to more specialised colleagues, as soon as is practicably possible, (whilst a single site service is being established).	Complete. All radical pelvic operations are now transferred to the Belfast City Hospital.

Section 8 – Clinical Workforce Requirements

	Recommendation	**Update**
21	To deliver the level of activity from 2008/09 and address	Complete - There are now 26 consultant urologists

P41	the issues around casemix and complexity it is recommended that the number of Consultant Urologists is increased to 23 wte.	currently funded across the region. There are 24 currently in post.
22 P41	Urology Teams must ensure that current capacity is optimised to deliver the number FCEs by Consultant as per BAUS guidelines (subject to casemix and complexity). This may require access to additional operating sessions up to at least 4 per week (42 weeks per year) and an amendment to job plans.	Complete - The Board has agreed volumes of activity per team consistent with the BAUS recommendations. The teams have implemented changes to the consultant job plans to implement the team model. In 2017/18 the teams overperformed by 4.2% against their annual inpatient/ day case elective plan.
23 P43	At least 5 Clinical Nurse Specialists (cancer) should be appointed (and trained). The deployment of these staff within particular teams will need to be decided and Trusts will be required to develop detailed job plans with caseload, activity and measurable outcomes agreed prior to implementation. A further review and benchmarking of cancer CNS's should be undertaken in mid 2010.	Ongoing - Belfast Trust have two Uro-oncology CNS and three general urology specialist nurses, the Southern Team has one general CNS, SET have two general CNSs and Team Northwest have 5.6 WTE general urology CNS and 5.0WTE uro-oncology nurses. The teams have provided the detailed job plans for each of the existing Urology CNS both cancer and non-cancer

Section 9 – Service Configuration Model

	Recommendation	**Update**
24 P44	Urology services in Northern Ireland should be reconfigured into a 3 team model, to achieve long term stability and viability.	Partially Complete - Two of the proposed teams have been established and are operational. The configuration of Team East has not progressed due to the oncall difficulties supporting two acute sites.
25 P46	Teams North and East (Northern, Western, Belfast and South Eastern Trusts) should ensure that prior to the creation of the new Teams, there are clear, unambiguous and agreed arrangements in place with regard to Consultant on-call and out of hours arrangements.	Complete - The teams have agreed arrangements for out of hours and Consultant on call (subject to issue raised in point 24).
26-46	Each Trust must work in partnership with the other Trust/s within the new team structure to determine and agree the new arrangements for service delivery, including inter alia,	Complete - The teams have agreed new team arrangements and structures across the relevant Trusts.

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

Urology Review Project Implementation Board Meeting
1 July 2010 at 2pm in the Conference Room, Templeton House

1. Attendees

Present	**Apologies**
Beth Malloy	Valerie Jackson
Mark Fordham	Hubert Curren
David McCormick	Chris Hagan
Diane Corrigan	Stephen Hall
Patrick Keane	Patricia Donnelly
Dermot Hughes	Seamus McGoran
Gillian Rankin	Sara Groogan
Michael Taylor	
Michael Young	
Brian Armstrong	
Bronagh McCann	
Margaret O'Hagan	
Diane Keown	
Geraldine Hillick	

2. Urology Review

The Urology Review included the expected actions for implementation – Page 47. These are summarised and shown below.

- To implementation of the review recommendations a recurrent investment of £3.5m (including £637,076 previously allocated to Belfast Trust)
- Discussions with GPs, in relation to referral pathways and patient flows in the context of 3 team model
- Trusts will be required to submit detailed business cases prior to funding being released
- Trusts and Commissioners will need to agree timescales and measurable outcomes in terms of additional activity, improved performance, a phased reduction in IS usage and service and modernisation plans.
- ….Where capital requirements are identified. Trusts should process these bids through their normal capital and business planning cycle.
- The new teams (Trust partnerships) will be required to submit project plans for the implementation of the new arrangements which is envisaged to be on a phased and managed basis.
- The new HSCB will establish an Implementation Board to oversee the process.

3. Terms of Reference for Project Implementation Board

The draft terms of reference were approved by the members. Please see below for information.

Urology Review Overall Purpose

To develop a modern fit for purpose in the 21st century, reformed service model for Adult Urology Services which takes account of relevant Guidelines (NICE, Good Practice, Royal College, BAUS, BAUN). The future model should ensure quality services are provided in the right place, at the right time by the most appropriate clinician, through the entire pathway from Primary Care to Intermediate to Secondary and Tertiary Care.

TERMS OF REFERENCE FOR THE UROLOGY REVIEW PROJECT IMPLEMENTATION BOARD

1. Ensure the changes resulting from the implementation of the urology review are designed to meet the needs of patients.
2. Recommend to the Board how the £3.5m available funding should be allocated.
3. Agree Performance Indicators to demonstrate the successful implementation of the Urology Review recommendations.
4. Devise a SBA to include clinical standards, volumes, patient outcomes and patient pathways for each of the urological services for recommendation to the Board's SMT.
5. Advise the Board on the recommended timescale for the phased implementation of the additional funding.

4. Team Update on Progress

Geraldine Hillick on behalf of the North/ West Team confirmed the implementation plan would be submitted to the Board by 31 August.

Action – Sara Groogan/ Geraldine Hillick

Baseline staffing position for 2009/10 in the requested format for each of the teams to be provided to Board by end of July

Action – Team North/West - Sara Groogan
Team East - Brian Armstrong

5. Themes from the Plans

The themes from the plans received are shown below.

- *Variable levels of detail in plans eg baseline information.*
- *Lack of evidence of the outcomes for patients from the investment.*
- *Limited details to show the patient pathway and how support services will be provided across the teams- e.g. pathology, radiology, medical records/secretarial.*
- *Baseline capacity assumptions have limited evidence of improved working practices.*
- *Data collection inconsistencies – diagnostics recorded as day cases.*

6. **Approach to Implementation**

The Project Board agreed with the proposed approach to implementation.

- All the plans from the 3 teams will be required to be submitted to the Board to progress further.
- Meetings will be arranged with each of the teams to discuss the plans received will be arranged.
- Patient outcome measures from the investment will be required to be clearly understood by all parties.
- Evidence of modernisation to the urological service will be required.
- Service and Budget Agreement – standards, outcomes and volumes will be agreed with Trust/Teams.
- A final Business Case will be required.
- Annual review of clinical measures and audited results to support clinical appraisal and management performance.

The Board shared summary benchmarking information across each of the Trusts, it was agreed that as part of the discussion regarding the KPIs and patient outcome measures the Project Board would agree the local standards and peer comparisons required. The benchmarking information would be shared and more detail analysis would be completed for the next meeting.
Action – David McCormick

ACTIONS

Board will arrange a meeting with each Trust to discuss the content of their implementation plans by 30 September.
Action – Beth Malloy

Board and Trusts to ensure that implementation plans are agreed for recommendation to the Board's SMT by 31 October.
Action – Beth Malloy and Team Project Chairs

Trusts to ensure that implementation plans and associated funding arrangements, adhere to the guidance detailed in the Green Book standards.
Action – Team Project Chairs

Trust should develop and submit detailed business cases prior to funding being released.
Action – Team Project Chairs

Where capital requirements are identified. Trusts should process these bids through their normal capital and business planning cycle.
Action – Team Project Chairs

It was agreed that improved working practice and modernisation needed to be evidenced in the team implementation.
Action - Team Project Chairs

Annual review of clinical measures and audited results to support clinical appraisal and performance management to be considered at the next meeting
Action - Project Board

7. Agree Next Steps

The proposed next steps and timetable was agreed:

Baseline staffing position for 2009/10 to be provided by each Team	31 July
North/ West Team to submit implementation plan	31 August
Detailed Patient Pathways as outlined in the Review to be submitted for each team by the end of August	31 August
Board to arrange feedback meeting with each Trust	30 September
Trust Teams to ensure that revised implementation plans are submitted to the Board	31 October
Board SMT to approve the team plans and expected output from the additional investment	30 November

It was agreed that the Project Board need to agree both the GP referral pathways and communication arrangements back to GPs (including what patients would be referred back to Primary Care. It was agreed this would be considered at the next meeting, as part of the discussion concerning each of the pathways.

Action - Project Board

8. Any other Business

It was agreed that the Project Board would develop Performance Indicators and patient outcome measures to measure the successful implementation of the Urology Review recommendations.

Each Team to submit suggested additional indicators to Beth Malloy by mid August.
Action – Beth Malloy
Team Project Chairs

Replacement Consultant in Northern Trust

M O'Hagan referred to the proposed replacement of a consultant post in the Northern Trust. It was agreed that this post would require both specialty and College Advisor Approval.

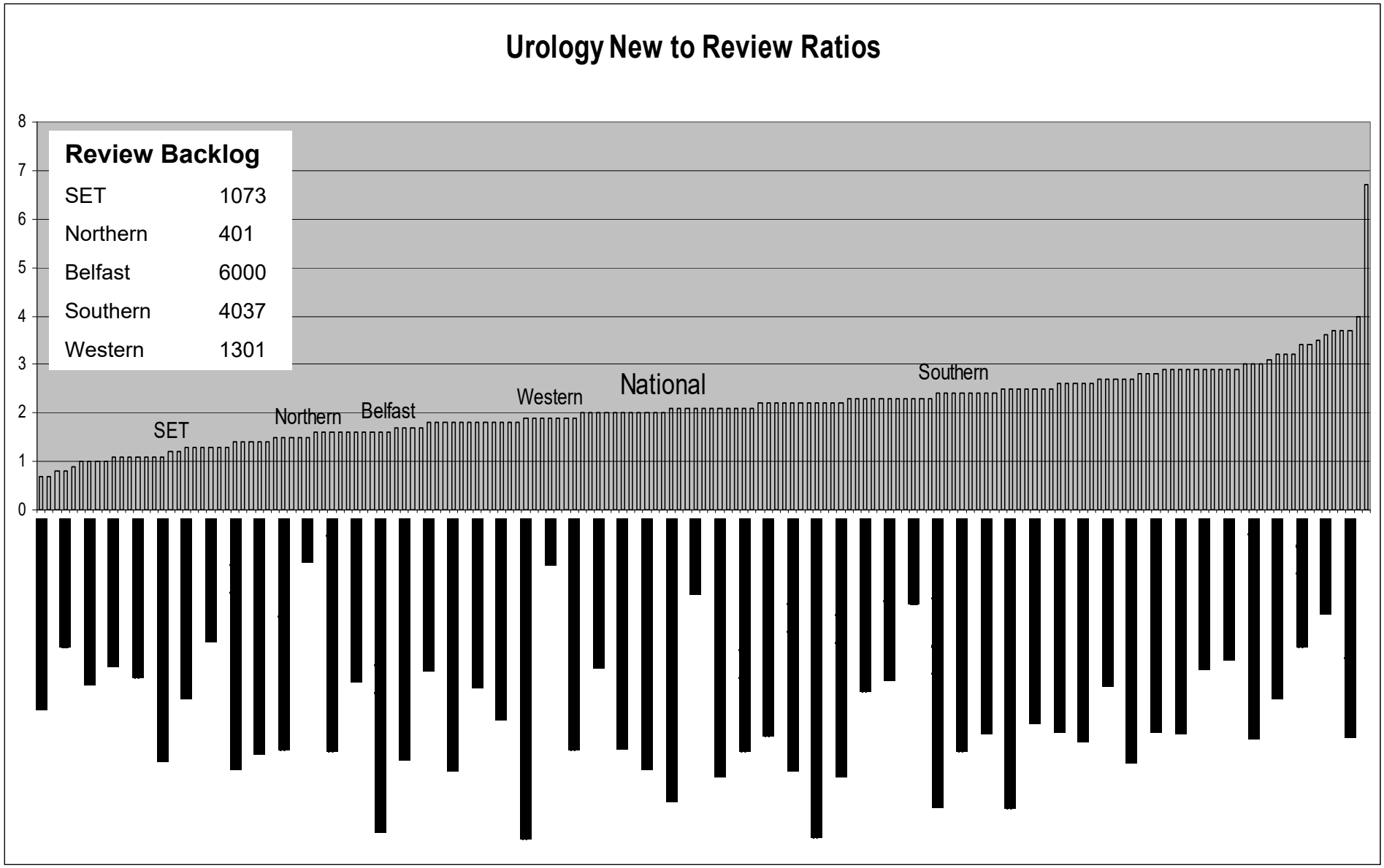
Action- Margaret O'Hagan.

9. Date of Next Meeting

Date agreed for Friday 1 October, 1.00pm in Templeton House.

Benchmarking Indicators

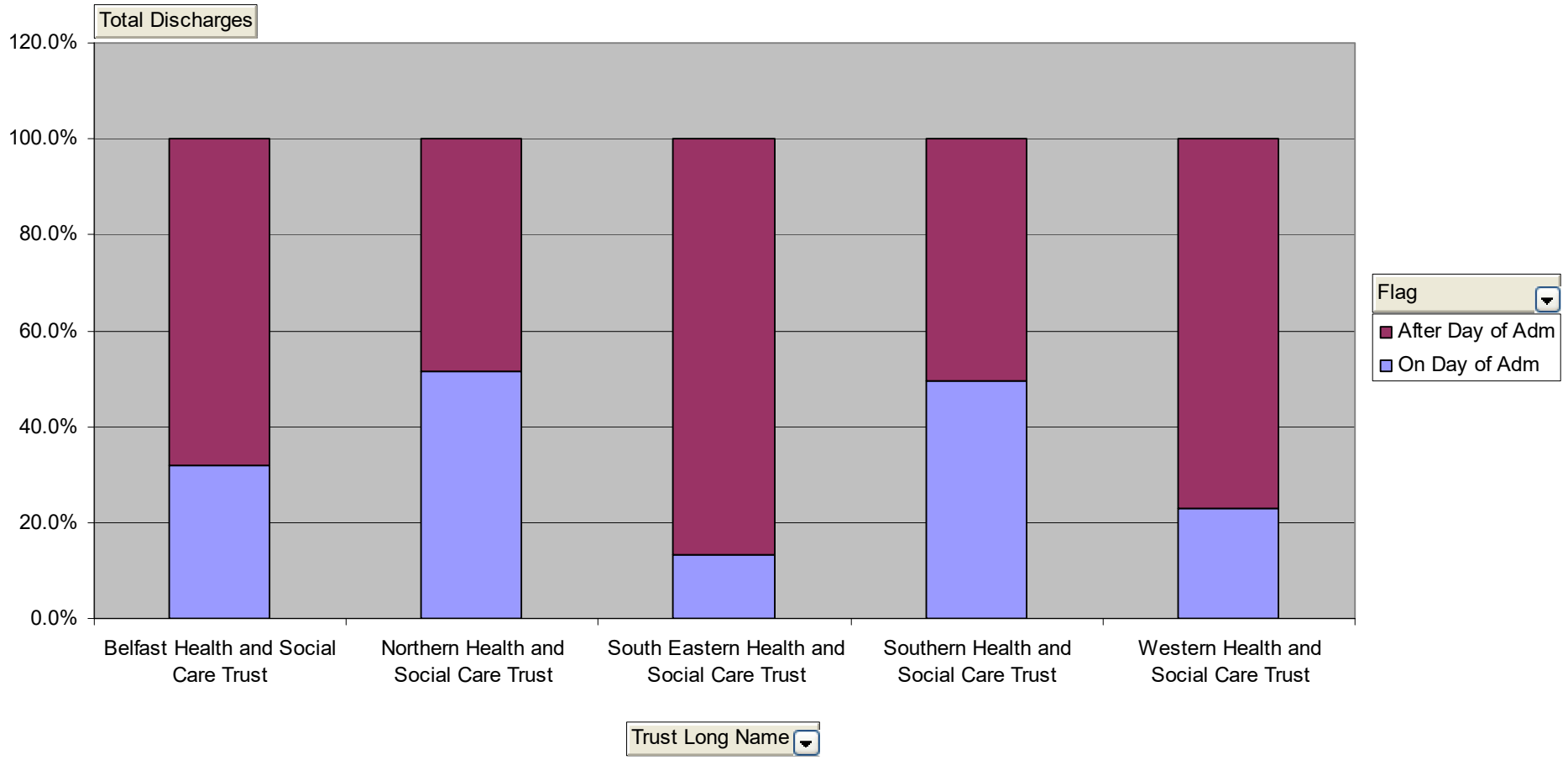
Urology New to Review Ratios



Received from DOH on 16/11/2022. Annotated by the Urology Services Inquiry.

Hospital on Adr	(All)	Specialty On A	Urology	Consultant on A	(All)	Intended Manag	Normal Inpat	Year	Y2009	Procedure Grou	(All)	MOA Type	Elective

% of Discharges Admitted on Day of Surgery 2009



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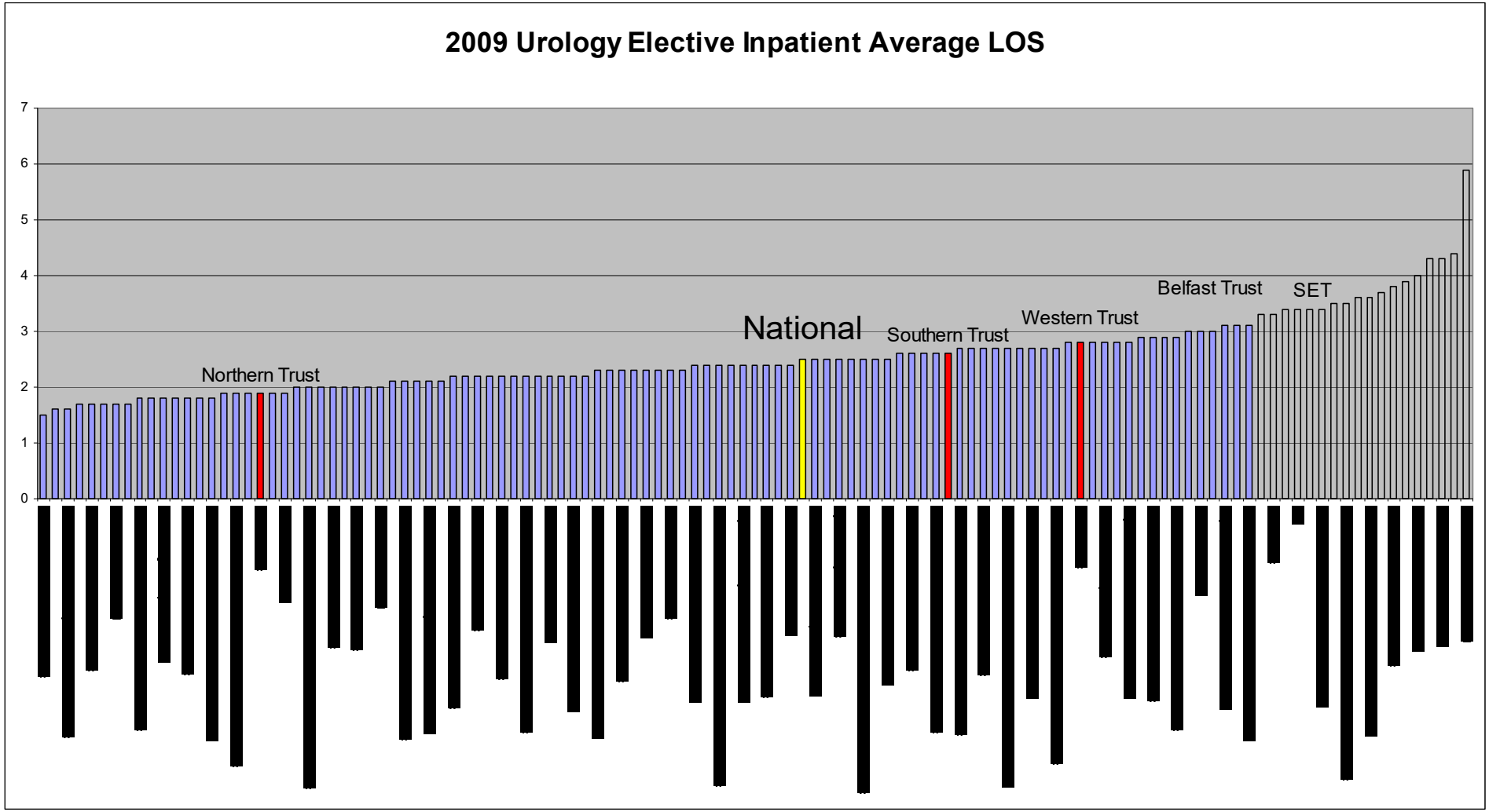

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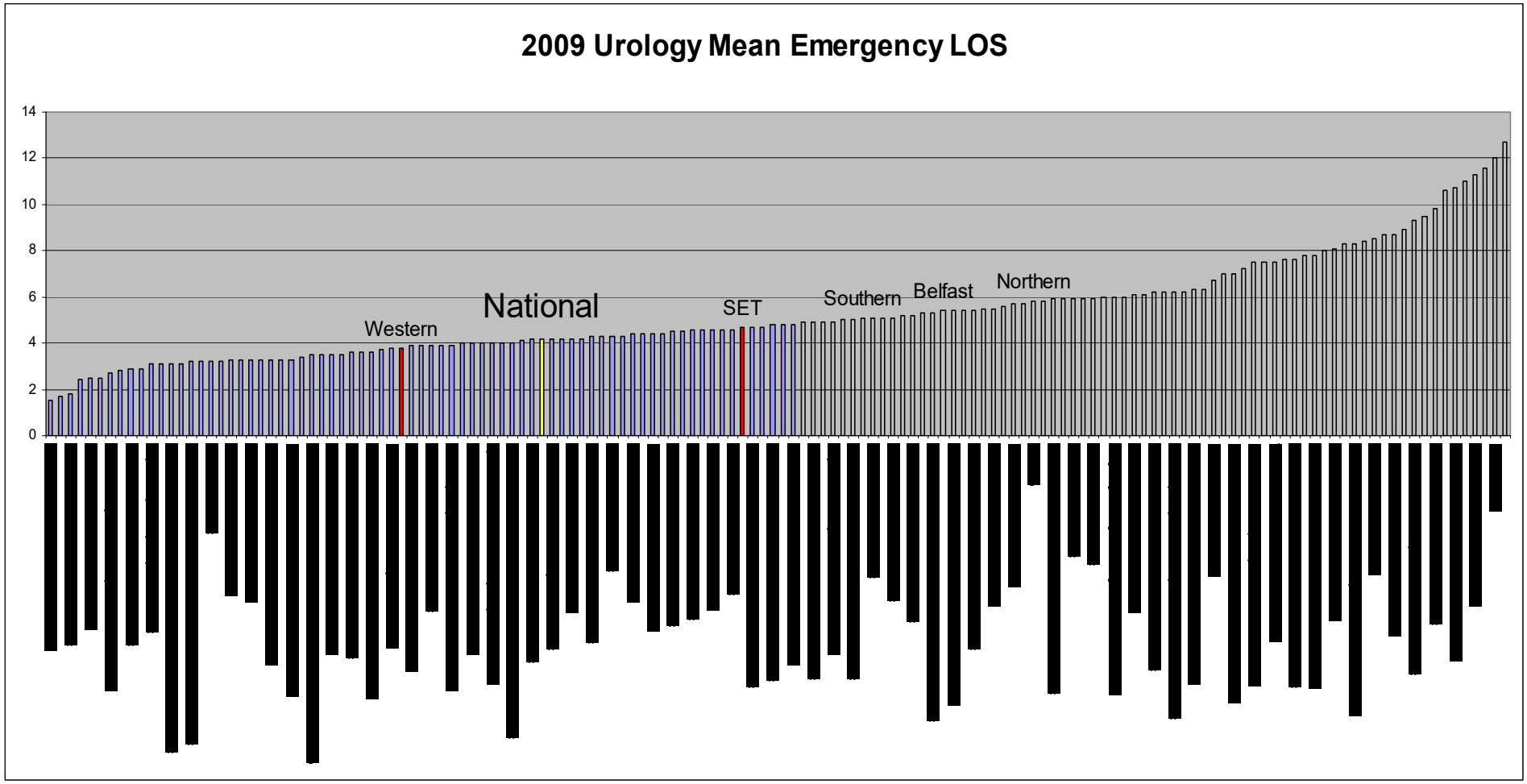
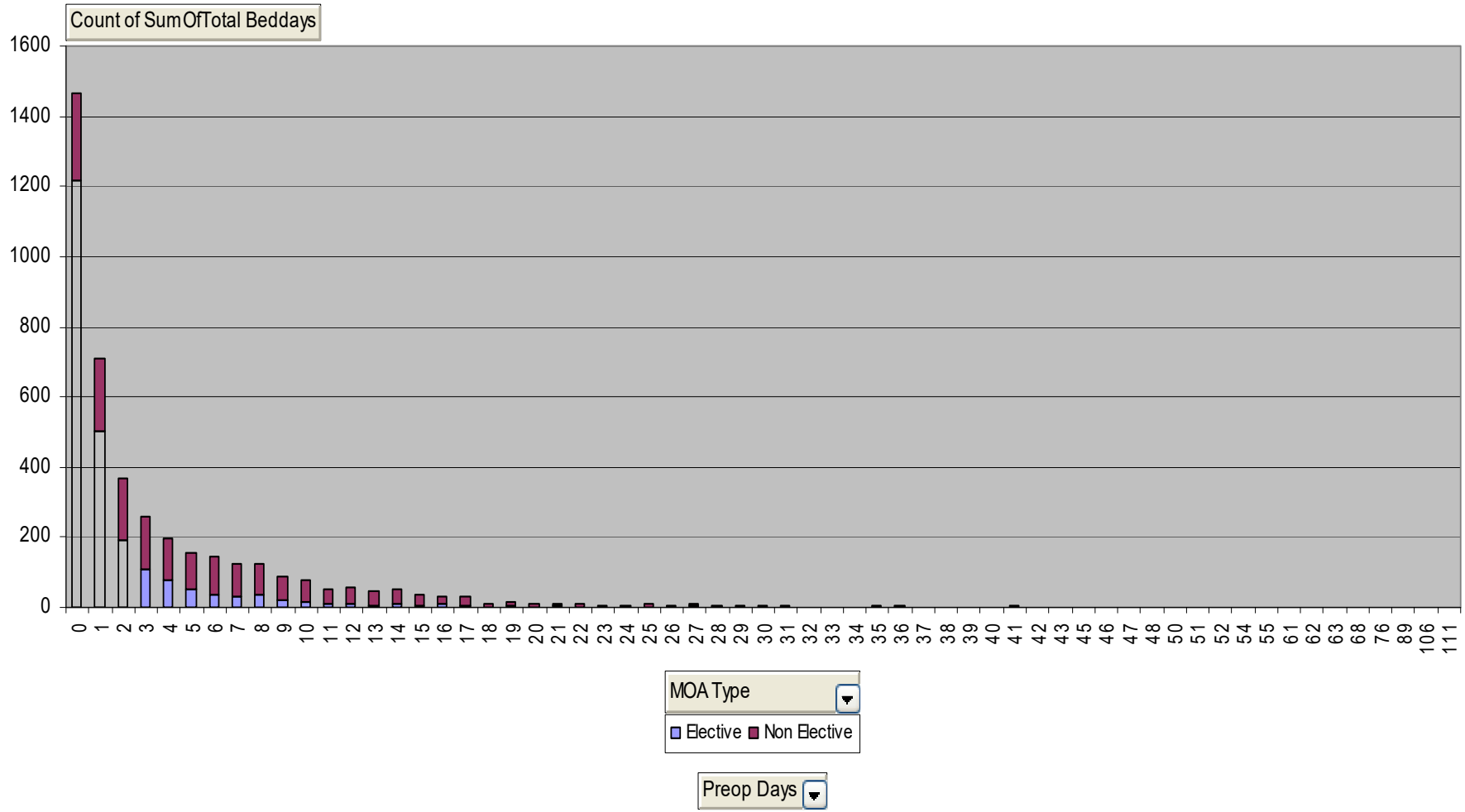


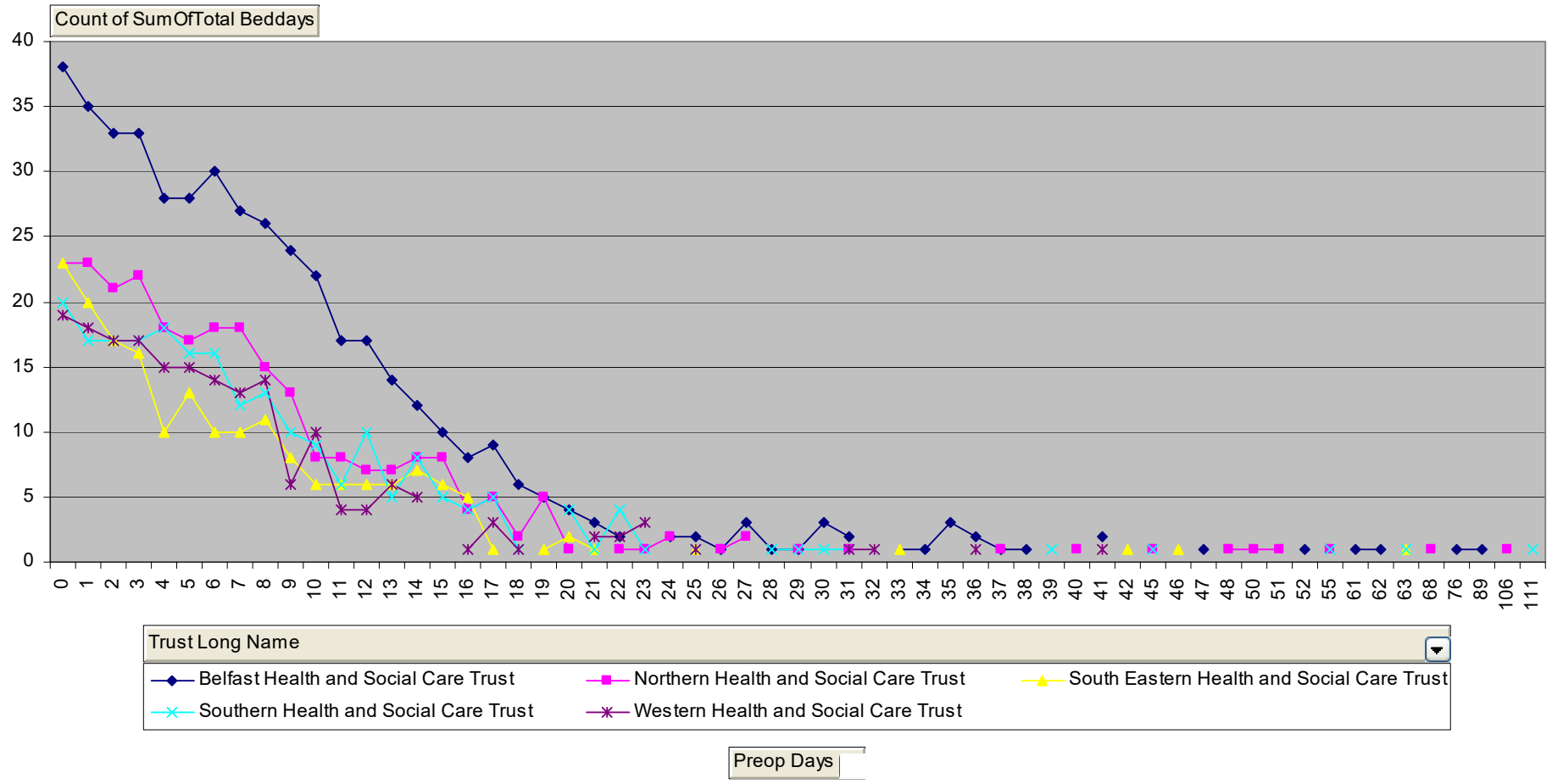
Received from DOH on 16/11/2022. Annotated by the Urology Services Inquiry.

Trust Long Name (All) | Specialty On Admission (R) (All) | Hospital on Admission (All) | Procedure Group (All) | Intended Management (R) (All) | Year Y2009

Pre-Op Beddays by Method of Admission



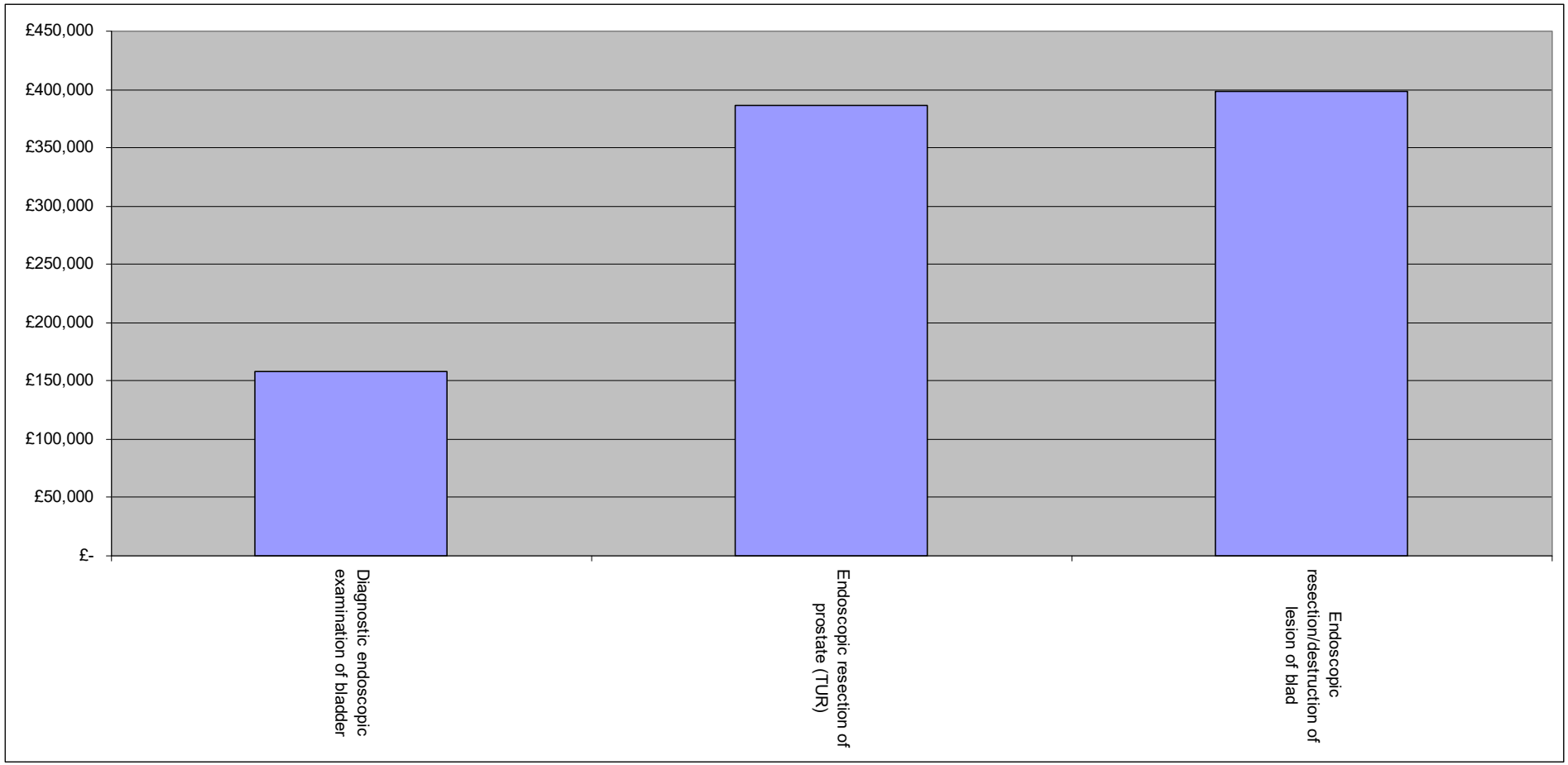
Specialty On Admissior (All) | Hospital on Admission (All) | Procedure Group Non BADS Procedur | Intended Management (All) | Year Y2009 | MOA Type Non Elective



Received from DOH on 16/11/2022. Annotated by the Urology Services Inquiry.

Potential Bed Day Savings Using BADS

(@£300 per bed day)



FYE			
Team East Proposed Activity			
	New	Review	Total
9 Cons wte - core	4536	6804	11340
3 Cons wte - oncology	1008	2016	3024
Specialist Drs 1.0 wte*	420	420	840
0.5 wte Specialist Dr		420	420
CNS 1 wte	588		588
Other Support		790	790
Overall Total	**6552**	**10450**	**17002**
Belfast Element			
	New	Review	Total
6 Cons wte - core	3024	4536	7560
3 Cons wte - oncology	1008	2016	3024
Specialist Drs 1.0 wte*	420	420	840
0.5 wte Specialist Dr		420	420
CNS 1 wte	588		588
Other Support		790	790
Overall Total	**5040**	**8182**	**13222**
SET Element			
	New	Review	Total
3 Cons wte - core	1512	2268	3780
Overall Total	**1512**	**2268**	**3780**

PYE

Team East Proposed Activity

	New	Review	Total
9 Cons wte - core	4158	6237	10395
3 Cons wte - oncology	1008	2016	3024
Specialist Drs 1.0 wte*	105	105	210
0.5 wte Specialist Dr		420	420
CNS 1 wte	98		98
Other Support		790	790
Overall Total	**5369**	**9568**	**14937**

Belfast Element

	New	Review	Total
6 Cons wte - core (ii)	2646	3969	6615
3 Cons wte - oncology	1008	2016	3024
Specialist Drs 1.0 wte (iii)	105	105	210
0.5 wte Specialist Dr		420	420
CNS 1 wte (i)	98		98
Other Support		790	790
Overall Total	**3759**	**7300**	**11157**

SET Element

	New	Review	Total
3 Cons wte - core	1512	2268	3780
Overall Total	**1512**	**2268**	**3780**

(i) Assumes CNS only in post for 2 months in 2011/12
(ii) Assumes new consulant in post for only 3 months in 2011/12
(iii) assumes specialist Dr only in post 3 months

IPDC Nurse Led activity in Urology Apr15 to 8th March 2019

Profession	(Multiple Items)
* Admission Type	(All)

Select IP or DC

Apr to 08/03/19

Sum of Adm+DC	Fiscal Year of Admission			
Month	FY2015/2016	FY2016/2017	FY2017/2018	FY2018/2019
Apr	2	42	10	27
May	7	28	31	39
Jun	7	10	38	33
Jul	5	3	48	44
Aug	9	20	19	50
Sep	14	17	31	44
Oct	15	28	53	53
Nov	14	32	42	63
Dec	5	23	16	49
Jan	7	42	28	51
Feb	12	84	20	52
Mar	7	85	25	13
Grand Total	**104**	**414**	**361**	**518**
			FYE	46
				551

Profession	(Multiple Items)

Apr to 08/03/19

Sum of Adm+DC		Fiscal Year of Admission			
* Admission Type	Month	FY2015/2016	FY2016/2017	FY2017/2018	FY2018/2019
Admission	Apr			1	4
	May	1		3	7
	Jun			3	8
	Jul	1		2	16
	Aug			1	9
	Sep	1	2		1
	Oct		7	2	3
	Nov	1		4	2
	Dec		3		
	Jan		1		2
	Feb	1			3
	Mar	4	1	1	2
Admission Total		**9**	**14**	**17**	**57**
Daycase	Apr	2	42	9	23
	May	6	28	28	32
	Jun	7	10	35	25
	Jul	4	3	46	28
	Aug	9	20	18	41
	Sep	13	15	31	43
	Oct	15	21	51	50
	Nov	13	32	38	61
	Dec	5	20	16	49
	Jan	7	41	28	49
	Feb	11	84	20	49
	Mar	3	84	24	11
Daycase Total		**95**	**400**	**344**	**461**
Grand Total		**104**	**414**	**361**	**518**
				FYE IP	5
					60
				FYE DC	41
					491

Specialty on Admission	Profession
NURSE LED UROLOGY(N)	Nurse
UROLOGY - ADD (C)	Cons
UROLOGY (13/14)(IS)	Cons - IS
UROLOGY (14/15)(IS)	Cons - IS
UROLOGY (C)	Cons
UROLOGY (IRR)(C)	Cons
UROLOGY (IS)	Cons - IS
UROLOGY (IS)(C)	Cons - IS
UROLOGY (N)	Nurse
UROLOGY (WLI)	Cons - WLI
UROLOGY (WLI)(C)	Cons - WLI
UROLOGY (WLI)(N)	Nurse - WLI
UROLOGY (WLIO)	Cons - WLI
UROLOGY (WLIO)(C)	Cons - WLI
UROLOGY BHSCT (C)	Cons
UROLOGY LETTERKENNY (C)	Cons
UROLOGY REGIONAL PROJECT (C)	Cons
UROLOGY(18/19)(IS)	Cons - IS
UROLOGY(C)	Cons
URO-ONCOLOGY NURSE (N)	Nurse
VIDEO URODYNAMICS (C)	Cons

Outpatients Nurse Led activity in Urology Apr15 to 8th March 2019

Trust Long Name	(All)
Hospital of Clinic Name	(All)
Profession	(Multiple Items)

Apr to 08/03/19

Sum of Attendances	Column Labels			
Row Labels	FY2015/2016	FY2016/2017	FY2017/2018	FY2018/2019
FM01	491	587	456	539
FM02	409	501	558	632
FM03	454	590	504	689
FM04	401	408	439	654
FM05	421	453	524	728
FM06	465	372	549	709
FM07	438	446	573	924
FM08	420	487	699	743
FM09	406	316	497	545
FM10	454	427	700	657
FM11	522	468	506	652
FM12	489	487	546	187
Grand Total	**5370**	**5542**	**6551**	**7659**
			FYE	679
				8151

Trust Long Name	(All)
Hospital of Clinic Name	(All)
Profession	(Multiple Items)

Apr to 08/03/19

Sum of Attendances (New)	Column Labels			
Row Labels	FY2015/2016	FY2016/2017	FY2017/2018	FY2018/2019
FM01	119	152	150	130
FM02	137	156	194	208
FM03	134	193	172	214
FM04	123	144	114	185
FM05	158	116	175	184
FM06	180	94	143	149
FM07	159	143	142	207
FM08	133	178	182	201
FM09	128	109	119	152
FM10	135	113	206	168
FM11	156	124	144	140
FM12	179	155	151	43
Grand Total	**1741**	**1677**	**1892**	**1981**
			FYE	176
				2114

Trust Long Name	(All)
Hospital of Clinic Name	(All)
Profession	(Multiple Items)

Apr to 08/03/19

Sum of Attendances (Follow up)	Column Labels			
Row Labels	FY2015/2016	FY2016/2017	FY2017/2018	FY2018/2019
FM01	372	435	306	409
FM02	272	345	364	424
FM03	320	397	332	475
FM04	278	264	325	469
FM05	263	337	349	544
FM06	285	278	406	560
FM07	279	303	431	717
FM08	287	309	517	542
FM09	278	207	378	393
FM10	319	314	494	489
FM11	366	344	362	512
FM12	310	332	395	144
Grand Total	**3629**	**3865**	**4659**	**5678**
			FYE	503
				6037

Clinic Speciality	Profession
NURSE LED UROLOGY(N)	Nurse
URODYNAMICS (N)	Nurse
UROLOGY (C)	Cons
UROLOGY (ICATS)	ICATS
UROLOGY (IRR)(C)	Cons
UROLOGY (IS)	Cons - IS
UROLOGY (IS)(C)	Cons - IS
UROLOGY (N)	Nurse
UROLOGY (WLI)	Cons - WLI
UROLOGY (WLI)(C)	Cons - WLI
UROLOGY (WLIO)	Cons - WLI
UROLOGY AMBULATORY (C)	Cons - Amb
UROLOGY ED (C)	Cons
UROLOGY FLOW RATE (N)	Nurse
UROLOGY FLOW RATE (WLIO)(N)	Nurse - WLI
UROLOGY INTRAVESICAL (N)	Nurse
UROLOGY METABOLIC STONE (N)	Nurse
UROLOGY NURSE LED (WLI)(N)	Nurse
UROLOGY REVIEW (N)	Nurse
UROLOGY VIR (IRR)(C)	Virtual
UROLOGY VIR (WLIO)	Virtual
UROLOGY(18/19)(IS)	Cons - IS
UROLOGY(C)	Cons
URO-ONCOLOGY NURSE (N)	Nurse

TEAM EAST

IMPLEMENTATION PLAN

October 2010

Belfast Health and Social Care Trust

South Eastern Health and Social Care Trust

Northern Health and Social Care Trust

CONTENTS

1.0 INTRODUCTION

This paper outlines the vision for provision of Urology services across the Team East area, comprising of the Belfast Health and Social Care Trust (BHSCT); South Eastern Health and Social Care Trust (SEHSCT) and the southern sector of the Northern Health and Social Care Trust (SHSCT). It sets out;

- a description of the current services; (Section 2)
- the demand (current and projected) associated Urology services across the Team East area(Section 2, Table 17);
- the future model of service configuration(Section 3);
- Deliverables for the investment (Section 5); and
- the gap that will exist when all funded services are in place (Section 5)

1.1 CONTEXT

1.1.2 Regional Review of Urology Services

A regional review of (Adult) Urology Services was undertaken in response to service concerns regarding the ability to manage growing demand, meet Cancer and elective waiting times, maintain quality standards and provide high quality elective and emergency services.

A multi-disciplinary and multi-organisational Steering Group was established under the Chairmanship of Mr H. Mullen, Director of Performance and Provider Development and this group met on five occasions between September 2008-March 2009.

An External Advisor, Mr Mark Fordham, a Consultant Urologist, Royal Liverpool and Broadgreen University Hospital Trust, was appointed and attended all Steering Group meetings and a number of other sub group sessions.

The overall purpose of the review was to;

Develop a modern, fit for purpose in 21century, reformed service model for Adult Urology Services which takes account of relevant guidelines (NICE, Good Practice, Royal College, BAUS, BAUN). The future model should ensure quality services are provided in the right place, at the right time by the most appropriate clinician through the entire pathway from primary care to intermediate to secondary and tertiary care.

The review made a total of 26 recommendations across 9 sections that are required to be implemented. A number of these recommendations have been highlighted below.

Recommendations of the review include:

- Acute services should be reconfigured into a 3 team model, to achieve long term stability and viability. The "Team East" Urology Network comprising the Departments of Urology of the Belfast Trust and South Eastern Trust and serves a population of **approximatley** 900,000, and in addition covers the southern sector of Northern Trust (Newtownabbey, Carrickfergus, Larne and Antrim).
- Radical surgery for prostate and bladder cancer should be provided by teams typically serving populations of one million or more and carrying out a cumulative total of at least 50 such operations per annum. Whilst these teams are being established, surgeons carrying out small numbers (five or fewer per annum) of either operation should make arrangements within their network to pass this work on to more specialist colleagues.
- To modernise and redesign outpatient clinic templates and administrative processes booking to maximise capacity for new and review patients.
- The requirement to redesign and enhance capacity to provide single visit outpatient and assessment for suspected urological cancer patients.
- To (where possible) admit on day of surgery through ensuring pre-operative assessment is fully implemented and to increase the number of day surgery procedures.

The formation of Team East provides an opportunity to build on the high quality general Urological service delivered on each of its hospital sites, ensuring that patients consistently get to the right person, in the right place, at the right time, and that our service is modern, high quality and fit-for purpose.

1.1.3 South Eastern Trust Strategic Vision

The South Eastern Health & Social Care Trust (SEHSCT) came in being in 2007. It is a community and acute hospitals Trust that provides integrated health and social services to the population of North Down, Lisburn, Down and Ards Council areas and acute services to a wider catchment, which takes in parts of east Belfast.

The Trust provides general hospital services at the Ulster and Lagan Valley Hospitals and a comprehensive range of health, social and primary care services at one enhanced local Hospital in Downpatrick, and two community Hospitals located at Bangor, and Newtownards.

The Trust wishes to ensure that it provides:-

Local access to services, where appropriate, in a timely manner

- Safe & effective care that ensures that governance issues are addressed so that patients experience high quality outcomes
- Skilled staff that are equipped and motivated to adopt innovative and efficient ways of working
- Efficient services in a way that demonstrates a commitment to value for money
- Engage in meaningful discussions with stakeholders

This vision takes account of the DHSSPS' Developing Better Services (June 2002) as this remains the Province's strategic direction for the delivery of services. In addition, in November 2008, SEHSCT issued a consultation document entitled Local Services for Local People: Safe and sustainable services for populations. This document highlighted how changes to health and social care services have been characterised by the need to provide as many services as possible in the persons' own home or as close to home as possible e.g. in a local clinic, health centre or a local hospital. The Trust is constantly striving to ensure that this is the reality for the vast majority of its services.

The Consultation document also emphasised that, as a service becomes more complex, and the level of expertise required increases, it is inevitable that, to ensure safety and sustainability, these will have to be centralised at particular locations. In this way, the people receiving the service can be confident that staff have the right experience and are properly trained. This may mean people will have to travel to these centres of expertise, though the Trust is confident that this will be for a small number of services.

Taking account of the above factors, SEHSCT will continue to develop its services, in a way that reflects the Ulster Hospital's status as an acute hospital. This means that more complex cases (whether inpatient or day case) will be performed on this site with more routine cases being provided in other hospital sites within the Trust, dependent on capacity and availability of resources.

1.1.4 Belfast Trust Strategic Review of Acute Services

Belfast Health and Social Care Trust was formed in April 2007 from the merger of six Trusts. Four of these were acute trusts – The Royal Hospitals, Belfast City Hospital, the Mater Hospital and Greenpark. Two were community Trusts, serving north and west Belfast and south and east Belfast.

The new Belfast Trust is working to build on the fine legacy established by these six Trusts to deliver integrated and seamless citizen-centred health and social care.

There should be no unnecessary duplication of services and that the Trust should keep trying to find better ways of providing high quality care.

Belfast Trust's overall purpose is to improve health and wellbeing and reduce health inequalities – putting people's needs at the centre of all decisions, providing services locally where possible and making the best use of all our buildings and other resources.

The Trust began a conversation on the future delivery of health and social care services in Belfast in 2008 when they explained the way they want to do things in the future for the

benefit of service users. The citizens of Belfast gave these proposals – outlined in a document called New Directions – a fair hearing and encouraged the Trust to proceed.

In looking at how the Trust might best provide acute hospital services in the future they outlined a number of key principles, such as:

- To localise services where possible and centralise services only where necessary
- To develop clear pathways to access appropriate emergency care
- To re-profile services to make best use of each emergency department and to improve patient flows
- To develop protected elective services
- To reduce unnecessary duplication and fragmentation of service

1.1.5 Guiding principles for the delivery of Urology services across the Belfast Trust

These general principles have been taken from the relevant sections of the Trust's consultation document New Directions, and form the basis of the Trust's development of Urology services.

- To provide safe, high quality, effective care – This is a core objective of the Belfast Trust.

- Localise where possible, centralise where necessary – Services are more easily accessed by people when they are delivered locally, while specialist services benefit from the concentration of expertise and experience required to deliver the highest possible levels of clinical care. The Trust therefore aims to provide its services locally where the standard of service can be assured and centralise its services where it will raise the quality of provision.

- Provide clear directions to services, developing clear pathways to access appropriate emergency care.

- To re-profile services to make best use of each emergency department and to improve patient flows.

- To develop protected elective services.

- To reduce unnecessary duplication and fragmentation of services.

- Maximise utilisation of assets – There is a clear need to make best use of all existing health and social care infrastructure across the Trust and keep the need for new buildings to a minimum while also addressing risk issues, such as those attached to ageing buildings.

In addition, New Directions proposed that Emergency Services would be retained at the Mater Hospital, Belfast City Hospital and Royal Hospitals. However, there would be differentiation of services to improve patient care, based on the type of patient's condition and needs:

- The provision of a major acute hospital, encompassing trauma services and emergency services on the Royal Hospitals site.
- The provision of a range of acute hospital services on the Mater Hospital site.
- The provision of a range of acute hospital services, encompassing cancer and renal services, the chronic admissions centre as well as the major elective centre for Belfast on the Belfast City Hospital site.

1.1.6 What will these changes mean for urology services and Team East?

The changes in service configuration across the 3 trusts may have an impact upon how and where urology services are delivered in Team East. For example, the BHSCT are currently consulting on the bringing together of urology services onto one site at the BCH. This would mean that in the future urology services are not provided on either the RVH or MIH site. It is anticipated that as each of the Trust's set out their strategic vision for services, it **may** impact on where urology services are delivered across Team East. At this point however, it is difficult to ascertain exactly what that impact will be.

2.0 CURRENT SERVICE PROVISION

2.1 Service Profile: Belfast Health and Social Care Trust

The Urology service within the Belfast Trust is provided by 8 (funded establishment) consultant Urologists and 3 nurse specialists, across 3 sites, the Belfast City Hospital (BCH) and the Mater Hospital (MIH) and the Royal Victoria Hospital (RVH). There are 7 consultant Urologists working currently in Belfast, with a funded establishment equivalent to 8 consultant Urologists. Although the service is delivered on 3 sites it is anticipated that in the short term future the service will be provided from single site, the BCH. As is, the data set out below outlines what occurs at the 3 sites currently, however for the purposes of this paper, all activity and capacity in the BHSCT should be viewed as a cohesive entity.

In BCH the service provided covers a wide spectrum of work. Specialist cancer services are based in BCH; where there are three designated 'cancer' Urologists, and it is up to 40% of the overall Urology workload delivered on this site. With regard to special interest Urologists, there are currently two in Belfast Trust that provide a Stones/Endourology service. There are currently two Consultants [redacted] in Belfast who specialises in the area of reconstruction and they work closely with the Uro-oncology team and with supra regional support provided by University College Hospital London.

There are currently two consultants at the MIH who deliver predominantly, a core Urology service with an element of non-specialist Cancer work. The service is the RVH is provided on an outreach basis from the BCH and is on an outpatient and daycase basis only.

2.1.1 Capacity within the BHSCT Service

As has been stated above the all Urology surgical work is provided by seven consultants. The Urology theatre capacity of the 7[1] consultants is shown overleaf in Table 1. The current BHSCT theatres service level agreement (SLA) is based on funding for **42 weeks of the year**.

[1] [1] 1 consultant on long term sick leave since August 2007. The other Consultants in BHSCT have picked up the PA's and associated theatre capacity.

Table 1: Urology Theatre Capacity (elective & emergency) of Urology consultants at the BHSCT

Theatre Capacity per site per week (42 week year) (capacity in theatre lists)			Theatre Capacity per site per year (42 week year) (capacity in theatre lists)	
	Inpatient	**Daycase**	**Inpatient**	**Daycase**
BCH	11	10	462	420
MIH	6	0	252	0
RVH	0	1	0	42
Total	**17**	**11**	**714**	**462**

2.1.2 Activity within the BHSCT Service

The BHSCT Urology activity recorded over the last 3 years and from 2005/06 is shown below in Table 2; the data has been collated from the Belfast Trust's information department.

Table 2: Urology Inpatient Activity BHSCT: Beddays, Finished Consultant Episodes & Average Length of Stay (Elective & Non Elective)

	Episodes			Beddays			Average Length of Stay		
Fiscal Year	**Elective**	**Non Elective**	**Total**	**Elective**	**Non Elective**	**Total**	**Elective**	**Non Elective**	**Total**
FY 2005/06	2587	1079	3966	10094	5846	15940	3.90	5.42	4.35
FY2007/2008	2792	977	3769	9754	4761	14515	3.49	4.87	3.85
FY2008/2009	2622	803	3425	9117	4305	13422	3.48	5.36	3.92
FY2009/2010	2724	845	3569	9022	4233	13255	3.31	5.01	3.71

The data above shows fairly consistent levels of activity for inpatient Urology services, with a decreasing length of stay year on year, which highlights the work done to move to a shorter length of stay for inpatients, and such initiatives as increased admission on the day of surgery. This activity however does not show the levels of work that has been sent to the independent sector on a non-recurrent basis. This is shown in greater detail in table 8.

Activity from 2005/06 has been presented along with the past three years data. This is due to the fact that existing SBA levels are based upon 2005/06 activity.

Table 3: Daycase Urology Activity BHSCT

Hospital	FYE 05/06	FYE 07/08	FYE 08/09	FYE09/10
BCH	4846	3266	3575	3628
MIH	727	885	943	874
RVH	85	167	203	168
TOTAL	5658	4318	4721	4670
Urology Day Care	N/A	1716	1828	1796
TOTAL	**5658**	**6034**	**6549**	**6466**

The information in table 3 above shows all daycase activity that is undertaken in the Belfast Trust as Urology. Urology day care activity has been split out, as although it is technically coded as daycase procedures, it is diagnostics as opposed to treatment and is not carried out in a theatre. This equates to 28% of the total number of daycases carried in 2009/10.

From the 6,466, daycase procedures carried out in the BHSCT, around 60% year on year are diagnostics, for example, TRUS biopsy, Urodynamics and Cystoscopy. UDC was not operational in 2005/06, and this work was undertaken in BCH daycase theatres, hence the reduction in activity in 2007-2010. Diagnostics in BCH are currently coded as daycases for SBA purposes, and are delivered by a consultant led team. It is recognised that going forward as Team East there it will be necessary to ensure consistency in coding of diagnostics, as diagnostics as opposed to daycases. This approach will be consistent across Team East.

BHSCT Outpatients

Table 4: BHSCT Urology Outpatient Activity – New

Outpatient New	09/10	SBA Contract Level TOTAL 09/10
New outpatients seen by Cons	2855	-
New OP not delivered by Cons (ie nurse led/IS/WLI)	2033	-
TOTAL	**4888**	**2170**

Table 5: BHSCT Urology Outpatient Activity - Reviews

Outpatient Reviews	09/10	SBA Contract Level TOTAL 09/10
Review outpatients seen	5805	-
Review OP not delivered by Cons (ie nurse led/IS/WLI)	1407	-
		-
TOTAL	**7212**	**5365**

The Trust currently has a review backlog of approximately 6000 patients. The BHSCT undertook a project in June 2010 to address and manage the existing backlog review. Key actions to date have included data validation, ongoing clinical validation by all of the consultants, telephone review clinics, revised protocols and reviewing of existing clinic templates. This work is ongoing as of October 2010. Further work will include looking at patients who may not have to be reviewed via revised review protocols.

The new/review ratio is 1 new to 1.5 review of patients actually seen. Taking into account the review backlog, the ratio is increased to 1:2.7. This reflects the conservation and medical management for some urology patients.

2.1.3 Capacity and Demand Analysis BHSCT

Capacity within the BCHSCT is measured by the SBA contract volumes that it is commissioned to provide. Table 7 below sets out the existing capacity within the BHSCT to deliver Urology services as they are currently configured.

Table 7: BHSCT Urology – Capacity - Service and Budget Agreement Levels and Activity 2009/10

	Capacity - SBA	Actual Outturn based on SBA	Variance / Gap
Elective Inpatients	2241	2738	497
Non-elective Inpatients	962	838	-124
Daycases	4660	5242	582
New Outpatients	2170	2855	685
Review Outpatients	5365	5805	440

Table 7 demonstrates consistent over performance against SBA that the Urology service at the BHSCT delivers. The high proportion of daycases to outpatient data indicate the frequent number of patients who require multiple procedures through different FCE's, for example repeat check flexible cystoscopies. A proportion of the workload in 09/10 was sent to the independent sector to help alleviate the gap and hold maximum re-negotiated waiting times at 26 and 52 weeks (in 2009/10) for inpatients and daycases.

Table 8: Capacity and Demand for Urology Services at BHSCT Based on 2009/10 Analysis

Demand							**Service Level Agreement 09/10 (funded capacity)**	
Inpatient Activity 09/10	**Inpatient Independent Sector 09/10**	**Daycase Activity 09/10**	**Daycase Independent Sector 09/10**	**Waiting List Growth**	**Planned Backlog**	**Number of Patients Breaching 13 weeks at 31/03/10**	**Inpatients**	**Daycase**
3569	225	6466	675	318	815	345	3203	4660
DEMAND =12413 ROTT (IP and DC) rate as per BHSCT Info Dept =8% DEMAND less ROTT = 11420							TOTAL CAPACITY BASED ON SBA = **7863**	
TOTAL DEMAND = 11420							**TOTAL CAPACITY =7863**	
GAP = 3557 IP and DC								

The gap identified above is what is required in terms of investment to deliver the demand associated with Urology in Belfast. In order to reduce waiting times to 13 weeks there is an additional 345 cases that need to be treated in year, along with the waiting list growth identified above.

Current cancer breach patients are included within the overall demand. However, we still have breaches due to the limited level of current capacity for cancer patients and competing demand for waiting time targets. Although many of these patients can breach the 31/62 day pathway, they are treated in year, therefore are included in the analysis.

2.2 Service Profile: South Eastern Health and Social Care Trust

There are currently 3 consultant Urologists and 1 nurse specialist in post at the SEHSCT. They are based in the main at the Ulster Hospital Dundonald (UHD), however they also provide outreach sessions to the Downe; Lagan Valley hospitals and Newtownards hospital - on a daycase and diagnostic basis in the main.

As has been stated above the Urology surgical work is carried out by three Urology consultants and nine General Surgeons. The general surgeons provide only limited inpatient and day case urology activity ie vasectomies, circumcisions etc. The Urology theatre capacity of the 3 Urology consultants is shown below in Table 9.

Table 9: Urology Theatre capacity of 3 Urology consultants at the SEHSCT

Capacity per site per week (capacity in theatre lists)			**Capacity per site per year (42 week year) (capacity in theatre lists)**	
	Inpatient	**Daycase**	**Inpatient**	**Daycase**
UHD	2.5	0	105	0
LVH	0	3*	0	126
Downe	0	1	0	42
Ards	0	2+2 scopes		168
Total	**2.5 (Including 3rd urologist)**	**6 daycase and 2 scopes**	**105**	**252 DC sessions 84 scope sessions**

2.2.1 Activity within the SEHSCT Service

The SEHSCT inpatient Urology activity recorded over the last 3 years is shown below in Table 11; the data has been collated from the SEHSCT's information department. The activity

below includes all inpatient Urology activity, whether it was undertaken by a General Surgeon or a Urologist.

Table 10: Inpatient Urology Activity SEHSCT: Beddays, Finished Consultant Episodes & Average Length of Stay (Elective & Non Elective)

	Episodes			Bed days			Average Length of Stay		
	Elective	Non-elective	Total	Elective	Non-elective	Total	Elective	Non-elective	Total
FY2005/2006	361	449	810	1437	1773	3210	3.98	3.95	3.96
FY2007/2008	374	377	751	1470	1566	3036	3.93	4.15	4.04
FY2008/2009	434	461	895	1468	1625	3093	3.38	3.52	3.46
FY2009/2010	435	447	882	1434	1822	3256	3.30	4.08	3.69
FY 2006/07 has been omitted, as in the original document.									
The figures have been re-run on 10/09/10, to include a wider range of diagnostic codes, eg patients admitted non-electively under General Surgery and possibly transferred to Urology. This has increased the number of non-elective episodes.									

The data above shows an increasing demand for inpatient Urology services.

Table 11: Daycase Urology Activity SEHSCT (including Urology activity by General Surgeons)

Hospital	05/06	07/08	08/09	09/10
Ards	1432	1512	1778	1707
Downe	980	284	362	311
LVH	539	940	854	808
UHD	84	84	68	2
Independent Sector			265	379
TOTAL	**2435**	**2820**	**3327**	**3207**
Percentage of which = cystoscopies/biopsies	**47.47**	**42.34**	**45.33**	**43.53**

The general surgeons in 09/10 undertook 410 daycase and inpatient episodes -a total of 10% of the total urology activity. **If the numbers of General Surgeons who carry out Urology reduce, there will be a requirement for this resource to move to Urology**. The Regional Review noted this issue and the recommendation regarding this stated:

"Trusts should plan and consider the implications of any impending retirements in General Surgery, particularly with regard to the transfer of "N" Code work and the associated resources to the Urology Team".

This activity therefore has been included as part of the demand going forward for Team East, and negotiations around associated resources will need to be undertaken by the Team East steering group.

Table 12 Outpatient Activity - New

Outpatient New	05/06	07/08	08/09	09/10	SBA Contract Level*
New outpatients seen	1499	1795	2336	2046	2046
Independent Sector			106	1008	-
WL Initiatives			68	143	-
TOTAL	**1499**	**1795**	**2510**	**3197**	**-**

* As there is no specific SBA for Urology within SEHSCT, activity delivered has been assumed as a proxy for capacity for 09/10 and going forward.

Please note:

- There are a number of General Surgeons who see Urology patients within the figures above. These figures are excluded as reason for referral cannot be extracted from PAS;
- Haematuria referrals go straight to cystoscopy and therefore are not seen as a new OP;
- IS activity for 05/06, 07/08 is not included as it was not recorded on PAS and therefore is not an accurate reflection;
- In 09/10 PAS guidance re additional in-house was not implemented until late in the year and therefore the figures represented as additional in-house are not fully reflective of what happened; and

- Activity above includes nurse led clinics as a proportion of the new outpatient in-house workload as all nurse led new appointments are consultant to nurse referrals.

Table 13: Outpatient Activity - Reviews

Outpatient Reviews	05/06	07/08	08/09	09/10	SBA Contract Level*
Review outpatients seen	1956	2673	3444	3387	3387
Independent Sector		190	154	145	-
WL Initiatives				62	
TOTAL	**1965**	**2863**	**3598**	**3594**	**-**

* As there is no specific SBA for Urology within SEHSCT, activity delivered has been assumed as a proxy for capacity for 09/10 and going forward.

The Trust currently has a review backlog of 1073 patients. The new/review ratio is 1 new to 1.1 review. The current actions ongoing to address the OP back log in SEHSCT include clinical, data and patient validation.

2.2.2 Capacity and Demand Analysis SEHSCT

Capacity within the SEHSCT is measured by the SBA contract volumes that it is commissioned and funded to provide. There is currently no Urology specific SBA information available for SEHSCT. The Urology SBA is contained within the overall General Surgery SBA. However, there is data available on projected outturn and this is shown in Table 14 below.

Therefore any additional investment associated with the delivery of the review of Urology services is identified to bridge the existing gap, between SBA commissioned activity, additional activity in addition to SBA, waiting list growth, demand sent to the independent sector and the planned backlog. Table 14 below sets out the existing capacity within the SEHSCT to deliver Urology services as they are currently configured.

Table 14: Demand and Capacity (Please note that some emergency work would be carried out in the emergency theatre but we are unable to quantify this at present)

	09/10 Demand	Predicted Demand 10/11	Capacity	Gap
Elective Inpatients	414	454	456	2
Non-elective Inpatients	343	377	368	9
Daycases	3207	3527	2828	699
New Outpatients	3569	3997	2046	1951

The capacity within SEHSCT has been calculated on the assumption that actual activity done in 2009/10 is a proxy for capacity. This was the only way to ascertain capacity at this stage, as there is no specific SBA for urology at SEHSCT.

Table 15: Capacity and Demand required for Urology Services at SEHSCT

Demand						**Service Level Agreement 09/10 (funded capacity)**	
Inpatient Activity 09/10	**Inpatient Independent Sector 09/10**	**Daycase Activity 09/10**	**Daycase Independent Sector 09/10**	**Waiting List Growth**	**Planned Backlog**	**Inpatients**	**Daycase**
882*	0	3207	379	5	158	824	2828
DEMAND =4631 ROTT (IP and DC) rate as per SEHSCT Info Dept =8% DEMAND less ROTT = 4261						TOTAL CAPACITY BASED ON SBA = 3644	
TOTAL DEMAND = 4261						**TOTAL CAPACITY = 3644**	
GAP = 617							

*This activity includes the unfunded 3rd Consultant post at SEHSCT.

The gap identified above is what is required in terms of investment to maintain waiting times at 13 weeks, which is where they currently sit within the SEHSCT (end 2009/10), and to recurrently fund the independent sector gap that has maintained these waiting times on a previously non-recurrent basis. Team East will provide equitable access to Urology services in terms of waiting times.

It has been assumed that General Surgery activity continues to be provided until such time that the capacity and resources are re-provided to the Urology team.

2.3 Northern Health and Social Care Trust

At present there is a Urology service in the Causeway Hospital that will fall within Team North West. There is no Urology service currently at Antrim Area Hospital, and patients requiring Urological services from the southern sector of the Northern area, are by in large treated by the Belfast Health and Social Care Trust. It is not anticipated there will be any change to the general surgeon complement within the NHSCT in the immediate future.

The table below shows the NHSCT activity undertaken in the BHSCT in 2009/10.

Table 16: BHSCT NHSSB Activity

BHSCT Urology NHSSB Activity for 01/04/2009 - 31/03/2010

Produced by Information Services Department

Hospital Description	(All)
Consultant Name	(All)
Board Name	Northern Board
Postcode	(All)

Sum of Episodes + Daycases		Casetype			
Urology	2009/10	Daycase	Elective	Non - Elective	Grand Total
Grand Total		1826	820	213	2859

2.4 Conclusion

Table 17 below presents the existing demand and capacity across Team East based on 09/10 actual activity levels, Independent Sector work, waiting list growth, planned backlog and patients not being treated in 13 weeks. This is the estimated demand that Team East will need to meet.

Table 17: Total Inpatient and Daycase Demand and Capacity across Team East Area Based

Inpatient and Daycase Capacity and Demand Analysis									
	Demand							**Service Level Agreement 09/10** **(funded capacity)**	
	Inpatient Activity 09/10	**Inpatient Independent Sector 09/10**	**Daycase Activity 09/10**	**Daycase Independent Sector 09/10**	**Waiting List Growth**	**Planned Backlog**	**Number of Patients Breaching 13 weeks at 31/03/10**	**Inpatients**	**Daycase**
BHSCT	3569	225	6466	675	318	815	345	3203	4660
SEHSCT	882	0	3207	379	5	158	824	2828	882
	DEMAND =16968 less ROTT of 8%=15627							TOTAL CAPACITY BASED ON SBA = 11573	
	GAP = 4054								

Outpatient Capacity and Demand Analysis						
Demand					**Service Level Agreement 09/10**	
New outpatients seen by Cons	**New OP not delivered by Cons (ie nurse led/IS/WLI**)**	**Review outpatients seen**	**Review OP not delivered by Cons (ie nurse led/IS/WLI)**	**Review Backlog**	**New Outpatients**	**Review Outpatients**
4901	3184	9192	1614	7073	4216	8752
DEMAND= **25,964 + 182 x 9 week breaches BHSCT = 26,146** Average ROTT* (OP) rate = 23% DEMAND less ROTT = 20,133					TOTAL CAPACITY BASED ON SBA = **12,968**	
TOTAL GAP = 7,165						

*ROTT rate at SEHSCT is 30% and 16% at BHSCT. These rates are at this level due patients who are directly booked to haematuria clinics for example, without the need for a new outpatients appointment, but an outpatient registration is still opened. Although this is classified as ROTT, the activity is still delivered as an IP or DC. Going forward Team East will use a discharge code that allows some new referrals to move directly to treatment. This will allow a more accurate representation of ROTT to be assessed.

Table 17 above includes the non-recurrently funded resources that were available in 2009/10 to meet maximum waiting times of 9 weeks in ESHSCT and 13 weeks in BHSCT. BHSCT also had 182 patients that breached 9 weeks despite using the IS/WLI which needs to be included in the demand.

Table 18 below demonstrates the theatre sessions that are currently funded and utilised in Team East.

Table 18: Total Existing Theatre Capacity across Team East Area Based on Existing Urology Theatre Sessions

Existing Capacity per Trust per week (capacity in theatre lists)			**Existing Capacity per Trust per year (42 week year) (capacity in theatre lists)**	
	Inpatient	**Daycase**	**Inpatient**	**Daycase**
BHSCT	17	11	714	462
SEHSCT*	2.5	8	105	336
NHSCT	0	0	0	0
Total	**19.5**	**19**	**819**	**798**

*****Including 3rd urologist

3.0 FUTURE SERVICE MODEL

3.1 Proposed Model

Team East will deliver all aspects of Urological care to a population of 900,000 (this figure was a working assumption at the time of the Review, that may be re-scoped going forward) across Northern Ireland. It will also provide tertiary pelvic cancer and reconstruction services on a regional basis. Team East aspires to provide services on 3 sites in the long term, but will initially provide services where theatre resources can be accessed, that is on 6 sites.

The service model proposed for Team East is comprised of the following:

- Team east will be delivered across 6 sites in the short terms: UHD; BCH; AAH; LVH; Ards and the Downe
- Urology admissions in Team East will be admitted via three streams - as direct admission to in-patient beds, as day case to a Day Surgery Unit and as 23-hour day case. The service will be 'streamed' to reflect demand, by inpatients / 23 hour stay / daycase / diagnostics / outpatients.
- Inpatients will delivered from 2 sites- one as the main acute site at BCH and also UHD which will have a particular focus on rapid turnaround;
- AAH will have an onsite Urology presence from a Specialty Doctor and Consultant at specified times; it will also have access to the on call Urologist via telephone advice and management of non-elective patients via regionally agreed pathways.
- Emergency admissions will be delivered from a single site in the main, particularly cases likely to need surgery out of hours, these will be transferred directly to BCH;
- There will be emergency access for acute Urology patients across all of Team East;
- Consultants may not have or need inpatient lists; and
- There will be a role for specialty doctors and nurse specialists.

3.2 Principles for Service Delivery

1. **Team East will be delivered locally where possible and centrally where necessary.** This will only be realised after each of the Trust's have developed and delivered their strategic vision for acute services, which is not anticipated in the short term. A number of changes outwith the management of Team East will require to occur in order for the model to be fully realised, for example the location of services across

the Trusts and capital builds to be completed and commissioned at both the UHD, Phase B completion is estimated to be 2015 and will contain wards, DPU, endoscopy and support services and BCH new build DPU still in planning stages.

2. **Equity of access to services across Team East**

Team East aspires to have equity of service provision for its patients, including access to all elements of the Urology service in a timely way, regardless of where the patient lives. This will be achieved by:

- a central management agreed system that will ensure effectiveness and efficiency of service delivery, specifically - management of referrals; waiting lists and theatre scheduling;
- PMSID and commissioners working with Team East to agree backstop maximum waiting times;
- Pooling of key procedures where feasible; and
- Reducing duplication where possible to maximise the utilisation of resources –such as people; buildings and equipment.

3. **Team East will benchmark against key performance indicators** to deliver a modern service that is fit –for-purpose. For example, Team East will admit as the norm on day of surgery (unless for clinical reasons this is not suitable). This will have to be done with appropriate anaesthetic pre-operative assessment. The additional funding required to deliver this is not within the Review allocated resources and does not exist at the present time across all of the sites

3.3 Elective Inpatients

Elective inpatients will be delivered from 2 sites- one as the main acute site at BCH and UHD which will have a particular focus on rapid turnaround. Core Urology will be delivered at both inpatient sites.

The BCH site will be the Team East centre for acute surgical Urology admissions; Uro-Cancer; reconstruction and complex stones. BCH will be the centre for complex, acute longer stay inpatients, including most of the cancer and reconstructive Urology surgery. BCH will also be the regional centre for radical pelvic surgery, as per recommendation 19 in the Review. To date the BHSCT have accepted a number of radical pelvic referrals from the SHSCT, and from September 2010 the SHSCT have been participating in the regional MDT.

UHD will continue to deliver inpatient services with a primary focus on rapid turnaround cases. UHD will primarily carry out core Urology, selected cancer and stone work. SET will

need to acquire capital and revenue funding for the necessary equipment to develop the stone service. Until then the BCH would continue to provide the primary stone service for Team East.

3.4 Non-Elective IP

Specific acute emergency admissions that present to any of the units (UHD; AAH; LVH; Downe and Ards) within Team East should (once a specific Urological diagnosis is made) be transferred to BCH. These conditions are further detailed within the proposed regional Urological pathways which will be signed off at a Regional level by end November 2010. There are certain non-elective admissions that are currently managed by general surgery in the UHD, for example testicular torsion, which will continue to be managed by general surgery under Team East.

3.5 23 Hour Stay /Rapid Turnover

23 hour stay will be delivered at both the UHD and BCH site in Team East. There will be a definitive shift under the Team East model to increase 23 hour surgery rates for appropriate procedures. This will result in an improved service for patients by allowing patient choice and will make best use of capacity. In order for Team East to fully develop the 23 hour stay model, the necessary infrastructure, for example access to theatres, need to be secured going forward.

The patient journey would run along similar principles to that of the patients being admitted to day surgery, in that all patients would undergo pre-assessment to ensure their fitness for surgery. The criteria for admission would be similar to that of day surgery, recognising patients' needs for social support following discharge. A key difference from the day surgery is that the patient will be booked for an overnight stay, due to (a) the type of surgery that the patient is to undergo (b) the need for an extended recovery time.

There are a number of points, which it must be emphasised, are vital to the success of establishing a 23 hour stay model in Team East:

• Pre-assessment must be in place so that problems are identified and corrected before the day of surgery and so patients are appropriately routed to day surgery or 23-hour surgery. It is therefore important that pre-assessment of patients is comprehensive and the selection criteria specific. This will require Consultant Anaesthetist input.

• Appropriate support needs to be in place for patients following their discharge, as is the case following day surgery. This may include pre-packaged take-home analgesia, written information, telephone support and links with the clinical nurse specialists, who will be key in providing a role in this model of service.

3.6 Productivity and Modernisation

There will be a net decrease in beddays through delivering 23 hour stay as the service will meet and maintain the benchmarks set down in the BADS daycase rate and the Elective Reform Programme. This will contribute to each of the Trust's delivering their CSR savings, as well as providing a more efficient and effective services to our patients.

The model of 23 hour stay realises many of the recommendations set out in the Regional Review, these are set out below. Further work will be carried out in the next 6 months to develop the detail and operational arrangements regarding these recommendations, for example where the additional funded lists should be located. For the purposes of this plan, the key principles have been set out at this time, with a view to further development over the coming months.

- Trusts should implement the key elements of the elective reform programme with regard to admission on the day of surgery, pre-operative assessment and increasing day surgery rates.
- Trusts should participate in a benchmarking exercise of a set number of elective (procedure codes) and non-elective (diagnostic codes) patients by Consultant and by hospital with a view to agreeing a target length of stay for these groups of patients.
- Trusts will be required to include in their implementation plans, an action plan for increasing the percentage of elective operations undertaken as day surgery, redesigning their day surgery theatre facilities and should work with Urology Team in other Trusts to agree procedures for which day care will be the norm for elective surgery.

3.7 Daycases

Daycases will be delivered across a number of sites in Team East to fully utilise existing accommodation and theatre resources balanced with not duplicating services unnecessarily. The final location of the sites for daycase will be agreed following each of the Trust's consultation on their strategic vision for services. Initially the following sites will provide daycase services:

- BCH; AAH; LVH; Downe and Ards

Currently there is no capacity for daycases at the UHD. Team East aspires long term to deliver services on 3 sites, but this is dependent on how each Trust reconfigures their

services and the availability of key resources such as theatres. There will still be some day surgery and diagnostics carried out at BCH, however, it will be difficult to facilitate an increase or change in profile of this work until the new day procedure unit (DPU) is complete at the BCH. This is critical to Team East delivering on its KPI's, primarily those related to achieving the BADS benchmarks.

3.8 Key Operational Changes

In particular Team East has identified the requirement for two fundamental operational issues to be modified as the service takes shape. These are on call arrangements and management of referrals.

3.8.1 On Call

The objective is to deliver 1 on call rota for Team East, through an out of hours service that meets the needs of the patients. Team East are keen to develop a consultant of the week model, subject to ensuring that activity is not reduced.

Further work is ongoing to ascertain the definitive model for on call, this is expected to be agreed with the clinicians by end November

Any discussions regarding on call must take account of the current arrangements in place with General Surgery at the UHD, regarding specific Urological non-elective admissions. It is anticipated the status quo would remain.

On call payments – BCH consultants are remunerated for on call, UHD are currently not. Further discussion around the funding of these additional PA's will be required to take place.

3.8.2 Referrals

Team East will move to implement a system of central triage and referral to ensure equitable management of demand and provide a fairer service to our patients. This will be challenging to implement immediately, as issues such as administration teams, processes, IT systems etc need to be amalgamated. Waiting lists and theatre scheduling will also need to be centralised. Further discussions with commissioners regarding accountability arrangements for SBA volumes and maximum waiting times are essential in the coming months to deliver this objective. Team East will develop a paper outlining different models and methodologies for consideration.

Team East will seek out early opportunities to pool and manage core Urology for example piloting the pooling of TURPS.

4.0 Team East Review Allocated Costs

The resources allocated from the Regional Review are set out below. The Team East steering group have re-aligned this allocation to reflect the identified need within Team East on the assessment of best value for money. Primarily the key change involves the inclusion of 1.5 WTE speciality doctors and the reduction of clinical nurse specialists (CNS).

Table 19: Review Allocated Resources

Review Allocated Costs	WTE	Team East – Revenue Consequence	Unit Cost	Team East Capital Cost
Staffing Costs				
Consultant Urologists wte (10 PA)	2	Commercially Sensitive Information redacted by USI	[redacted]	
Consultant Anaesthetist @ 0.6 wte per Con. Urologist	1.2	Commercially Sensitive Information redacted by USI	[redacted]	
Specialty Doctor	1.5	Commercially Sensitive Information redacted	[redacted]	
Imaging		Commercially Sensitive Information redacted		
Band 5 Theatre Nursing @ 1.8 wte per Con. Urologist	3.6	£Commercially Sensitive Information redacted	[redacted]	
Band 3 Nursing @ 0.46 wte per Con. Urologist	0.92	Commercially Sensitive Information redacted	[redacted]	
Band 7 Specialist Nursing	1	Commercially Sensitive Information redacted	[redacted]	
Band 5 Nursing @ 0.64 wte (day surgery)	0.64	Commercially Sensitive Information	[redacted]	
Band 8A Team East Clinical Co-ordinator	1	Commercially Sensitive Information redacted	[redacted]	

Support Costs				
Surgical G&S @ [redacted] per Con. Urologist		[redacted]	[redacted]	
Theatre Goods/Disposables @ [redacted] per Con.Urologist		[redacted]	[redacted]	
Radiology G&S per Con. Urologist		[redacted]	[redacted]	
CSSD @ [redacted] per Con. Urologist		[redacted]	[redacted]	
Outpatients Clinics/Medical Records @ 2 per Con. Urologist		[redacted]	[redacted]	
Review Allocated Costs Sub-Total		[redacted]		

4.1 Total Investment Identified for Team East

Table 20: Total Allocated Cost Less Funding to Date

	Sub Totals
Review Allocated Costs	[redacted]
Less funding in 2008/09	[redacted]
TOTAL	[redacted]

5.0 PROPOSED DELIVERABLES FOR NEW INVESTMENT

5.1 Increased SBA Volumes

This plan has clearly identified the fact that there is a gap between existing capacity and demand. This gap equates to 3,914 inpatients and daycases per annum. In order to deliver 13 weeks maximum waiting time across all of Team East, meet the growth in demand, stop utilisation of the IS and deliver the planned backlog, this gap will require to be resourced. The Regional Review has identified 2 additional consultants (1 already in post and this activity has been considered within the overall capacity), which will not deliver this gap.

The table below quantifies the uplift in SBA that will be realised through the funding of 6 additional lists per week as set out in the Review. The 3rd Urologist appointed by SET in 2009/10 has to date been utilising 2.5 (2 daycase and 0.5 inpatient per week) of these 6 lists to date, therefore the uplift from this activity has already been realised and is not additional in the analysis below. However, a gap will still exist as identified below of 3,914 FCEs per annum.

Table 21: Revised IP and DC SBA Based on Investment for 6 Additional Lists*

Current Team East SBA (IP and DC)	11,515
TOTAL Uplift in SBA with 1and 1/6* additional posts	1,278
TOTAL new SBA	12,793
GAP after funding 1.5 Consultants based on Total Demand of 16,707	3,914 FCEs per annum

- *3rd Urologist was appointed to SEHSCT in 2009/10. He currently has 2.5 theatre sessions per week and will only have an uplift of 0.5 of a session or 1/6 of overall consultant activity levels with the recurrent funding.

The uplift of 1,278 assumes that the current volumes of service SBA will continue to be delivered per consultant in Team East as is current (1,096 IP and DC average per annum). **Existing delivery depends on middle grade staff support**, and there will be a requirement to fund the specialty doctor posts to maintain this level of service.

There will be a significant reduction in the ability to deliver some elements of the service in the coming years, due to the reduction in junior doctors and the requirement to deliver a compliant rota, unless the specialty doctor posts are prioritised.

5.2 IP and DC - Maximum Waiting Times Post Investment

In real terms the Team will only be delivering an additional 3.5 lists with the new investment. In 2010/11 the current renegotiated maximum waiting time is 36 weeks. The SEHSCT have predicted no 36 week breaches in 2010/11, due to the addition of the 3rd Urologist post. BHSCT are predicting approximately 600 inpatient and daycases breaching 36 weeks at end 201/11, unless non-recurrent investment is allocated and delivered.

It is estimated that the additional investment under Team East will deliver maximum waiting times waiting times of around 30 weeks. In order to reduce waiting times further, to the 13 week ministerial target, the additional investment to fund the gap of 3,914 would need to be resourced.

The identified gap of 3,914 in inpatients and daycases equates to a further 3.5 consultant posts in addition to the Review allocated resources. Based on the capacity and demand analysis this would allow the service to deliver maximum waiting times of 13 weeks. There would also be the requirement for associated infrastructure and support costs for these additional posts, for example specialty doctor /middle grade support, anaesthetists, nurses, imaging and goods and services costs.

5.3 Revised OP SBA Post Investment

The table below shows the uplift in terms of SBA post investment of 1 (1 consultant already in post) additional consultant and 1.5 specialty doctors. The uplift is based upon a consultant delivering 2 outpatient clinics with support from either a CNS or specialty doctor. This figure takes into account sub specialty interest, eg oncology.

The specialty doctor posts can also deliver an additional 2 clinics per week, with a lower throughput of 5 new and 5 reviews per clinic. The additional CNS (anticipated job plan included in Appendix 1) would deliver a number of additional nurse led clinics – 1 x flow rate per week and 2 x LUTs clinics per week, realising uplift in activity. They would also support consultants to deliver projected activity levels, at outpatients, daycase lists and results clinics.

Table 22: Revised Outpatient SBA Post Investment

Current Team East SBA OP	**12,968**
TOTAL Uplift in SBA with: **1 additional consultant post (2 OP per week)** **1.5 specialty doctor (support for consultant plus additional 2 OP clinics)*** **1 additional CNS –**	 1,281 new and review OP 840 new and review OP 588 total LUTS and flow rate OP
TOTAL UPLIFT	2,709 TOTAL
TOTAL new SBA	15,677
GAP after funding based on Total Demand of 20,133	4,456

The investment which will deliver 2,709 additional new and review appointments per annum will reduce the current waiting time from 21.5 weeks (average across Team East) to approximately 14.5 weeks.

In order to meet waiting times of 9 weeks and clear the existing backlog the additional 4,456 would require to be funded going forward. This equates to an additional 3 consultant posts to fully meet demand.

5.4 Urology Service to Antrim Area Hospital

A key feature of the Regional Review was the establishment of a level of Urology service within Antrim Area Hospital. The primary elements of the AAH service are outlined below.

5.4.1 Non-Elective Service

There will be clear regionally agreed clinical pathways in place to ensure the appropriate management of non-elective patients who present at AAH. The solution proposed will deliver an onsite Urology presence several days per week. There will be 365 access to Urology support out of hours by telephone via the consultant on call rota.

5.4.2 Elective Service

There will be a Speciality Doctor presence in Antrim Area Hospital providing outpatients with a focus on diagnostics and day surgery, with some consultant input. The service proposed in Antrim would necessitate the funding to be made available for a Speciality Doctor.

There will be 4 sessions of specialty doctor and consultant time spent in AAH on a weekly basis. The post may require a level of backfill which would be provided on a planned basis by the Team consultants and specialty doctors. The table below sets out the proposed workload of the AAH specialty doctor and consultant on a weekly basis.

Table 23: Proposed Elective Sessional Commitment at AAH

	Specialty doctor	Consultant
Session 1	1 x OP (concurrent with consultant)	1 x OP
Session 2	1 x DPU/diagnostics list	1 x DPU/diagnostics list

Team East will take opportunities to further develop the service at AAH in co-operation with the NHSCT.

The BHSCT undertook 1836 NHSSB daycases in 2009/10. The development of the service at AAH will allow approximately 20% of this activity to be delivered locally at AAH. The remaining 80% of this activity will continue to be delivered in BHSCT.

5.5 Regional Agreement up to KPI's –Performance and Patient

Team East have developed a number of key performance indicators they are committed to delivering in conjunction with the additional investment and the formation of the new Team. The indicators set out below are not exhaustive and are subject to regional sign off with the team developing indicators and pathways for end November 2010.

To date only performance indicators are set out, and key patient indicators will be developed separately for 19th November 2010.

- **Outpatients:**
    a. Team East will review current discharge protocols for specific patients in relation to review outpatient appointments.
    b. Team East will deliver new to review ratios as set out by benchmarked peers. This is however subject to each of the Trusts clearing their review backlog.

- **BADS Benchmarks** - Team East will work to deliver the benchmarks set out in the table below. All of the procedures listed in the table below are core Urology. This will be a phased process as the team develops. Performance will be monitored on an ongoing basis with PMSID and commissioners.

Urology BADS Rates for 2009/10

	BADS Optimum Rates		
Proc Group	**BADS Rate%**	**23 Hour stay%**	**<72 Hour Stay%**
Cystoscopy +/- Biopsy	40 (+50% in Outpats)	0	10
Cystostomy And Insertion Of Suprapubic Tube Into Bladder	90	10	0
Endoscopic Extraction Of Calculus Of Bladder	50	50	0
Endoscopic Incision Of Outlet Of Male Bladder Nec	50	50	0
Endoscopic insertion of prosthesis from ureter	90	10	0
Endoscopic pyelography	90	10	0
Endoscopic Resection Of Lesion Of Bladder	20	50	30
Excision Of Lesion Of Penis	50	50	0
Excision Of Lesion Of Testis	90	10	0
Frenuloplasty Of Penis	90	10	0
Lap' nephrectomy	5	70	25
Lap' prostatectomy	10	80	10
Operations on Urethral orifice	90	10	0
Optical Urethrotomy	90	10	0
Orchidectomy	90	10	0
Orchidopexy	90	5	5
Orchidopexy-Bilateral	75	20	5
Other endos' procedures on ureter	90	10	0
Removal Of Tubal Prosthesis From Ureter	100	0	0
Renal biopsy	90	10	0
TURP (prostate resection-Endoscopic)	15	45	40
Ureteroscopic Extraction of calculus of ureter	50	50	0

In order for Team East to fully deliver BADS, additional capital and revenue investment is required specifically, Greenlight and Holmium Laser at UHD. Separate bids will be made by SET for this funding. Team East will ensure consistency of equipment specification.

Theatre throughput will not be improved or made more efficient through the change of practice set out above. The productivity delivered through implementation of BADS benchmarks will be reduced beddays.

Additional KPI's

- Team East will deliver benchmarked peer 75th percentile admission on day of surgery rates.
- Team East will deliver benchmarked peer 75th percentile overall length of stay.
- Team East will deliver and maintain PFA target: **Cancelled operations:** from April 2010, all surgical patients should have appropriate pre-operative assessment, and no more than 2% of operations should be cancelled for non-clinical reasons.
- Team East will deliver and maintain readmission and mortality rates in line with benchmarked peers.
- Team East core Urologists will deliver:
    - **Outpatients (new and review) -** A Consultant working alone should see between 1176 and 1680 patients per annum. Consultants with a major sub specialty interest e.g. oncology, will see significantly fewer patients due to case complexity and a need to allocate more time to each patient. Teaching, particularly under graduates and house officers, will also reduce the number of cases per clinic. (British Association of Urological Surgeons)
    - **In patient/day case activity -** The average Consultant Urological Surgeon, and his team, should be performing between a 1000 and 1250 inpatient and day patient FCEs per annum. The exact number will depend on sub specialty interest, case mix, the number of operating sessions in the job plan and whether the Urologist has an obligation to train a specialist registrar. For example, some specialists in oncology, who perform lengthy complex procedures, would be expected to have fewer FCEs than their generalist counterparts. (British Association of Urological Surgeons)

These numbers will be adjusted appropriately to take into account of complexity of cancer; stone and reconstruction work. Sub specialists are likely to deliver between 800-1000 FCEs and daycases per annum. Currently BHSCT Urologists delivered 1064-1466 FCEs (elective and non) and daycases in 2009/10. Consultants are currently supported by SpR's, who will

reduce substantially going forward, therefore reducing the FCE's and daycases per annum, unless appropriate specialty doctors are appointed.

Other proposed key service improvements:

- One stop Haematuria clinics have been piloted successfully to date at BCH. Team East will allocate appropriate funding to developing and rolling out this service as demand requires.
- Direct access to TRUS biopsy currently being considered by some consultants within the Team. Further consultation with NICAN and GPs will be required to take this forward.
- Telephone follow up established with one consultant in Team East, this will be developed further as required.
- Whilst Team East is addressing the backlog review new to review ratios will not be in line with peers.

All KPI's are subject to regional agreement by end November, therefore those set out may be further amended.

5.6 Regional Patient Pathways

A key deliverable through the Regional Review is the development and roll out of specific patient pathways. Team East clinicians are currently working with Team South and Team North West to ratify regional patient pathways for a number of specific urological conditions, these are:

- Testicular torsion/infections
- Renal colic/Acute kidney obstruction
- Infection – recurrent UTIs/pyelonephritis
- Urinary retention/haematuria

These pathways will be submitted at the end of November 2010, subject to regional agreement where feasible. Implementation would be anticipated within 6 months subject to a period of engagement with GP's and other linked specialities, eg. general surgery.

5.7 Radical Pelvic Surgery

One of the key recommendations within the report was the requirement for all radical pelvic surgery to be undertaken at BCH by March 2010. The estimated impact of this on BCH is thought to be 25-30 cases per annum. This has reduced from 2006/07. This complex surgery requires one full theatre list to complete.

To date the BHSCT have accepted a number of radical pelvic referrals from the SHSCT, and from September 2010 the SHSCT have been participating in the regional MDT. This recommendation will be fully ratified once the recurrent funding from the Review is released.

6.0 Next Steps

- Team East need to gain consensus regarding regional pathways and KPI's ;
- Team East need to agree model of on-call that best fits the service;
- Individually the Trusts need to prepare their capital requirements and make bids accordingly;
- Further engagement needs to take place with the NHSCT to agree the level of input for AAH;
- Team East need to discuss with commissioners and PMSID how to meet the identified gap that will still exist post investment into 2011/12;
- Team East needs to agree internally a process to review existing resources such as theatre sessions, and plan as to how best to utilise these going forward;
- Team East will work with commissioners and PMSID to agree how issues like SBA volumes; performance management accountability and maximum waiting times are managed under the 'Team' arrangement.

APPENDIX 1: Sample CNS Job Plan

Team East CNS –Proposed Sample Job Plan

	Day 1	***Day 2***	***Day 3***	***Day 4***	***Day 5***
AM	Haematuria clinic with Consultant Urologist / Speciality doctor	LUTs clinic	Outpatients Backlog Review – with Consultant	Telephone follow up etc. Results Clinic with Consultant	DPU Flexible Cystoscopies alongside Consultant Ward patients Referrals
PM	Flow rate clinic Clerical work etc.	LUTS clinic Telephone follow up etc.	Results Clinic with Consultant	Results Clinic with Consultant	Administration time

APPENDIX 2: Sample Team East Consultant Job Plan

Sample Consultant Job Plan for Team East

Operating Theatre	3 NHD
Diagnostic	0.5 NHD
Outpatient Clinics	2 NHD
On Call	1 NHD
Ward Round	1 NHD
1 MDT	1NHD
SPA	1.5 NHD
Patient Administration	1 NHD

This job plan is a sample and may be subject to individual flexible arrangements, eg, 1SPA for educational training. The notionally allocated PA's for outpatients is dependent on adequate specialty doctor support to run further outpatients independently.

On-call rota 1:12

Southern Health and Social Care Trust

Quality Care - for you, with you

Regional Review of Urology Services

Team South Implementation Plan

V0.3 revised 09 Nov 10

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1. Background

A regional review of (Adult) Urology Services was undertaken in response to service concerns regarding the ability to manage growing demand, meet cancer and elective waiting times, maintain quality standards and provide high quality elective and emergency services. It was completed in March 2009. The purpose of the regional review was to:

'Develop a modern, fit for purpose in 21century, reformed service model for Adult Urology Services which takes account of relevant guidelines (NICE, Good Practice, Royal College, BAUS, BAUN). The future model should ensure quality services are provided in the right place, at the right time by the most appropriate clinician through the entire pathway from primary care to intermediate to secondary and tertiary care.'

One of the outputs of the review was a modernisation and investment plan which included 26 recommendations to be implemented across the region. Three urology centres are recommended for the region. Team South will be based at the Southern Trust and will treat patients from the southern area and also the lower third of the western area (Fermanagh). The total catchment population will be approximately 410,000. An increase of two consultant urologists, giving a total of five, and two specialist nurses is recommended.

The Minister has endorsed the recommendations and Trusts have been asked to develop implementation plans to take forward the recommended team model.

The Trust submitted an Implementation Plan for Team South in June 2010 (draft v0.2). Further work was undertaken on the patient pathways and these were revised and submitted under separate cover. They have not been replicated in this document.

2. Current Service Model

The current service model is an integrated consultant led and ICATS model. The service's base is Craigavon Area Hospital where the inpatient beds (19) and main theatre sessions are located. There are general surgery inpatient beds at Daisy Hill Hospital (and at the Erne Hospital).

The ICATS services are delivered from a purpose built unit, the Thorndale Unit, and a lithotripsy service is also provided from the Stone Treatment Centre on the Craigavon Area Hospital site.

Outpatient clinics are currently held at Craigavon Area Hospital, South Tyrone Hospital, Banbridge Polyclinic and Armagh Community Hospital.

Day surgery is carried out at Craigavon and South Tyrone Hospitals. A Consultant Surgeon at Daisy Hill Hospital who maintains close links with the urology team also undertakes urology outpatient and day case work. It is important that capacity to deal with the demand from the Newry and Mourne area is built into the new service model as it will need to be absorbed by the Urology Consultants following Mr Brown's retirement.

The Urology Team

The integrated urology team comprises:

- 3 Consultant Urologists,
- 2 Registrars (1 of the Registrar posts will revert to a SHO Doctor from August 2011),
- 2 Trust Grade Doctors (1 post is currently vacant)
- 1 GP with Special Interest (7 sessions per week)
- 1 Lecturer Practitioner in Urological Nursing (2 sessions per week)
- 2 Urology Specialist Nurses (Band 7)

The ICATS Service

Referrals to urology are triaged by the Consultant Urologists and are booked directly to either an ICATS or consultant led clinic by the outpatient booking centre. Red Flag referrals are managed within the Cancer Services Team. Consultant to consultant referrals go through the central referral and booking office and are booked within the same timescales as GP referrals.

The following services are provided within ICATS:

- Male Lower Urinary Tract Services (LUTS)
- Prostate Assessment and Diagnostics

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

Current Sessions

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

Table 1: Current Urology Sessions

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

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

Main Theatres (CAH)	Weekly	
	6	3 all day lists

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

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

Current Activity

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

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

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

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

Table 3: Activity by Consultant for 2009/10

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

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

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

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

Pre-operative Assessment

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

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

Suspected Urological Cancers

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

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

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

3. Benchmarking of Current Service

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

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

Table 4: Regional Benchmarking

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

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

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

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

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

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

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

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

4. Demand for Team South Urology Service

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

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

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

Table 6: Projected Outpatient Activity for Team South

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

Notes:

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

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

3) Actual attendances at ICATS clinics.

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

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

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

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

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

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

Table 7: Projected Activity for Team South

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

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

5. Proposed Service Model

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

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

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

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

The projected demand from Tables 6 and 7 was used to calculate the number of sessions which will be required to provide the service. These are summarised in Table 8 below with the detail of the calculations provided as Appendix 1. **Note –** as previously stated, demand from Newry and Mourne has not been included in the calculations.

Table 8: Weekly Sessions for New Service Model

	Weekly Sessions	Weeks	Personnel
Consultant Led OPs			
General	5.5	42	
Stone Treatment	1.5	42	
ICATS			
Prostate Assessment	1.5	48	Registrar & Specialist Nurse
Prostate Biopsy [1]	2	48	Consultant Urologist/ Radiologist & Specialist Nurse
Prostate Histology [2]	1	48	Specialist Nurse & Consultant/Registrar
LUTS	3	48	Specialist Nurse & Registrar
Haematuria	1.5	**42**	Specialist Nurse & Registrar
Andrology/General Urology/Stable Prostate Cancer	5	42	GPwSI & Nurse Lecturer
Urodynamics	1.5	48	Specialist Nurse
	15.5		
Main Theatres	9	42	
Day Surgery			
GA	4	42	
Flexible Cystoscopy	3	42	
Lithotripsy	2	42	

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

Table 9: Proposed Consultant Led Sessions

	Weekly Sessions
Outpatients (including Stone Treatment)	
Craigavon	4.5
South Tyrone	1
Armagh	0.5
Banbridge Polyclinic	0.5
Erne	0.5
Total OPD	**7**
Prostate Biopsy	**2**
Day Surgery	
CAH	1
STH	2.5
Erne	0.5
Lithotripsy	2
Total Day Surgery	**6**
Main Theatre	**9**

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

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

		Core Activity
2009/10	Consultant Led New OP	850
	Consultant Led Review OP	2151
	Total Activity	3001

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

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

Consultant	Location	Day	Frequency	Sessions/ Annum	Travel Time	New	Review	New/ Annum	Review/ Annum
Mr Young		Mon am	Monthly	10	45	6	6	60	60
	ACH	Mon am	Monthly	10	50	6	6	60	60
	CAH (STC)	Mon am	Weekly	42	0	5	11	210	462
	CAH	Fri pm	1,2,4 & 5	32	0	5	7	160	224
	BBP								
Mr O'Brien	BBP	Mon am	Monthly	10	45	5	7	50	70
	ACH	Mon am	Monthly	10	50	5	7	50	70
	CAH	Tues pm	Weekly	42	0	5	7	210	294
Mr Akhtar	CAH	Mon pm	Weekly	42	0	4	7	168	294
	STH	Tues pm	Monthly	10	60	6	3	60	30
Total Annual Slots								**1028**	**1564**

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

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

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

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

* Please note that templates are draft at present. An additional 0.5 weekly Stone Treatment OP session will be required which still has to be worked in to the job plans.

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

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

* Please note that templates are draft at present. An additional 0.5 weekly Stone Treatment OP session will be required which still has to be worked in to the job plans.

6. Timetable for Implementation

Task	Timescale
Submission of Team South Implementation Plan	23 June 10
Re-submission of Team South Implementation Plan	09 Nov 10
Approval to Proceed with Implementation from HSCB	17 Nov 10
Completion of Job Plans/Descriptions for Consultant Posts	Nov 10
Completion of Job Plans/Descriptions for Specialist Nurses	Nov 10
Consultant Job Plans to Specialty Advisor	Dec 10
Advertisement of Consultant Posts	January 11
Advertisement of Specialist Nurse Posts	January 11
New Consultants and Specialist Nurses in post	July 11

APPENDIX 1

Calculation of Sessions Required for Team South

Calculation of Sessions Required for Team South

Prostate Pathway (Revised)

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

1st appointment – the patient will be assessed by the specialist nurse (patient will have ultrasound, flow rate, U&E, PSA etc). A registrar needs to be available for at least part of the session eg to do DRE, take patient off warfarin etc. 5-6 patients can be seen at an assessment clinic (limited to a maximum of 6 by ultrasound). In the afternoon appropriate patients from the morning assessment would have a biopsy. 4-6 patients can be biopsied in a session (though additional biopsy probes will need to be purchased). Not all patients will need a biopsy and the session will be filled with those patients from previous weeks who did not have a biopsy on the same day as their assessment (because they needed to come off medication, wanted time to consider biopsy etc). Based on 2009/10 figures it is estimated that 434 patients will require biopsy.

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

378 patients had prostate biopsy in 2009/10 (Note some patients will come directly for biopsy from the ward or OPD). Uplifting this for Fermanagh region gives a requirement for 434 slots @ 5 per session = 87 sessions per annum. 2 biopsy sessions per week (over 48 weeks).

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

2nd appointment will be to discuss the test results – patients with positive pathology and those patients with benign pathology who are not suitable to receive results by telephone. 180 patients had positive pathology. Uplifting this for Fermanagh region gives a requirement for 215 patients needing a second appointment. These patients will be seen by a consultant or registrar.

3rd appointment will be discussion of treatment with the estimated 215 patients per annum, following MDT. The consultants would prefer to see their own patients and feel that the appropriate model is for each to have a weekly 'Thorndale session' to do:

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

LUTS

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

419 new patients @ 4 per session = 105 sessions

336 reviews @ 8 per session = 42 sessions

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

Registrar input is required.

Haematuria (Revised)

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

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

241 new patients @ 5 per session = 48.2 sessions = **1.5 per week** (over 42 weeks)

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

Andrology/General Urology ICATS

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

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

Urodynamics

These will be located alongside consultant clinics.

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

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

Consultant Clinics

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

Stone Treatment

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

Day Cases

Flexible Cystoscopy

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

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

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

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

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

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

Lithotripsy

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

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

Other Day Cases

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

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

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

Of the 2735 day cases:

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

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

727 @ 5 per list = 146 lists = 3.5 lists (over 42 weeks). To maximise the potential to treat patients on a day case basis, 4 weekly lists are planned .

Inpatients

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

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