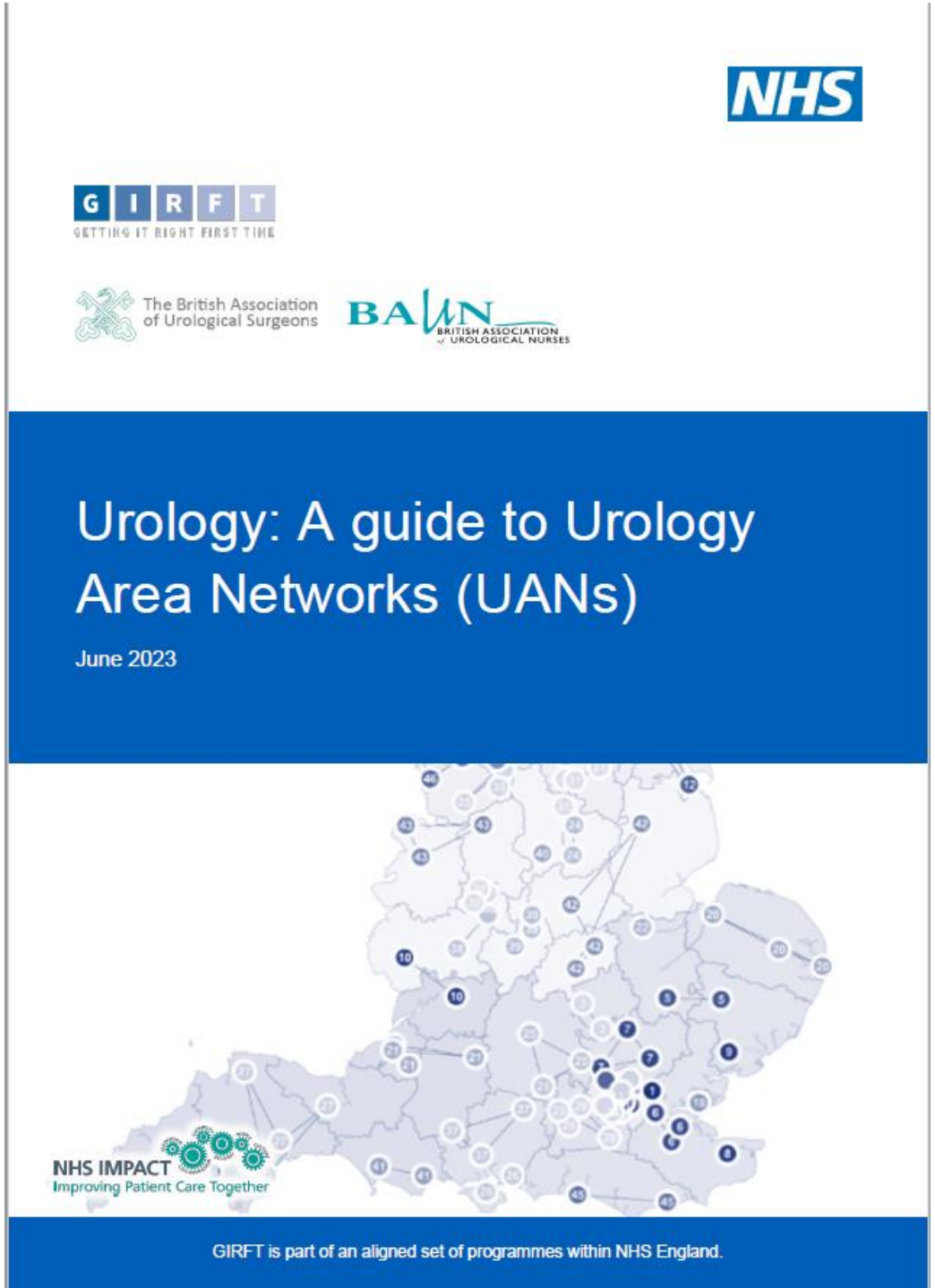

Mid-Yorkshire and Barnsley General Hospitals Joint Urology Department

– *the accidental development of a Urology Area Network*

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WHY a Urology Area Network?

>10% consultant vacancies

15% consultant posts filled with locums

Fragile services

Recruitment & retention issues

Need for change, working together

1 Case for change

1.1 Introduction – fragile services

Many UANs have been established in response to concerns about increasingly fragile services and an understanding that, as urological surgery has evolved, it is not possible for all types of surgery to be delivered in all trusts. In some cases, the development of a network has occurred as a response to the collapse of an adjacent service, most commonly due to consultants moving trusts or retiring.

While there is no set definition of what constitutes a 'fragile' or 'vulnerable' service, a reasonable definition would be 'a service that is unlikely to be able to sustain high quality care during the upcoming 12-month period and beyond.' Often these fragile services will share one or more of the concerns below:

Red flag concerns	Other concerns
Workforce	
• Single-handed consultant core service or where sub-specialisms are single consultant and not networked • Small service, 3 substantive consultants or fewer, with: ▪ High turnover of consultant staff ▪ Reliance on locum appointments ▪ Persistent clinical vacancies ▪ % vacancy exceeding ability to cover gaps safely ▪ Workforce demographic >55 years old ▪ Increase in staff turnover ▪ High sickness absence ▪ Over-reliance on specialist nursing team	• Poor skills mix, impacting levels of expertise required to deliver the service
Standards and outcomes	
	• Ability to consistently meet national clinical standards • Lowest decile for GIRFT sentinel metrics • SIRIs, harm reviews, staff concerns about clinical safety • Higher number of patient complaints
Capacity and demand	
• Service closure, e.g: ▪ Closed to new referrals ▪ Closed at night ▪ Persistent service closures / diverts ▪ Unplanned cancellations (clinics, theatre, ward rounds) • Elements of the service delivered by underperforming / failing SLA • Requirement for out-sourcing of work	• Persistent outlier performance for cancer, RTT • Rapid increase in PTL • Low volume procedures / patients such that staff are not able to maintain skills over time

Service fragility arises usually through a deficit, absolute or relative, in the specialist clinical workforce. This may be because of:

- **Capacity and demand** - The workforce is unable to deliver against current or predicted future demand. Many services have become destabilised as recovery from the Covid pandemic continues with large numbers of patients waiting for assessment and /or surgery.
- **Clinical standards** - Nationally mandated standards require increasing workforce numbers particularly of specialist senior decision makers.
- **Recruitment and retention** - Despite a fully funded workforce commensurate with demand, it is not possible to recruit and retain to those posts. The main barriers to new consultant recruitment nationally are frequent on-call (with often poor middle grade support) and limited opportunities for sub-specialty practice offered in larger units.

BGH Urology

2014

Loss of BGH consultants

PGH assistance

2x dual appointments

Integrated weekend on call

2020

Loss of BGH consultants

Agreement for joint working

WHAT BENEFITS of a UAN?

Benefits to patients (as well as staff)

Critical mass for certain services to be available (both new and existing)

Numbers to set up one stop clinics

Prevent closure of a “fragile” local unit

1.2 Benefits to patients of Urology Area Networks

The range of investigations and procedures offered by urology departments has increased, thanks to advances in technology and practice. However, this has meant that it is increasingly difficult for a trust to offer comprehensive urology services in isolation. By operating as a network, urology departments can improve patients' access to both core and sub-specialist services, aiming to ensure that there is equity of access to services across the geographical area served by the trust comprising the UAN.

Increasing the population served and treatments provided can help services reach a 'critical mass' which is beneficial to skill development in staff and, if properly resourced, efficiency of service delivery. This means patients will receive better quality services and more timely access to investigations and treatment and reduce inequalities based on demographics and locality.

This critical mass can enable the adoption of make new types of technology and services viable in a network where they might not be practically or economically sustainable for an individual urology department. Making these new technologies or services available within the network should avoid patients being sent unnecessarily long distances. As an example, this might include the adoption of one-stop clinics, enabling flexible cystoscopy and imaging to be performed, reducing the inconvenience, travel time and expense for patients.

Most importantly, Urology Area Networks can support fragile services and avert potential closure of a service which is struggling to recruit. Non-sustainable services often build up longer than average waiting lists, and in the event of a service being closed, a large number of patients will need to be transferred to another provider.

The Strategy

3-5 year plan for full integration of Barnsley and Mid Yorks Urology

Dependent on substantive consultant appointments to manage on-call

Requirement for a BGH Urology Investigation Unit

Develop middle tier/Allied healthcare professionals to free up consultant capacity

Increase general urology activity and embed specialist services at BGH

Equity of urology provision across the region for patients

Equity in care provision

Daycase surgery

There are excellent examples of innovations in day case working at MYHT though the team recognise that there is scope for even greater improvement with day-case rates across the 'sentinel' procedures referred to in the GIRFT data pack (TURBT, ureteroscopy and bladder outlet surgery). In contrast, daycase rates at the Barnsley site are much lower across all the sentinel procedures - this is well-recognised by the team and is part of their active planning to address this gap. In MYHT, the urology lists tend to benefit from a consistent team of

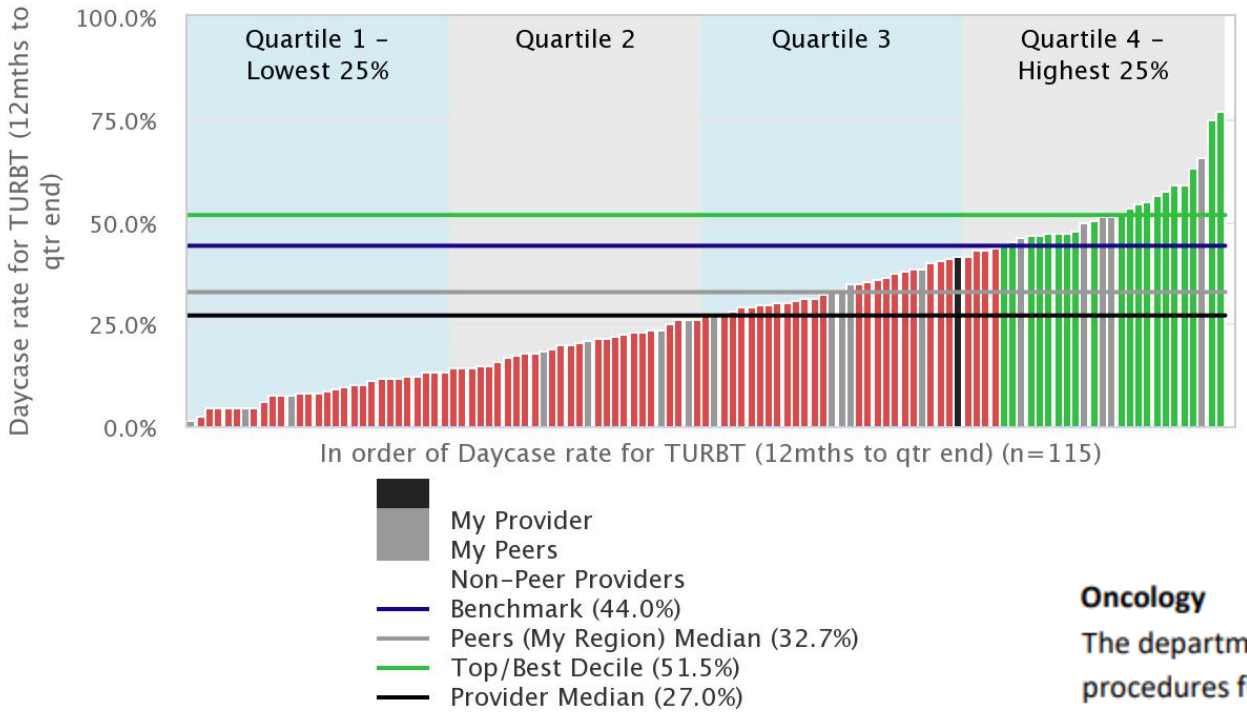
With regard to bladder outlet obstruction (BOO) surgery, the department at MYHT has one of the highest daycase rates in England and this is largely on the back of a long-standing green-light laser daycase service. Urolift is also available at Pinderfields Hospital and there are plans to introduce Rezum (Pinderfields) and HoLEP (BGH). Consideration needs to be given as to how daycase pathways will be evolved at Barnsley. The service currently only

Urology Investigation Units: specialist nurses, one stop clinics and the provision of cancer care

“The fact that there are four dedicated urology investigations units across the service is a flagship achievement for the department.”

Future plans

Daycase rate for TURBT (12mths to qtr end), National Distribution



Oncology

The department is a designated cancer centre and provides all the major operative procedures for pelvic and upper tract cancers. At present, patients from Barnsley are largely referred to Sheffield but it is certainly worth considering whether these pathways should become more aligned to the unit at MYHT. The department has a comprehensive 5-year

Behind the scenes management

In terms of workload, the unit is one of the busiest departments in England given its recent merger with the Barnsley service. Based on aggregate totals from the 2019 PLR GIRFT reports, the combined outpatient workload was 15,000 new out-patient encounters, alongside 27,000 follow-up patients. This would place the service in the top 10 and top 15 units in England respectively (of 126 units) for out-patient volumes. The ratio of new to follow-up cases suggest that the team are minimising inappropriate follow-ups. For emergency workload, the combined annual number of admissions was in the region of 4,250 and this represents the 3rd or 4th busiest unit in England based on volume of coded emergency activity.