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The British Association of Urological Surgeons

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BRITISH ASSOCIATION of UROLOGICAL NURSES

Urology: A guide to Urology Area Networks (UANs)

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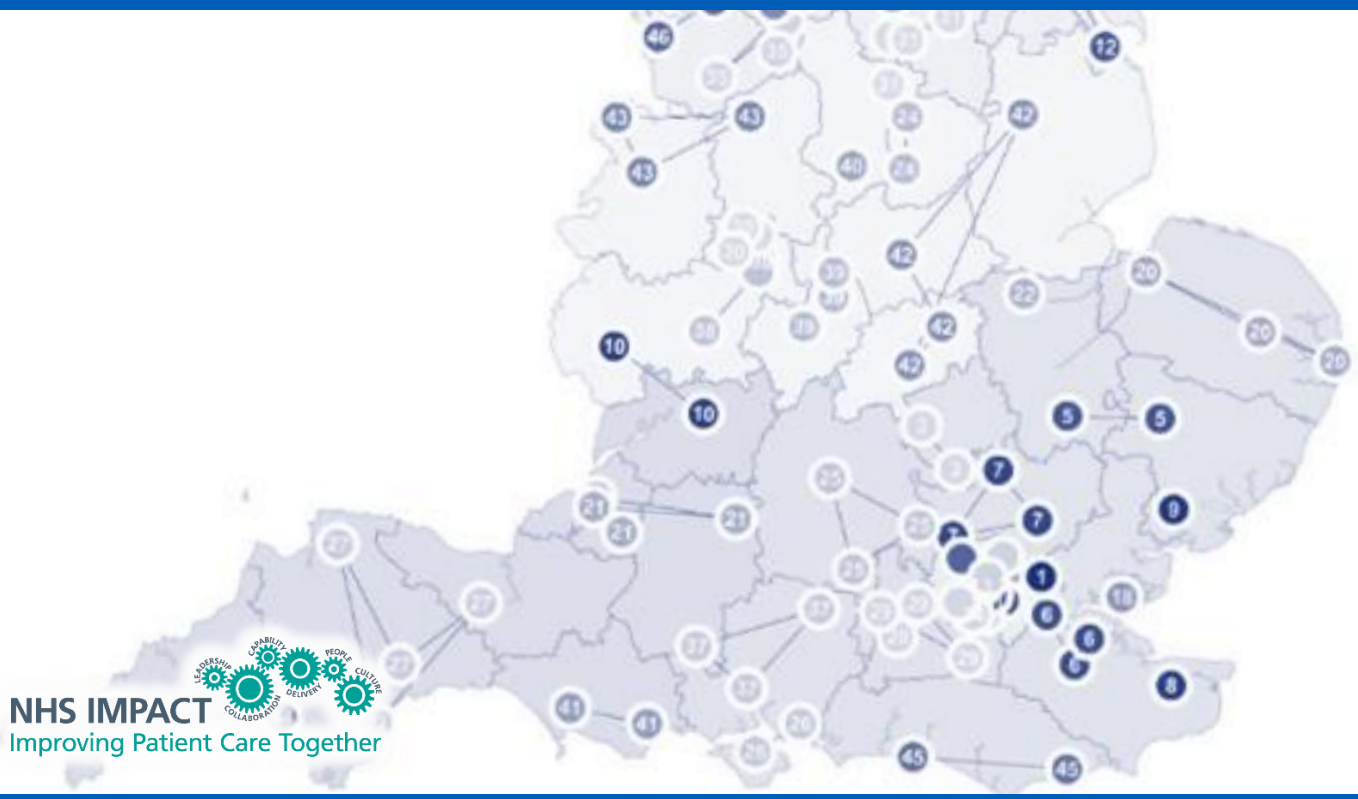

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Executive summary

Who should read this guide?

This document is aimed at clinicians who provide urological care, and managers who are responsible for providing or commissioning urological services.

What is the guide's aim?

The guide describes the key features of a functioning Urology Area Network (UAN) so that readers can evaluate their own local network against this description of "what good looks like". In particular, it describes the types of relationships, governance and financial arrangements that need to be put in place for a successful UAN to function effectively and the potential benefits and adverse effects of operating as a network. In addition, case studies and business planning materials are included to facilitate the implementation and improvement of a UAN.

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Foreword

Urology, as a specialty, has a tradition of rapid adaption to change. The GIRFT national review of urology services led to the conclusion that organising urological care on a trust by trust basis was unsatisfactory, as only a few trusts could offer comprehensive urology services in isolation. The 2018 GIRFT National Specialty Report for Urology recommended that Urology Area Networks (UANs) should be established in order 'to provide comprehensive coverage of urological services, beyond existing network arrangements, to optimise quality and efficiency'.

UANs can improve service quality through consolidation of emergency care, improving access to sub-specialist services and creating services which can reach a 'critical mass' of population. UANs build the resilience of urology services and optimise the use of clinical skills and time, as well as efficient usage of facilities and equipment.

Since the publication of the GIRFT urology report, many urology departments have explored and discussed forming UANs and some have already established networks. The GIRFT programme, through the strategic framework published for urology as well as direct engagement with the senior leadership at trusts has aimed to support the formation of UANs. From our conversations with colleagues who are exploring networks, it has been clear that there is an appetite for more detailed guidance on networks and interest in learning from the experiences of established and nascent networks elsewhere.

We hope that by providing advice from the experiences of existing UANs, this guide will help urology departments who are planning to establish a network or seeking to improve their existing network. Building stronger networks will provide a lasting legacy of increased capacity and resilience of our urology services and protect our ability to provide quality care to patients.

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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.

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.

2 The requirements of an effective network

2.1 On-call network, providing urgent and emergency care

Key quality actions:

- Engage with colleagues in emergency care, imaging and radiology and critical care at an early stage about network proposals
- Check if the proposed network aligns with Critical Care Operational Delivery Network boundaries and geographic ambulance guidelines
- Ensure the urology on-call team benefit from the network proposals

The on-call rota has a significant impact on the quality of working life of consultant urologists and is frequently cited as one of the most significant stress factors in consultant practice. Reducing the frequency of on-call (particularly for peripheral units) has the potential to be a key selling point for the proposed UAN.

The UK has a high vacancy rate for urology consultant posts (currently >10%) and services with high-frequency on-call rotas find it harder to attract, recruit and retain consultants. Approximately 15% of all consultant Urology posts are filled by locums. The reliance on locum cover can affect the efficiency of the service due to gaps in employment or restricted working practices, such as not providing on-all cover. These services risk becoming unviable, as they will struggle to recruit or maintain the team size necessary to deliver on call services and develop sub-specialisms. It is not uncommon that substantive post-holders are peri-retirement and or planning early retirement.

This section sets out several key considerations to ensure that networked on-call is a selling point for a proposed network and delivers benefits across the network in practice.

2.1.1 Sharing the benefits and the burdens

The impact of rota changes will differ between network sites and the team providing the service. While all sites and grades will benefit overall, it is important to be transparent about how the gains and costs will differ.

By unit size

	Larger unit	Smaller unit
Pros	• Decreased frequency of on-call • Adoption of 'consultant of the week' model when on-call • Increased opportunities for developing sub-specialisms • Increased opportunity to establish full middle grade cover	• Significantly decreased frequency of on-call • Increased possibility of being freed up from elective work when on-call • Opportunities to develop sub-specialist practice • Middle-grade staff available
Cons	• Increased volume of activity for on-call • Travelling to surgical emergencies in less familiar units	• Significantly increased volume of activity for on-call • Larger population covered will mean caring for more complex patients

By grade

	Consultant	Middle grade
Pros	• Decreased frequency of on call • Increased possibility of being freed up from elective work when on-call • Likely to be shielded from more work by middle grade doctors	• Improved training opportunities and opportunity to develop sub-special interest • Greater availability of consultant input and support
Cons	• Increased activity volume for on-call shifts Mitigation: increased possibility of being freed up from elective work when on-call	• Increased volume of activity Mitigation: audit emergency takes, increase middle grade rotas and workforce

2.1.2 Emergency department and ambulances

Emergency department teams should be engaged with the proposals for the UAN from an early stage. These discussions should consider:

- ED investigating in-house and making transfer / discharge arrangements
- The compatibility of network proposals with geographic ambulance guidelines
- Access to CT scans for suspected stones in ED, and the ability to house the patient for this period of time in an area such as a CDU (Clinical Decision Unit) to ensure that patients are only be transferred when they have definite requirements for in-patient care
- Direct access to the on-call consultant from the spoke unit within hours (e.g. 08:00 – 19:00) in order to avoid admissions / unnecessary transfers. This is particularly important if the spoke hospital site does not have its own urology team
- Making use of existing ED pathways for renal colic, urinary retention, ascending UTIs and testicular torsion.

Click here to access example ED pathways >

2.1.3 Urology on-call team

While networking may increase the intensity of on-call for consultants, this is compensated for by the reduction in frequency of on-call. It is important to remember that for the middle grade tier, they experience the increased activity volume without the corresponding change to their working pattern.

It is therefore worth auditing the extent of emergency activity particularly if concerns are raised by junior teams. The volume of activity and length of stay can be audited, both before and after the introduction of the network. Options for mitigating this risk include:

- adding doctors to the middle-grade rota, such as through medical training initiatives
- conversion of vacant consultant positions to middle grade. (For example, a 0.6WTE vacant consultant post could be converted to 1WTE registrar)
- introducing other forms of middle grade support such as Advanced Nurse Practitioners

It is helpful to consider other ways in which the proposed network may benefit junior teams, for example, the introduction of a 'Registrar of the Week' alongside 'Consultant of the Week'.

2.1.4 Imaging and radiology

Imaging and radiology teams, including those responsible for the provision of interventional radiology, should be engaged with the proposals for the UAN from an early stage. These discussions should consider:

- The change to volumes of activity in the different sites of the network
- The sustainability of the imaging and radiology team's rotas and whether the formation of a network can assist them in recruiting to their own rotas.
- There should be a formal Service Level Agreement (SLA) in place that sets out clear arrangements for emergency provision of interventional radiology.

2.1.5 Critical care

Engage with colleagues in Critical Care at an early stage to identify if the proposed network crosses Critical Care Operational Delivery Network boundaries. This will impact on the ability to transfer patients between network sites and may require agreements and procedures to be agreed for such situations, for example, some patients may need to be transferred to another network if they need intensive care with input from an on-site urologist.

2.1.6 Repatriation of emergency transfers

It is important to consider plans for repatriation of emergency transfers before planning the operating procedure for the network.

Many patients will be elderly and have social care needs which contribute to longer length of stay. Such patients can be stranded in the central hub as care packages are more easily established by the spoke hospital teams with connections closer to the patient's home. Buy-in from care of the elderly teams to support this will be beneficial and contractual arrangements should be strongly considered in the SOP.

2.1.7 Complex urosepsis

The arrangements for the management of urosepsis vary by trust with some patients presenting with pyelonephritis being looked after by the medical team and in other hospitals by the Urologists. Patients with complex urosepsis secondary to ureteric obstruction are generally looked after by the Urology team, with patients requiring urgent decompression by either retrograde stent placement or nephrostomy insertion. Nephrostomy insertion will generally require a trained uro-radiologist. Many trusts do not have 24/7 uro-radiology cover.

The option for timely retrograde stent placement and nephrostomy insertion should be available within the UAN, with a functioning SOP in place to allow the rapid transfer of the uroseptic patient, when required. Patients referred for nephrostomy insertion should be returned to their referring hospital, once they have been stabilised.

2.1.8 Testicular torsion

Testicular torsion occurs when a testicle twists on its axis, cutting off the blood supply. It affects approximately one in 4,000 boys and young men each year, causing severe pain and if not treated rapidly, resulting in the loss of the affected testicle. Salvage rates for torsion vary widely across England, with orchidectomy rates varying between 0 and 50%. Testicular torsion represents a challenge for hospitals and systems in terms of capability and delays in surgery as a result of transfers. Delayed or missed diagnosis of testicular torsion is also a cause of litigation. It is therefore important that there is a clear SOP in place across the UAN for the emergency management of this condition.

The management of suspected testicular torsion is time critical. The GIRFT national report on paediatric general surgery and urology recommends that all acute trusts admitting children should be able to offer emergency scrotal exploration in boys over the age of two. This age may be lower in trusts with an enhanced paediatric anaesthetic capability. Scrotal exploration is a straightforward surgical procedure and does not require advanced training. The Royal College of Surgeons (RCS), British Association of Urological Surgeons (BAUS), and medical indemnity providers support adult surgeons engaged in occasional paediatric practice to perform acute scrotal exploration and do not support surgeons who refuse to perform scrotal exploration. Both the general surgical and urology curricula mandate proficiency in this procedure for award of the Certificate of Completion of Training (CCT). Despite these points, many surgeons feel this procedure lies so far outside their normal surgical practice that they are not willing or capable of performing it. There is also a view held by some general surgeons that this procedure is a urological rather than general surgical procedure, and that the urologists should perform it. At a minimum, each UAN needs to have a clear trust policy (supported by the senior medical management) in place for the management of patients presenting with suspected torsion.

2.2 Finance and contractual arrangements

Key quality actions:

- Engage financial teams in all trusts in the network from an early stage in order to understand the intended approach and allow more time for arrangements to be agreed
- Understand that differing payment mechanisms should not be a barrier to forming a UAN (PBR, block contracts or blended payment)
- Ensure SLA is reviewed on a regular basis (around every 2 years)

In general, UANs have developed on a clinical basis ahead of financial or contractual arrangements being made. However, it is recommended that he trusts' finance teams are involved at the earliest possible stage to understand the approach to be taken and to allow time for any necessary contractual arrangements to be agreed. The financial and contractual arrangements will reflect wider practice in the Trusts and are not specific to UANs. UANs have been formed from both Trusts and Foundation Trusts. Financial and contractual arrangements can be challenging to work through but should not present a major barrier to the development of UANs.

The approach taken in most networks is to use invoicing between trusts on an as-necessary basis. These arrangements are typical for local collaboration between trusts and are governed by the normal national guidelines for trust finances, they are not novel or unique to UANs.

There are some networks where a different approach has been taken. This is the result of a wider strategic change, such as the network being part of an acute provider collaboration, rather than a circumstance specific to urology. The relevant finance teams will be able to navigate whatever arrangements are in place to support the network.

This section describes some of the financial setups or contractual arrangements seen in existing Networks. All these approaches are compatible with establishing and developing an effective UAN, but may have some specific advantages or disadvantages to consider.

Trusts maintain separate finances, with invoicing between Trusts for network activity

This is the default situation for UANs, as unless another arrangement is proactively agreed, the Trusts will negotiate between themselves on payment for services they provide to another Trust. For example, where consultants employed by Trust A regularly provide a clinic or procedure at Trust B, the trusts will have a Service Level Agreement (SLA) and Trust A will invoice Trust B for the costs incurred by that service. It is advisable to have Standard Operating Procedures for repatriation of patents once medically fit to be closer to home, to avoid issues of bed availability and redress any financial impact on Trusts. Each Trust keeps its own capital allocation and would develop its own business case for capital expenditure required to support the network. In rare circumstances a joint business case may be developed.

The major advantage of this approach is that it requires only ad-hoc agreement on services, rather than attempting to reach an all-encompassing agreement. It is adaptable as the Network evolves or as circumstances change, for example changes from payment by activity to block contracts or blended payments.

Disadvantages to an ad-hoc approach are that each time there is a change in services in the network, some of the contracts and agreements will need to be renegotiated. The finance teams in different trusts must work together to ensure that any financial risks are shared fairly between trusts in the network.

Single income stream, passed through to Network trusts

This approach is more likely to be used in situations where the trusts in the network are already integrated in their governance or finances, for example through an Acute Care Collaboration. In this situation it may make sense for the financial and contractual arrangements to reflect the governance of the network. For example, where one trust takes on the role of being sole employer for the urology workforce in the network and delivers services across the network. This trust can receive all the income for the network, cover the costs of the network and then pass on a portion of the remaining income to other trusts in the network.

This approach may make sense in areas where trusts are working increasingly closely together more widely than urology. It can also ensure that the trust bearing most of the risk and cost of the network, for example wage costs, also has security of income rather than relying on a series of changeable agreements with other trusts. In theory, this approach should make it easier to pursue strategic ambitions for the network, for example having one business case to introduce a new service rather than having to develop business cases for each trust and accompanying service agreements between the trusts.

This model is unlikely to be suitable for networks where trusts are maintaining high levels of independence or where the UAN isn't part of an overarching strategy. Risks include vulnerability to changes in payment approaches at the local or national level, for example a shift from payment by activity to block payments or blended payments.

Future service design and delivery under Integrated Care Boards and Acute Provider Collaboratives

After several years of local development and the passage of the Health and Social Care Act (2022), 42 Integrated Care Systems (ICSs) have now been established across England. These include Integrated Care Boards (ICBs) which are responsible for planning and arranging for the provision of health services in the ICS area, replacing the functions of Clinical Commissioning Groups.

Guidance published on Integrated Care Boards has highlighted the role of provider collaboratives in planning, delivering and transforming services. This includes new powers in the 2022 Act for providers to work together, and with local authorities, NHS England and the ICBs, by jointly exercising functions or delegating functions. For example, provider collaboratives can jointly make decisions, pool funds and share risks through a Joint Committee and an ICB can now commission services from a provider collaborative rather than from individual providers. Existing coordination between trusts, through structures such as Committees in Common, may evolve into provider collaboratives.

The detail of future changes may need to be worked through from a urology perspective, but the overall direction is amenable to the development of Urology Area Networks.

2.3 Governance and management structure

Key quality actions:

- Secure support from the Executive teams at all involved trusts from the outset
- Establish an oversight group with representation of all staff groups and senior management
- Address the big questions on workforce, waiting lists and contracts at the outset of the planning stage
- Develop a comprehensive 'Operational manual' for the network, which lists the points of contact across Network sites and practical instructions for systems and processes

2.3.1 Initial governance

The establishment of a Urology Area Network will require support from the Executive Teams of the Trusts involved. It is helpful to have this at the earliest possible stage, for example before proposals have been developed for the UAN, the Executive Teams may have agreed an overarching strategy for urology services and agreed to task a group with developing the UAN proposals. The increase in system-level working and introduction of Integrated Care Boards may provide opportunities for UAN proposals to be progressed alongside other system level work.

An oversight group should be established for the development of the UAN proposals if a suitable oversight group does not already exist within the ICB. There should be onward reporting arrangements in place to the Medical Director, Chief Nurse, Chief Operating Officer and Chief Financial Officer from each trust. Work on the UAN proposals is likely to be led by a clinical lead, supported by a dedicated project manager and operational team. Significant input from the clinical and operational leadership for urology in each of the network sites will be needed to ensure the timely progression of the initiative. Ensuring adequate dedicated and funded operational time with clear timelines is essential to the project.

As the UAN is being established, team building opportunities should be considered for staff working across different Trusts and sites.

2.3.2 Key questions on governance to be addressed in the Network proposals

Alongside operational and clinical aspects of the UAN proposals, there are several key decisions that will determine the future governance arrangements for the network. These include:

- Workforce: whether the UAN will be based on a single workforce under a single employer. This will have an impact on clinical governance, in addition to staff wellbeing and other HR responsibilities
- Waiting lists: Moving to a single managed and reported patient waiting list
- Contracts: Some networks will have a single provider contracted by the local commissioner for all services, with sub-contracts between the Lead Provider and sites. Other networks may have alternative contractual arrangements.

2.3.3 Business as usual governance

Weekly management meetings

These meetings are attended by the Urology Clinical Leads and service managers, and focus on the Cancer Patient Tracking List (PTL) and Referral-to-Treatment waiting times (RTT.)

Joint Clinical Governance Meetings

The Clinical Governance meetings for urology are held jointly with the relevant representatives from all sites in the network. These meetings review patient safety and risks.

Oversight Group

This group plays a key role in developing the UAN proposals and having oversight of the transformation, but may continue to meet less frequently after the UAN is established. The executive leadership of each Trust in the network are members, including the Medical Directors, Chief Nurses or Directors of Nursing, Chief Operating Officers and Chief Financial Officers. With the establishment of ICBs, such a group may already exist and offer the appropriate forum for oversight of UAN plans. The relevant divisional leadership in the trust should also be engaged.

Performance Management Group

The Performance Management Group meets monthly and includes the Clinical, Operational and Nursing leads for urology from each trust or site in the network. The group's agenda covers both the UANs establishment and its operation – reviewing workforce, activity, finance and service performance from a quality perspective.

Upwards reporting

The Performance Management Group will feed into Contract Review Meetings and Commissioner / Provider contract meetings on the commissioning side, and through Divisional Boards or Clinical Oversight Groups on to Trust Boards and ICB / local system boards.

2.3.4 Documentation

A comprehensive operational manual or information document is crucial to the effective operation of the network. This document should be viewed as the central repository for urology information and should contain:

- Clear descriptions of all urology services in the network. It is particularly important that it is clear exactly which services are provided at each site of the network. Some networks will not provide elements of urological care (e.g andrology, neurourology and reconstruction) and the onward arrangements/ pathways for such patients should be available for clinicians and managers to access.
- Contact details for key individuals in each site of the network and ideally a directory for all staff who work in the network, listing their roles and areas of work
- Any arrangements or processes for managing referral streams and transferring patients
- Clinical governance relationships
- Flowcharts for each eventuality covered by the network, for example management of incidents, referral of patients between sites

This document should be structured to be searchable, with clearly headed, discrete sections, so that staff can easily and quickly consult the sections relevant to them when needed.

Example operational manual >

Summary of example operational manual contents >

2.4 Clinical Information

Key quality actions:

- Involve senior level IT colleagues from UAN sites at an early stage
- Identify, develop and test any workarounds needed to access Electronic Patient Records across network sites
- Develop an IT guide, including direct contact details for secretarial, admin and nursing on each site

Ideally, all trusts within a UAN would use the same IT systems for electronic patient records (EPRs) booking systems, imaging and forms. Implementation of a single Electronic Patient Record between all trusts in the network makes patient transfers between sites considerably more efficient, by ensuring easy access to medical records and imaging.

Where the same systems do exist, such as ICE, it should be possible to create a similar or identical Urology set up or 'home page' on the system at each trust, to aid staff working at different sites to request investigations. It is important to consider the full range of staff who will need to work with different sites.

In practice, different trusts in the UAN are likely to be using different systems, with variable degrees of inter-operability. Moving to a single or readily compatible EPRs may not be viable for all networks and workarounds may be needed. The UAN should work with these current systems with a view to future improvements or potential mergers.

These workarounds should be identified, developed and tested before the Network is launched, and any administrative burden created by these factored in to plans. IT should be involved at an executive level from an early stage of planning, in order to identify potential IT barriers and agree extra support for the initial period of UAN operation.

An IT guide should be developed for all staff working across sites, including:

- Explanations of the systems used on each site
- Instructions for any 'workarounds' for working across sites
- Defined processes for IPT transfers and image transfers
- Accurate and reliable counterpart contacts on each site for secretarial, admin and UIU nursing staff, for ease of transfer of care between sites

Potential solutions to cross-site IT barriers include:

- Considering use of individual or shared laptops
- Creating of a Virtual Private Network (VPN) between sites to enable access
- Avoid duplication of mandatory training requirements for staff working on multiple sites
- Ensuring timely access to IT for new staff, such as registrars on rotation

2.5 Achieving and maintaining buy-in from urologists, nurses and other health professionals across sites

Key quality actions:

- Ensure buy-in of senior clinicians and equity of job plans across the network
- Schedule and plan visits between teams based in different sites and provide opportunities for team-building from the outset of the network
- Review protocols and policies in different network sites to identify differences and agree shared policy
- Be prepared for less enthusiasm for cross site working in certain staff groups, such as lower or middle grade nurses and some long term staff

Many urology services have already worked across different sites but within the same trust, where investigations, outpatient and day case procedures are located on different sites of the trust to the main theatres or inpatient wards. Urology Area Networks open the possibilities of working across different trusts. The full extent of cross-site working will depend on several factors:

- The scale of the network
- The roles of different sites, for example if there is a 'hub' and 'spokes', or where services are located in the network
- The geographical spread of the network and ease of travel between sites
- If there is a single employer for workforce in multiple sites, or shared clinical governance

Almost all networks will already operate across sites and trusts for the management of complex cases or where input from a specialist MDT is needed. This ensures that patients can access the full range of treatment options.

Most networks will work across sites and trusts to provide education, training and research opportunities to staff, which could not be delivered by a single site.

Engaging with the HR Department is vital to achieving cross-site working, in particular where contractual arrangements are affected, such as by transfers (through 'TUPE' arrangements) or honorary contracts.

Some networks have increased the scope of cross-site working beyond this, including:

- Shared protocols and policies across all sites
- Honorary contracts for staff to work at other sites
- Introducing a single employer for the urology workforce, or parts of the urology workforce. For example, all urology nurses being employed by the 'hub' trust
- Staff working in more than one site, in particular to provide a particular service in another site
- Shared clinical governance for the network
- Merging waiting lists for some or all services, with patients offered the opportunity to have an appointment at the site where they will be seen most quickly

Barriers to cross-site working

Networks should be aware of potential barriers to cross-site working and take steps to mitigate against these. Practical barriers include issues with parking in different sites, travel expense systems and policies, access to changing rooms and lockers. Staff in some networks also had issues with accessing HR systems or mandatory training in different sites (see tips on IT on page 13.)

The distance between sites can be the most significant barrier to cross-site working. As this can be difficult to mitigate, networks will need to gauge staff willingness to travel and factor this into their ambitions. Potential mitigations include factoring travel time into job planning.

Experience from existing networks suggests that there is greater willingness to work cross-site among the most senior members of the team, including consultants and consultant nurses, as well as the most recently recruited members of the team. Middle-grade members of the team, such as longer term employed band 6 and 7 nurses, sometimes showed less enthusiasm for cross-site working.

Team building

It is important to schedule and plan time from the outset of a network for staff to visit different network sites and meet the teams across the network. This builds relationships between teams and provides opportunities for staff to raise and discuss issues and suggest improvements to the network.

Opportunities for these team meetings included shared training sessions and also holding meetings to agree the protocols and policies for the network.

Existing networks have reported that it was particularly helpful to invite the nursing teams from different sites to meet and review their existing protocols and policies, identify the differences and agree where a protocol could be standardised across the network. This was done in cases where the network was intending to share clinical governance and have some staff working across sites.

2.6 Job planning

Key quality actions:

- Avoid differentials between colleagues, promoting equality
- Limit the number of hospital sites attended by any individual consultant
- Ensure an individual staff member works at only one site per day
- Avoid travel in the UAN being 'one-way', for example not just from the spokes to the hub

There are approximately 1,000 consultant urologists working in the UK, a relatively low number for relative to the UK population when compared to other countries in Europe. Consultant urologists have a challenging role in delivering expert and timely patient care. Careful job planning is crucial to enabling consultants to fulfil their roles successfully and deliver high quality and safe patient care.

At its most basic, job planning includes:

- Routine outpatients
- Diagnosis and management of complex cases
- Operating
- Contributing to the efficient running of the urology unit
- Reflecting on and reviewing patient care activities for continuous quality and safety improvement
- Participating in quality improvement initiatives, for example the Healthcare Quality Improvement Partnership (HQIP) Clinical Outcomes Publication (COP) programme, as supported by BAUS through national audits

The hallmarks of a successful job plan

A 'fit for purpose' process is key to a successful job plan. Job planning should be:

- undertaken in a spirit of collaboration and co-operation and completed in good time
- transparent, fair and honest; and fully agreed and not imposed
- reflective of the professionalism of being a doctor
- focused on measurable outcomes that benefit patients
- consistent with the objectives of the NHS, the employing organisation and the teams and individuals with whom the urologist will work
- clear about the supporting resources the trust will provide to ensure that objectives can be met
- flexible and responsive to changing service needs during each job plan year
- focused on enhancing outcomes for patients whilst maintaining service efficiency

Job planning in a UAN should give particular consideration to whether on-call is being centralised and emergency patients transferred to a hub site, as this will require consultants and the junior team to be freed up from other clinical activities in order to manage the increased workload. Job plans should reflect work on UAN functions.

Job planning should also consider departmental reorganisation taking into account the age of colleagues and avoiding burnout. For example, older colleagues may need to share an on-call slot if this becomes more onerous, or come off the rota altogether. This must be considered carefully, as these changes can have unintended consequences when a workforce is not evenly spread across age groups.

BAUS job planning document >

2.7 Developing new services

Certain urology services require a larger population of coverage to be viable:

- Clinicians developing a sub-specialism will need to be seeing a minimum volume of patients to gain and maintain expertise
- Technology and equipment will need to deliver a certain number of treatments in order to be economical, particularly where a significant investment is required.
- Larger populations will, in the long run, be reflected by a larger urology team, offering more training and career development opportunities, such as progression of nurses through advanced practice.

Urology Area Networks mean that trusts can effectively cater to two different populations:

- Their smaller, usual catchment area for the trust
- For specific procedures, technologies or services – a larger network-wide catchment area

The combination of sufficient volume of activity and a specialist workforce, in particular specialist nurses, means that it is viable to offer new urology services such as one-stop shops, or Urological Investigation Units to carry out more procedures in an outpatient setting.

The GIRFT guide to Urological Investigation Units describes the development of urology roles that can take place in a UAN, including:

- Healthcare Assistants, Nurse Associates and Assistant practitioners
- Registered nurses
- Specialist nursing and Advanced practice, including:
    - Clinical Nurse Specialists
    - Advance Nurse Practitioners
    - Advanced Clinical Practitioners
- Surgical Care Practitioners
- Consultant Nurses / Practitioners
- Ultrasonographers, radiography staff including for lithotripsy
- Medical students
- Trainee doctors
- Associate Specialist Doctors
- Consultants
- GPs with a Special Interest

and the new services that can be offered, including:

- One-stop services such as dedicated LUTS clinics
- Endoscopy, stent removal and custoscopic follow up
- Local anaesthetic trans-perineal prostate biopsy
- Imaging
- Urodynamics and flow tests
- Transurethral laser ablation (TULA)
- Novel therapies and minimally invasive treatment for bladder outlet obstruction
- Circumcision
- Extracorporeal shockwave lithotripsy (ESWL)
- Vasectomy

Click to read more on services and developing roles in urology in the GIRFT guide to Urological Investigation Units >

3 Services that can be considered for UAN working

While networked services in urology have largely been restricted to centralised cancer work and, increasingly, the provision of urgent and emergency care, there is now an appetite to consider the provision of other urological services.

When forming UANs and establishing initial workplans, it is often helpful to start with services where there is consensus that a networked approach is likely to be needed and that would work well. Special interest groups can be established within the UAN to lead on the specific area of the service.

The commonest areas being progressed nationally are referenced below. A UAN does not need to be constrained to these clinical areas but some pointers may be helpful when considering where to make a start and how to build the clinical and operational buy-in.

Bladder outlet obstruction surgery

This can include standardised, one-stop assessment at all sites then a centre of excellence model as a networked service – there are examples nationally where this is predicated on a single centre or alternatively it can be a 'virtual' centre of excellence across a number of sites. Single PTL waiting lists can be helpful in reducing variation in access to these services.

Bladder cancer

A networked strategy can drive key improvements in the care of patients diagnosed with bladder cancer. For example, the network can support the change to daycase as default across the UAN. Sharing best practice can improve the rates of single post-operative installation of mitomycin-C (SPI-MMC) at all sites. Implementation of TULA and upskilling of staff can be rolled out across all sites in the UAN. A nominated centre can lead on provision of photodynamic diagnosis (PDD) and treatments such as hyperthermic mitomycin-C (HT-MMC). Working as a network has also been shown to be effective in 'de-pressurising' cancer centres, where provision of major surgery poses capacity issues, by re-distributing minor and intermediate surgeries within the network.

Stone services

In nearly all regions, there is a strong rationale for centralisation of percutaneous nephrolithotomy surgery (PCNL), more so as the numbers decrease nationally due to improved endoscopic laser treatment of larger stones. A single fixed site lithotriptor (ESWL) with acute access across the UAN is often cost-effective and delivers better outcomes than mobile units. A HVLC hub may be beneficial for the region and allow a majority of ureteroscopy to be delivered as a daycase pathway.

Female and functional urology

Often a single centre within each UAN will take referrals for more specialist female and functional problems but, at present, network guidelines and referral pathways are sparse or non-existant in many regions. It is also common place to see single-handed surgeons working in relative isolation across a number of centres to provide female and functional specialist care. It is clear that significant benefits to patients and the service could be achieved by establishing a more networked approach in this subspecialty area.

Andrology services

There is a compelling case for andrology services to be clearly described and formally networked, in line with the comments above on female and functional urology.

4 Sustainability and Greener NHS

Building in sustainable practices

Healthcare contributes approximately 5% of global greenhouse gas emissions. There is a pressing need to consider opportunities to deliver more environmentally sustainable care pathways when developing healthcare services. This involves capitalising on opportunities to deliver more efficient and lean processes. We should also identify any risks of introducing less environmentally sustainable care and implement mitigation strategies where necessary. Urology area networks present both opportunities and risks in this regard.

When implementing Urology Area Networks, opportunities for delivering less carbon-intensive care include the following:

- **Regionally pooled resource.** Pooling certain resources regionally can facilitate their optimal use and avoid unnecessary duplicate purchases. Surgical equipment is often expensive and can have a high carbon footprint associated with manufacture and maintenance. There are therefore potential financial and sustainability benefits to pooling resources.
- **High volume care.** Expanding high-volume subspecialty practice within UANs by consolidating care across a region could offer several advantages.
    - It could offer more timely access to care by running more efficient subspecialty clinics and operating theatres. Patients who are assessed and treated in a timely manner are less likely to present to healthcare providers with uncontrolled symptoms or complications of their condition in the interim.
    - It might also offer fewer surgical complications due to increased subspecialty practice.
- **One-stop services.** By assessing patients in one-stop subspecialty clinics, unnecessary patient travel can be significantly reduced. One-stop clinics can also help to reduce the time to diagnosis and treatment.

By working across a region, any sustainability improvements are inherently more scalable and higher impact than if they were implemented in one hospital.

There are ways in which UAN working could inadvertently introduce inefficiency and less sustainable practices if not implemented effectively. Risks include:

- **Unwarranted patient transfer.** As outlined in this document, when implementing UAN working in urgent and emergency care, it will be important to work closely with A&E and other referring specialties to ensure that patients are only transferred out of hours if they require specialist urology treatment. A&E should have pathways for investigating and managing common urological conditions that allow on-site assessment and discharge, or triage to clinical decision units. This can avoid out-of-hours transfer in many instances.
- **Unwarranted clinician travel.** By supporting referring specialties to undertake appropriate investigations locally, cross-site travel during out of hours cover can be minimised. Furthermore, when planning clinician activities attempts should be made to minimise cross site travel during a given working day. This will minimise work-related travel, as well as avoiding inefficient travel time during a working day.

As awareness about the impact of healthcare on the climate grows, we are already seeing more sustainable practices emerging. Some relevant examples are:

- **Phasing out desflurane.** This anaesthetic agent is a highly potent greenhouse gas, and NHS Scotland have now entirely stopped using it, with NHS England making the same commitment. This is a highly important demonstration of commitment to tackling climate change through action. It can be improved upon further if clinicians opt to utilise options that avoid using all

volatile anaesthetic gases with high global warming potential. This could involve using spinal or total intravenous anaesthetics, local anaesthetic surgery, or non-operative management options when appropriate.

- **Increased utilisation of day-case surgery.** This is a priority theme for GIRFT, who have already demonstrated the estimated realised carbon emissions reduction by having increased day-case rates for bladder tumour resection in England. For many high-volume low complexity urology operations the day-case rates have increased over the past ten years, however there is still much scope for improvement. Optimising day-case surgery rates should be considered when designing UAN pathways, and lessons can be learned from consistently top performing urology units. These include Portsmouth Hospitals University NHS Trust, Mid Yorkshire Hospitals NHS Trust, Sheffield Teaching Hospitals NHS Foundation Trust, and Gloucester Hospitals NHS Foundation Trust.

Guidance

The surgical Royal Colleges have produced an "Intercollegiate Green Theatre Checklist". This evidence-based guide indicates ways to reduce the environmental impact of surgery. This document is relevant to all staff involved in delivering surgery and can be used when designing UAN services. It can be accessed through each of the Royal Surgical College websites.

5 Case studies - Different network models

5.1 Norfolk and Waveney acute services integration

Motivation and Aims

Urology was selected as a pilot specialty to be provided under a lead provider model across Norfolk and Waveney. The aim of the acute service integration was to ensure the long-term sustainability of quality clinical services to all patients and address a wide range of capacity, demand, patient flow and workforce challenges being faced in the area. This would improve the experience and outcomes for patients and ensure that staff were provided with rewarding careers and attracting talent to hard to recruit to roles.

What was done

The service integration was planned in three phases. Phase 1: an 'as is' service transfer, Phase 2: service redesign including staff and patient engagement, and Phase 3: transformation implementation. Taking place in the current year, after 1 year and in the 2nd and 3rd years respectively.

The first phase 'as is' transfer was intended to deliver a single clinical workforce and clinical governance, with a single patient waiting list and single commissioner managed contract – but with no changes to where and how services are delivered.

Successes / lessons learned

Cross-site working arrangements have reduced unwarranted variation between trusts by improving access to services and reducing waiting times for patients. Services which were vulnerable and unsustainable have been secured and the Network has been able to recruit to several positions that had previously been difficult to recruit to.

The first phase commenced immediately before the COVID-19 pandemic, which has had a significant impact on the work both in terms of resource pressures and operational pressures.

The network sites are working towards a single Electronic Patient Record but this has not yet been achieved. This was mitigated by workarounds being developed for cross-site access to patient records. There have been more cases of cross-site working than expected which has meant the additional administrative burden of these workarounds was greater than anticipated.

The transfer of urology staff was more straightforward for larger sites, where these staff tended to work only in urology services. For smaller sites, this was more difficult as many staff worked across multiple specialties and so could not be transferred.

Points of good practice

Establishment of the UAN has been supported from the top Executive level of the trusts as part of a wider strategic vision for Norfolk and Waveney. The Network has had strong support and buy in from Clinicians across all sites, who have driven the work. The urology teams from two trusts have been successfully transferred to the leading provider, and contractual arrangements have been established between Commissioners and the lead provider, and sub-contracts between the lead provider and other provider sites. The governance and oversight structure for the UAN has been implemented and the operational manual developed.

5.2 Mid Yorkshire and Barnsley UAN

Motivation and aims

An initial partnership between the Trusts arose from an executive directive to support a smaller, geographically close unit experiencing an unexpected medical workforce crisis. An interim five year period of partial recruitment was unfortunately followed by a lack of staff retention, leading to our Urology Area Network: one centralised urology department working across the two Trusts to provide a high quality and equitable service.

What was done

Several years of interim arrangements between the Trusts involved two key elements: firstly, merged weekend on-call from 5pm on Friday to 8am on Monday with centralised transfer of all emergencies to Mid Yorkshire; secondly, sub-specialisation work provided centrally by the Barnsley consultants.

The second medical workforce crisis in Barnsley drove the decision to form the Urology Area Network, combining the Urology units into one department, providing a full urology service across the patch, with as much work provided as close to the patient's home as possible. Ongoing recruitment of medical workforce is now conducted and contractually held centrally within Mid Yorkshire.

Organisation of emergency urology services was the first concern of the UAN and were centralised throughout the week to Mid Yorkshire with a roll-out of A&E pathways for renal colic, retention and testicular pain to prevent unnecessary patient transfer between Trusts. A&E engagement with support from General Surgical colleagues in Barnsley has been crucial to managing emergency patients awaiting a centralised bed-space. Some sub-specialist services, such as fixed site ESWL, were also centralised for consistency.

Following the organisation of emergency Urology services, the UAN has continued to develop with joint clinical protocols and the introduction of services not previously undertaken in Barnsley, such as urodynamics and nurse cystoscopy lists. The medical teams at consultant and middle grade level all work at both Trusts.

Successes / lessons learned

The interim organisation of emergency services between the Trusts for several years enabled the complete integration of the on-call arrangements across the week with minimal re-organisation. Centralisation of medical staff appointments has successfully led to subspecialist consultant recruitment and enhanced service development at both Trusts.

Supporting referring hospital specialties without the benefit of an on-site on-call team at Barnsley requires senior clinician engagement and team-working which brings cross-site travel on-call to a minimum.

Points of good practice

Rotational working of all senior medical staff provides equity of employment, a shared sense of responsibility and is enabling the development of subspecialist services within Barnsley. The use of shared protocols across the UAN has provided opportunities for career development within urology nursing roles at Barnsley.

5.3 Newcastle, Northumbria and Gateshead UAN

Motivation and Aims

Newcastle, Northumbria and Gateshead UAN was established over 20 years ago, with the aim of improving equality of patient care and ensuring sustainability of the workforce to provide both sub-speciality services and core urology. Prior to the network's establishment, urology was being delivered by a range of surgeons, including general surgeons with a urology interest, and at multiple sites of on-call activity, often delivered by 1-3 individuals.

The UAN involves 4 separate hospital Trusts and covers a large geographical area, providing urology services and cover to: Freeman Hospital, Royal Victoria Infirmary (RVI) in Newcastle, Gateshead General hospital south of the Tyne river, North Tyneside DGH, Wansbeck DGH, Alnwick Hospital, Berwick hospital on the Scottish border, Northumbria Specialist emergency care hospital. The network also provides specialist services to Cumbria Hospitals on the west coast and the Lake District.

What was done

The service integration was planned as a hub and spoke network. The Freeman Hospital in Newcastle serves as the hub of the network, with all inpatient surgery taking place here and on-call being based and delivered from the hospital. As a cold site, the Freeman has a large (60+) protected urology bed base which is less vulnerable to the bed pressures seen in hospitals with Emergency Department admissions.

All consultants in the Network have fixed sessions in the hub where they deliver their specialist interest service, and also 1 – 2 days in one of the spoke sites. Admitted urology patients are transferred to the Freeman from surrounding spokes, with the on-call surgeons occasionally travelling out to spoke sites for emergencies such as ureteric injury. Some inpatient surgery had previously been delivered at Wansbeck DGH, but in 2018 this was changed to day case only due to difficulty providing overnight surgical support.

The large workload of the hub has allowed for an on call rota of FY2/VT2 and ST3+ 24 hrs a day, 7 days a week.

Successes / lessons learned

The network has functioned successfully since its establishment and has grown to now include 25 FTE consultants. Care pathways are consistent across all sites and patient movement in and out of the hub is routine without the need for special arrangements or internal referral pathways. The Network has removed inequity in cancer waiting times between Network sites, as all cancer treatments are delivered in the hub regardless of where the patient starts their pathway.

The trusts in the Network are using different Electronic Patient Record (EPR) systems and Patient Administration Systems (PAS). These are not interlinked, beyond the GP based Integrated Clinical Environment (ICE) system. This means that electronic copies of letters need to be transferred with patients between the hub and spokes for continuity, and imaging requested prior to accepting on-call patients from spoke sites. A single EPR and interlinked PAS for urology across all trusts in the Network would be ideal but is unlikely to happen in the foreseeable future.

The on-call service is facilitated by the employment of a team of on-call specialist nurses. The specialist nurses track on-call patients and help with discharge planning so that on-call patients have follow up in the appropriate spoke site. Their role also includes transfer of patients in and out, assessment in the admissions unit, phone advice and supporting a daily acute on-call. Given the high number of sites in the Network, it is valuable to have these team members who are aware of the local hospital geography and who make sure follow up and discharge planning is correct.

Points of good practice

A single employer model and uniformity in job planning have been paramount in making the UAN functional and maintaining a harmonious team. It ensures a fair division of hub and spoke work, as well as the on-call, avoiding any member being marginalised and keeping all the team in regular contact for support and clinical governance. Annual SLA review is recommended.

The large team size has meant that although the on-call in the hub is busy, it is well supported by specialist nurses and junior doctors and the frequency is low. Keeping on-call at a single site limits the travel time and allows familiarity with theatres, allied staff, Interventional radiology support and ICU. This is only achievable because of the protected bed base and clear protocols for transfer of critical emergencies without delay.

The centralised approach of having all consultants working out of one hub has ensured that all services have sufficient consultants delivering them and are not vulnerable to the absence or retirement of an individual. The approach also promotes cross covering and allows a flexible approach to new appointments.

6 Appendices

Certificate of Eligibility for Specialist Registration (CESR) rotations within Integrated Care Systems (ICS) – November 2023:

This statement has been developed through discussions between GIRFT Urology, the SAC in Urology and the SAS@BAUS Group. It is being published on the BAUS and JCST websites. For further information – please contact Mr Khaled Hosny (Consultant Urological Surgeon).

Units in relevant ICS groups are encouraged to support their senior SAS/LED/NCHD and locum consultants to attain CESR requirements by working in three different units by facilitating a 4-6 month honorary contract. The SAC/JCST are looking for externality rather than fixed time; they are looking at assessments from different consultants in each one of the three units. Therefore, 1-2 days per week should be accepted provided that candidates submit 15-20 WBAs from each unit within their CESR application.

The bare minimum for the six index procedures 9 WBAs each are needed (total 54), 4 WBAs for special interest and, for the 14 critical conditions, at least one WBA each required (total 14). Therefore, a bare minimum of 72 WBAs are needed from three different units. The WBAs are to be considered hand in hand with other data such as MCR, CIPs, logbooks etc. i.e. all other requirement for the standard application to be completed as requested. Candidates are advised to refer to the curriculum guidelines for more information.

We would ask employers / ICS to facilitate an honorary contract with full access to clinics and theatres in order to allow candidates to fulfil the requirements in terms of exposure to clinical activities that would allow them to fill in WBAs and attain competencies as per the standard urology curriculum. Those placements should be complementary to each other and help cover the breadth of the curriculum.

Benefits for ICS:

- Retain senior candidates to continue working as consultants.
- Short- and long-term solutions for workforce issues across any ICS group.
- Provide an attractive environment for the recruitment of middle grades and locum consultants.
- Weekly assistance with workload, with an extra candidate working as a supernumerary in the unit.
- Benefits for candidates:

CESR:

- Reduce travel time.
- Reduce financial implications from changing Tier 2 visas to join a different unit on full time basis.
- Reduce financial implications from moving across the country, especially for those with young families.
- Experience in working in different trusts and different work environment.
- Networking and building up regional reputation.

CESR appendix glossary:

GIRFT Urology – Getting It Right First Time

SAC in Urology – Specialist Advisory Committee in Urology

JCST – Joint Committee on Surgical Training

SAS – Speciality & Associate Specialist Doctor

LED – Locally Employed Doctor

NCHD – Non-Consultant Hospital Doctor

WBA – Work Based Assessment

MCR – Multiple Consultant Report

CIP – Capabilities In practice

Glossary

CDU	Clinical Decision Unit
CCT	Certificate of Completion of Training
CT	Computed tomography scan
Fragile	There is no set definition of what constitutes a ‘fragile’ service, but 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.’
ICB	Integrated Care Board
ICS	Integrated Care System
ODN	Operational Delivery Network
PBR	‘Payment by results’ or activity based payment
PTL	Cancer Patient Tracking List
RTT	Referral-to-treatment waiting times
SIRI	Serious incidents requiring investigation
SLA	Service Level Agreement
SOP	Standard Operating Procedures
UAN	Urology Area Network
UIU	Urological Investigation Unit
UTI	Urinary tract infection
Vulnerable	See ‘Fragile’
WTE	Whole time equivalent

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