External Review

Southern DHB Urology Services

June 2017
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Executive Summary

Introduction
Southern District Health Board commissioned an external review of its district-wide Urology services provided at Dunedin and Southland Hospitals.

Brief
The review committee’s brief, in short, was to:
  a. conduct an external review of whole urology service provided by Southern DHB at both Dunedin and Invercargill sites
  b. recommend changes to improve efficiency of delivery of urology services across the Southern DHB.

Method
The review committee requested quantitative and qualitative information prior to the site visit and received most of the information prior to the visit.

The review committee conducted site visits at Dunedin and Southland Hospitals on 6 & 7 June 2017 and met with an extensive range of people involved with the management of Urology services in Southern DHB. A semi-structured interview format was used to enable information to be triangulated and consistent themes to emerge.

People interviewed were open, honest, and responsive, and willingly gave time to the review process. They expressed commitment to being part of the review implementation process, despite a number being personally affected by the current restructure proposal in Southern DHB. The review committee was very grateful for the contribution made by the people interviewed, and equally grateful to the people who put together the requested information.

The committee appreciated the coordination of the on-site programme, liaison with staff and support provided to the review committee at each site.

Everyone interviewed was provided with a copy of the committee’s draft report and invited to provide feedback on the accuracy of the committee’s fact finding. Most interviewees took the opportunity to give factual clarification and to support their view of the reasons for the review and the outcome they desired. The responses reconfirmed the need for changes in the service. Some respondents expressed doubt that the committee’s recommendations would achieve the changes needed. The committee has carefully considered these responses in finalising its report.

Background
Southern District Health Board (SDHB) is responsible for the provision of healthcare services for approximately 316,000 people in the southern-most, and geographically largest, DHB in New Zealand. Historically the district was serviced by two separate District Health Boards (DHBs): Otago and Southland. In February 2010, the then Minister of Health approved the two DHBs’ merger plan and the formation of a single entity: Southern DHB.
Secondary and tertiary urology services are provided at two sites within the DHB: Dunedin and Southland Hospitals. Both sites provide a comprehensive urology service and there is full on-site 24 hours after hours cover on both sites.

Key Observations
1. The 2 Urology units housed within Southern DHB function almost completely independently with little communication or collaboration between the 2 sites.
2. There is a significant level of clinical risk within the long-waiting patients at the Dunedin site.
3. There is poor understanding of the size of patient population being treated and the demand the Urology service needs to meet.
4. There is no district-wide planning for Urology services across the DHB.
5. There is a significant difference in the access to care between patients referred to the Dunedin site vs patients referred to the Southland site. Service changes cannot wait for the Dunedin facilities’ rebuild as that is at least 5–7 years away
6. There is a rift between clinicians and senior managers at the Dunedin site.
7. Clinicians at both sites do not see the current model of after-hours care as sustainable.
8. There is a lot of inaccurate information about what is, and can be, done at each site.

Key Recommendations
The following recommendations need immediate action:

1. Relationships and Collaboration
   Enable a facilitated process to build trust and collaborative relationships across the Urology service and sites between clinicians and management.

2. Urology Service Plan
   Develop a SDHB Urology Service Plan which:
   a. Reviews the size of service at both sites, including theatre and outpatient capacity, waiting times and after-hours care (see Recommendation 3, 4, 5, 6)
   b. Assesses whether current resources are adequate and distributed equitably
   c. Ensures facilities on the Dunedin site are upgraded as soon as possible as they cannot wait for the rebuild/upgrade to occur
   d. Is agreed between clinicians and management
   e. Is transparent about review and updating processes, and includes a clear governance structure for this to occur.

3. After Hours Care
   Consider district-wide provision of after-hours care based on the two options considered by the review committee:
   a. All SMOs within Southern DHB participate in a single on-call roster and do their on-call from where they live.
   b. On-call is delivered from a single site.

4. Standardise Protocols and Policies
   Standardise protocols and policies across the whole DHB, including but not restricted to:
a. Job sizing, remuneration and professional development of Senior Medical Officer (SMO) staff, and the Clinical Lead position
b. Job sizing, remuneration and professional development of nursing staff
c. Development and review of referral pathways
d. Healthcare information/pamphlets
e. Triaging of General Practice (GP) and internal referrals
f. Thresholds for access to surgical waitlists
g. Waiting times for outpatients and surgical procedures.

5. Nursing Service
   Review the nursing service to ensure nursing is standardised across the two sites with clear guidelines, protocols and policies, and designated Urologist support, as well as visible support from Southern DHB.

6. Dunedin Site
   5.1 Site Specific Recovery Plan
      Develop an immediate plan for managing the backlog of work and its significant attendant clinical risk to the patient population.

   5.2 Outpatients
      a. Make urgent changes to the outpatients booking process to improve its efficiency and throughput
      b. Make urgent changes to use of the physical space available in the outpatients area to improve efficiency and throughput:
         • The current physical space is restrictive and not used efficiently due to the way clinics are currently configured
         • The ‘flow rate’ cupboard is unacceptable
       These changes cannot wait until the details of the Dunedin facilities’ rebuild are confirmed
      c. Enable procedures to be performed in the outpatients area during clinics
      d. Make urgent changes to the deployment of staff in outpatients clinics to streamline the use of SMO and Clinical Nurse Specialist (CNS) time
      e. Review patients scheduled for follow ups to see if these are required
      f. Ensure consistent letters are sent across the DHB, based on the Southland model
      g. Introduce use of virtual clinics and surveillance databases, based on existing models available in Southland and other South Island DHBs.

   5.3 Theatre
      a. Use all lists allocated to urology currently
      b. Increase theatre lists.

   5.4 Staffing
      a. Review the roles of all staff members (clinical and non-clinical) working within the department because currently some staff are asked to perform roles well outside their scope
      b. Review SMO job plans and sizing
      c. Amend the SMO 2:3 weeks roster and give each SMO a specified job plan for each week.
Southern District Health Board
Southern District Health Board (Southern DHB) is responsible for the provision of healthcare services for approximately 316,000 people in the southern-most, and geographically largest, DHB in New Zealand. Historically this geographical area was serviced by two separate District Health Boards (DHBs): Otago and Southland. In February 2010, the then Minister of Health approved the two DHBs’ merger plan and the formation of a single entity: Southern DHB.

Urology services are provided predominantly at two sites within Southern DHB: Dunedin Hospital and Southland Hospital. Currently both sites provide a comprehensive urology service and there is full on-site 24 hours after hours cover on both sites. Essentially the 2 Urology units are functioning almost independently under a single DHB umbrella.

Impetus for the Review
Southern District Health Board commissioned an external review of its district-wide Urology services provided at Dunedin and Southland Hospitals.

The impetus for the review was three-fold:
1. Urology services have struggled to meet national elective services performance indicators, particularly on the Dunedin site
2. There has been escalating tension between clinicians and senior management, particularly on the Dunedin site, and since the appointment of two new Urologists in 2014
3. Both sites wish to preserve all services and, in the absence of a district-wide Urology service plan, have been “competing” for what is seen as their “fair share” of resources (human, operational and capital expenditure) within the DHB without clarity and transparency about the “rules” or decision making processes.

Southern DHB’s Chief Medical Officer supported clinician and management requests for an external review to look at current service provision and developing a plan for the sustainable delivery of Urology services.

Review Outputs
The review brief is included in Appendix 1. The outputs requested of the review were to include:
- An agreed plan for overall service delivery volumes
- An agreed triage prioritization process consistent across the district
- A future workforce plan
- A contribution to the facilities design
- A process to agree guidelines for treatment and management of urological conditions across the SDHB
  - Within the specialist service
  - Across the hospital and primary care providers using HealthPathways.

Review Method
The review committee requested quantitative and qualitative information prior to the site visit.
A full list of the information requested, and provided, is included in Appendix 2. Where relevant, the data quoted in this document is provided in detail in the Appendices.

The review committee conducted site visits at Dunedin and Southland Hospitals on 6 & 7 June 2017 and met with an extensive range of people involving with the management of Urology services in Southern DHB.

A semi-structured interview format was used to enable information to be triangulated and consistent themes to emerge.

People interviewed were open, honest, and responsive, and willingly gave time to the review process. They expressed commitment to being part of the review implementation process, despite a number being personally affected by the current restructure proposal in Southern DHB. The review committee was very grateful for the contribution made by the people interviewed, and equally grateful to the people who put together the requested information.

Everyone interviewed was provided with a copy of the committee’s draft report and invited to provide feedback on the accuracy of the committee’s fact finding. Most interviewees took the opportunity to give factual clarification and to support their view of the reasons for the review and the outcome they desired. The responses reconfirmed the need for changes in the service. Some respondents expressed doubt that the committee’s recommendations would achieve the changes needed. The committee has carefully considered these responses in finalising its report.

The committee appreciated the coordination of the on-site programme, liaison with staff and support provided to the review committee at each site.

A full list of interviewees is included in Appendix 3.

Key Observations
1. The 2 Urology units housed within Southern DHB function almost completely independently with little communication or collaboration between the 2 sites.
2. There is a significant level of clinical risk within the long-waiting patients at the Dunedin site.
3. There is poor understanding of the size of patient population being treated and the demand the Urology service needs to meet.
4. There is no district-wide planning for Urology services across the DHB.
5. There is a significant difference in the access to care between patients referred to the Dunedin site vs patients referred to the Southland site.
6. There is a rift between clinicians and senior managers at the Dunedin site.
7. Clinicians at both sites do not see the current model of afterhours care as sustainable.
8. There is a lot of inaccurate information about what is, and can be, done at each site.
Discussion of Key Observations

1. The 2 urology units housed within Southern DHB function almost completely independently with little communication or collaboration between the 2 sites

   It is readily apparent that although a single DHB, the two units function independently with little visibility at each site about what the other site is doing.

   Clinicians at the Dunedin site had the perception that the Southland site has been preferentially looked after and over resourced. There is a perception from the Southland site that they have tried to share ideas and resources to help Dunedin but this has generally been rejected.

   There are clear differences in nursing services across the two locations and the service as a whole would benefit from greater standardization and communication.

   In Southland, the nurse role is clearly defined and there are 2 nurses who make up the 1.0 FTE. They have a proactive role supported by the SMO. They triage, case manage and control outpatient and theatre bookings for the urology patients. The nurses are involved in every step of a patient’s movement through the service. Having two nurses working to cover 1.0 FTE allows for collegial support and covers leave and sickness. The nurses operate a “one stop shop” for the outpatient service. Patients are prepped appropriately prior to coming for a clinic thus minimising the visits. The nurses do not do additional work outside of their role i.e. continence, cancer, post-operative trial removal of catheter (TROC). These things are managed by other nursing services within the hospital or in the community.

   In Dunedin there is one 1.0 FTE nurse. She is supported by the three SMOs but there is no formal method for communication and decision making is slow. The nurse has triaged referrals for about a year. Most GP referrals are accepted, even those not made in accordance with the HealthPathways. A lot of time is spent getting the referrals ready for the FSA on the basis of avoiding delays for patients. The nurse is undertaking more duties than are reasonably possible, e.g. taking on cancer care, continence (enjoyment of the work, no alternative service available) and education. There is no nursing involvement in booking patients to outpatients or theatre.

   We understand in the past there have been some meetings between the departments but they currently do not occur. Service managers from both sites do meet from time to time, usually via video-conferencing.

   The service, and patients, would benefit from service staff agreeing that they are one service delivering care from 2 sites and building a one service two site plan from this point. What each site does has an impact on the other site. For example, if one site is not meeting targets, this will impact on targets at the other site because they will be reported to the Ministry of Health (MoH) in a single report. Another example is equipment purchases where it seems there are separate operational and capital expenditure budgets on each site and little collaboration on equipment purchasing, or decision making about the priority areas for expenditure. For example, we heard that urodynamic equipment...
may be purchased for the Southland site without clear articulation that this was the next Urology service priority for the whole DHB. Similarly, the decision to replace SMO staff resource in Southland was not a clear service decision made with all SMOs involved, or at least the incoming Clinical Lead. Indeed, there was a lack of transparency about the decision making process given the context of an impending review and strained relationships, even though the committee accepts it was for replacement FTE. The decision continues to cause tensions as responses to this review, and the draft report, attest.

Other advantages we see in functioning in a more combined manner include improved ability to deliver sub-specialised care, improved collegiality, easier coverage of absences and leave.

2. The level of clinical risk within the long-waiting patients at the Dunedin site needs to be identified with urgency, and managed as an immediate priority

For example:

a. Surveillance cystoscopy is up to 1 year overdue and these patients have potential to develop invasive transitional cell carcinoma which can be a lethal disease
b. Serious clinical events have already occurred and will continue to occur
c. Some patients are 3 years overdue for follow-up
d. Major oncology operative cases can wait for 6 months or longer for surgery
e. Patients seen by an SMO and assessed as needing follow-up are having their case reviewed by a CNS and discharged because follow-ups cannot be accommodated. This places an unacceptably large burden of risk on the CNS, and is possibly outside the Nursing Council scope for practice if there are no guidelines in place from the SMOs.
f. The Oncology department will accept referrals from Urology without a histological diagnosis because they have concerns about how long the ‘chaotic’ Urology service may take to adequately work up the patient.

It is the review committee’s view that the apparent level of clinical risk is concerning and that urgent action is required to fully identify the level of risk and manage it as a high priority to avoid patients being adversely affected.

3. The size of patient population being treated, and the demand the urology service needs to meet, are not well understood

The review committee were surprised that no-one interviewed was able to give an accurate picture of the population size or the service size for the whole district. Estimates of the size of the population in the DHB are easily accessible to the general public and found within DHB documents. Without understanding the size of the service, where the demand is, what resource and outputs are currently available it would be impossible to know whether there is sufficient resource to meet demand.
4. There is no district-wide planning for Urology services across the DHB

The review committee was surprised that no-one seemed to be able to describe the future plans for delivery of the service across the DHB. This was particularly so on the Dunedin site. The managerial staff on the Southland site did seem to have some vision of the future but only of service delivery at Southland Hospital rather than a district-wide view.

Southern DHB’s population size is relatively static, with some parts of the district declining. However, Queenstown, Wanaka, and Central Otago areas are rapidly growing, even if off a low population base. Population projections predict that by 2030 the population in these three areas will be similar to the current population in the traditional Southland Hospital catchment. Future planning will need to consider how service is delivered to these areas. This may either be in the form of local delivery of services, or ongoing review and reconsideration of the traditional catchments for Dunedin and Southland Hospitals in order to achieve more equitable access to services. The travel distances for patients would be similar.

5. There is a significant difference in the access to, and timeliness of, care between patients referred to the Dunedin site compared with patients referred to the Southland site.

The disparity requires urgent correction.

6. There is a rift between senior management and clinicians (especially those based in Dunedin)

This rift, seemingly, was one of the main drivers for this review.

Relationships with service managers were satisfactory, although the Dunedin site has had three service managers in the last 18 months, with the present service manager only in the post for 4 months.

The issues described related to the relationship with senior, rather than service, managers.

Clinicians in Dunedin all expressed frustration and anger because they feel they are not listened to and that they have been misled.

The common example cited was that the two most recent appointees were told prior to signing their contracts that a fourth Urologist would be employed for 0.5 full time equivalent (FTE) on the Dunedin site (funded by Southern DHB), with a philanthropic donor funding the adjunct 0.5 FTE professorial position at the University of Otago. They perceive that as soon as they had signed on and started working that the 0.5 FTE funding was shifted to Southland. The committee probed this issue given its significance to the SMOs. The committee was satisfied with the information provided that Southland has been funded for 1.8 FTE Urologists for many years: 2 urologists, and some locum cover, depending on the FTE arrangements for the urologists. This did not change when Dunedin
employed its 2 new urologists, and, rightly or wrongly, provided the rationale for the recent appointment.

Clinicians also said they had been repeatedly told that if they did additional clinics and outsourced operations to meet targets then senior management would make changes to improve outputs over the longer term. However, from their perspective, no changes were ever looked into, or proposed.

Clinicians said this external review was promised in November 2016 yet it did not happen until June 2017. In November 2016 the clinicians agreed between themselves that they would not consider any additional work (either insourced or outsourced) until a service improvement plan was in place. This decision has resulted in a significant decline in waiting times and ability to meet targets over the last 6 months at the Dunedin site.

Senior managers, whilst acknowledging clinicians’ frustrations, felt the clinicians had engaged in unhelpful behaviours such as refusal to cover other clinicians’ clinics and operating lists when they were on leave. When the review team asked whether that represented cross cover and what remuneration was given, the response was that clinicians, as professionals, would cover colleagues’ leave. It was not clear whether this was an explicit Southern DHB expectation, that was included in all SMO contracts, or an implicit expectation that may not have been discussed with SMOs.

Overall, senior managers did not articulate a clear pathway to achieve more collaborative relationships and a more efficient and effective service.

The development of the Clinical Nurse Specialist (CNS) role in Dunedin had a long gestation, even though there was only one Urologist on the Dunedin site for some years. It is only relatively recently that a 1.0 FTE position has been available (reportedly funded mostly from ward funding), compared to the long-standing CNS role in Invercargill originally developed in response to a lack of Urologist resources there. The 1.0 FTE position in Dunedin is clearly inadequate.

The impact of the Infection Control teams’ views are also different at both sites. In Dunedin, they have prevented use of Tristel wipes, yet these are accepted for use in Southland and in other DHBs across NZ.

For the Urology service to function efficiently and successfully relationship bridges will need to be built between senior management and clinicians. Clear and regular communication will be the key. Identifying the key issues the parties have and aiming to resolve them or work out a suitable solution is vital. Given where the relationship is currently an external facilitator may be needed at meetings for the short term.

Currently it seems meetings involving service managers, clinicians and nursing staff are erratic and run in an ad hoc, casual manner. Formal minuted meetings where planning and decision making can be implemented are essential. There must also be a clear connection with senior managers to enable transparent planning and decision making and build relationships based on trust and performance.
7. Clinicians at both sites do not see the current model of afterhours care as sustainable.

Three models were proposed to the review committee:

a. The Dunedin clinicians expressed a desire to have a single site of afterhours care based in Dunedin Hospital. Acute admissions to Southland Hospital would be transferred to Dunedin for urological care. They felt there could be a single urologist working at Southland Hospital who may or may not be involved in the on-call roster and could potentially just provide elective care. The general surgeons at Southland Hospital would cover patients who could not be immediately transferred, or who needed immediate care; for example testicular torsion.

Data provided showed very similar acute admission numbers at both sites so there would be a significant volume of patients transferred.

b. The Southland Hospital clinicians expressed a desire to change from a 1:2 on-call to a 1:3 on-call. This would involve Dunedin covering the third weekend with 2 urologists on-site at Southland doing 1:3. With Dunedin having 3 SMOs it was felt this would mean each SMO in Dunedin was only covering Southland 1:9 and so would not be overly onerous.

c. A third model proposed was all Southern DHB Urologists participating in a single on-call roster, covering on-call from where they live. This would mean 2:5 cover would be in Southland and 3:5 in Dunedin (assuming there remains a 2:3 split of SMO staff at each site).

In any of these models there would be some degree of cover provided by the general surgeons. We had the opportunity to discuss this with general surgery in Southland but not in Dunedin.

The general surgeons in Southland have for many years provided some cover of urology. More senior general surgeons have reasonable experience in urology and feel comfortable with covering the service. It was pointed out, however, that younger surgeons do not have the same breadth of experience and would likely not feel comfortable covering urology, at least not without some additional training.

We understand, but did not directly confirm, that general surgery in Dunedin has stated they would not be willing to cover urology patients at all.

There are established models in other centres, e.g. West Coast, South Canterbury and Masterton, where general surgery covers urology with oversight by a Urologist from a distant centre. Helpfully, 2 Southern DHB urologists have experience in working with these models which could be shared.
8. There is a lot of inaccurate information about what is and can be done at each site

It was apparent that a lot of what is perceived about the delivery of urology services at each site is based on a number of assumptions, perceptions, historical anecdotes and experiences, some of which are probably not accurate.

a. Access to ICU services

For example, during our visit in Dunedin the review committee was given the impression that Southland Hospital has very limited ICU services and as a result there are a lot of cases, particularly acute cases, transferred from Southland to Dunedin.

When we asked staff at the Southland Hospital site about this we were told that patients are rarely transferred for this reason. Southland Hospital has a Critical Care Unit that can have up to 6 patients at a time.

The team at Southland Hospital could only recall 2 urology patients transferred out in recent months because the local service could not provide the necessary care. [Section redacted to protect the privacy of patient]

This transfer seems entirely appropriate and extremely complex cases like this are rare (probably less than 1 per annum) and should only be done on one site within Southern DHB or arguably (although outside the scope of this review) should actually be referred on to a quaternary service at another DHB. [Section redacted to protect the privacy of patient]

b. Clinical Nurse Specialist FTE

The Dunedin site stated that Invercargill had 1.4 or more FTE of CNS time for urology. In fact, there is only 1.0 FTE of CNS time in Invercargill but this time is shared by 2 CNSs (0.8 and 0.2) which actually works very efficiently because then they are available to cover each other’s leave.
c. After Hours Work

The impression given to the committee in Dunedin was that very little afterhours work is done in Southland. In fact, the annual acute admission numbers per site are almost identical based on the data provided. There are more procedures performed on acute admissions in Dunedin compared to Southland so there are presumably differences in the indications and thresholds for acute admissions on each site.

The review committee noted that the Southland site has only had 1 SMO since February 2017, with limited access to locum resources. This is a long time for 1 person to cover a service with little support. A new SMO is expected to be in post about August. This will take the Southland site back up to the 1.8FTE SMO resource.
Discussion of Key Recommendations

1. Review the service size and gain an understanding of theatre and outpatient capacity and waiting times on both sites

   a. Assess whether current resource is adequate and distributed equitably

      The review committee observed that on the Dunedin site there was limited knowledge of what the service size is and therefore what demand for services there is.

      In Southland there seemed to be good understanding of the service demand within their historical catchment area but not of the total DHB demand.

   Urologist Resources

   The Dunedin clinicians have a strong view that they require at least 0.5 more FTE.

   Nationally, the average number of Urologists per capita is approximately 1:80,000. Smaller, more rural DHBs, tend to have lower ratios compared to larger urban DHBs. Southern DHB has a high rural population, and also a slightly higher proportion of elderly than the national average.

   Southern DHB population is about 316,000. From this, we would estimate that Southern DHB needs approximately 4-4.5 FTE Urologists to deliver adequate urological care to its population.

   According to the data sent to us, in the 12 months to February 2016, there was 1.8 FTE in Southland, 1.6 of which was for permanent staff and 0.2 for locum staff. In Dunedin there is 2.1 FTE divided evenly between 3 SMOs.

   The Southern DHB website estimates Dunedin Hospital’s traditional catchment area is about 208,000 people and Southland’s is 108,000 people.

   Therefore, based on the available population data for the traditional catchment areas, Dunedin has a ratio above the national average, and Southland has a ratio below the national average. The Urologists split could be suggested as 2.6 FTE and 1.35 FTE across the two sites to reflect the traditional catchment areas. However, activity, efficiency, population distribution and facilities also need to be considered.

   In terms of volume of work, the 2016/17 case weight discharges on the Dunedin site were 808 whereas in Southland this volume was 641. A split of 55.7% in Dunedin and 43.3% in Southland. The numbers for 2015/16 were almost identical to this. (Appendix 6). We understand the split of case weight discharges in the orthopaedic and general surgery departments is approximately 57% / 43% with the higher volume done in Dunedin. The current distribution of urology FTE is 54% in Dunedin and 46% in Southland. In Dunedin for 2016/17 there were 2311 outpatients seen. There were 977 FSA appointments and 1334 follow-up appointments. In Southland 2316 outpatients appointments were seen with 783 being FSA appointments and 1533 follow-up appointments. The proportion of Southern DHB FSA appointments seen in Dunedin
was 55.7% vs 44.5% in Southland. The number of acute admissions for 2016/17 was 280 in Dunedin and 257 in Southland. 157 patients in Dunedin underwent a recorded intervention during their acute admission. That compares to 105 patients undergoing an intervention in Southland. A breakdown of those procedures is provided (Appendix 8).

There is a fulltime Urology Registrar at the Dunedin site who is a SET trainee but generally SET 1 or 2. Southland site has a non-training registrar, but the registrar is shared with general surgery which limits their input into the urology service.

Before any consideration is given to increasing Urologist FTE or deciding how the FTE should be divided between sites it is essential to consider the following:

- Is there sufficient theatre time to meet the population demand? The review committee believes theatre time is inadequate currently, as evidenced by good theatre utilisation data on both sites but a failure to meet ESPI targets and a moderate proportion of outsourcing, particularly on the Dunedin site.
- Where is there theatre capacity within the DHB? In other words which locale actually can deliver more theatre time? This may determine in which locale the FTE is placed. It may also influence where referrals from patients in the Central Otago region are directed (as travel time is similar to Dunedin or Southland).
- Will increased FTE be devoted to increasing theatre output or increasing outpatient output, or more likely what mixture of these?
- Are there ways of running outpatients and theatre more efficiently so more patients are reviewed and treated without increasing resources?
- If more outpatient throughput is required despite efficiency gains, then which location has the physical space to accommodate this?
- Where will complex, tertiary level, procedures take place? There is clear evidence in literature that patient outcomes from complex procedures is related primarily to the volume of such cases the hospital is doing. Some countries, the United Kingdom for example, require certain volumes for a hospital to be credentialed to perform those procedures. With this in mind it is the committee’s opinion that complex cases (e.g. cystectomy, partial nephrectomy, complex open nephrectomy, RPLND, complex abdominal reconstructive procedures (fistula’s, bladder augmentations)) would be done in a single site within the DHB. Dunedin would be the most appropriate site for this given the onsite tertiary services and support. A decision to do all complex procedures at a single site would also influence the ‘split’ of FTE as these procedures take up a lot of theatre time and require intensive post-operative care.

These questions, and therefore the ‘split’ of FTE, can only be answered by robust discussion between the clinicians and management from both sites as they develop a sustainable urology plan for the DHB.

In general, a 1.0 FTE Urologist would have 2 sessions of major, inpatient operating, and another session of day case surgery or other minor procedures (e.g. ESWL) each week. There would generally be a ratio of time devoted to clinic and to inpatient
theatre sessions of approximately 1:1. They would also engage in other clinical activity such as Radiology and Multidisciplinary meetings, GP triaging, report writing (e.g. for ACC or HDC). There is also the MECA suggestion of a minimum of 30% non-clinical time.

The Dunedin site currently has 4 sessions per week of inpatient operating time but probably should have more theatre time. The fact that theatre utilisation data is good (88%) on data provided to us but waiting lists are not meeting MoH elective services performance indicator (ESPI) targets in Dunedin suggests there is a shortfall of theatre time. Historically it appears this shortfall was met by outsourcing which both the clinicians and management have made clear is not a desirable or sustainable long-term solution. There are also significant issues with maintaining a trainee post if outsourcing of core urology cases to private continues. We would estimate that the Dunedin site requires at least another half day session per week of inpatient operating to meet its demand.

The Clinical Lead role is currently a fixed term position with little clarity about the timeframe for the role, and job size allocation it attracts. This is a critical role to lead the changes envisaged in this review document and needs commitment from the Southern DHB to ensure there is adequate time and support to undertake this developmental role. Other DHBs would typically allocate 0.3 FTE to this role.

Urology Nursing Resources
The Clinical Nurse Specialist staffing is 1.0 FTE at each site. The nurse at both sites are working hard to meet targets and care for urology patients. However, there are differences in the way the services are structured and there is almost no contact between the two sites. The review committee was impressed with the Southland nursing framework and recommends that it is used on both sites, with a transition period to embed it in Dunedin.

The key elements of the framework are:
- Clear CNS role with defined work parameters
- SMO support and clear lines of communication for nurses
- One stop shop system to prevent unnecessary outpatient visits
- SMO agreement about the triaging guidelines to be applied to reflect the HealthPathways, and patient management, and practice that meets this agreement, enabling the nurse to do triaging following the agreed guidelines, with referrals sent back to GPs if they do not meet the HealthPathways and guidelines
- Broad nursing overview of all urology patients including booking to theatre and outpatients
- Better utilisation of theatre space and planning of theatre lists. In this respect it may be possible to involve the urology nurse working in the Dunedin theatre who could liaise with the CNS to plan lists.

The review committee recommends the appointment of a second urology nurse in Dunedin.
Proactive commitment from the DHB is required to achieve the change to the nursing service. This will involve:
- Education support for nurses
- Information flow between the two sites, planned meetings for nurses, collegial support.

To support the suggested changes the SMOs across both locations need to come to an agreement with regards to triaging guidelines and patient management and then work to these rules. These guidelines should be visible to all staff managing urology patients.

The review committee has made available some guidelines for the nurse role, workflow and triaging which are used in other DHBs. The triaging guidelines endorsed by the NZ Urological Society have previously been circulated to all DHBs.

**Administrative Resources**

At the moment, on the Dunedin site, there are non-clinical staff in effect making clinical decisions (secretaries/booking clerks) because of the frequently stressful work they are doing in the patient management area e.g. dealing with phone calls from patients including those about complaints, and not having a clearly defined route for clinical decisions to be made.

We were told there is a folder for routine patients which has no review process, so patients do not know whether they have been accepted for an outpatients appointment or not. This information was disputed in some submissions on the review draft. The committee’s verbatim interview record confirms the statement was made. To allay any concerns and risks these referrals must be reviewed by clinical staff and managed appropriately.

We were also not clear who is responsible for managing complaints.

There needs to be a review of these patient-related activities, including bookings, with some coming back to the nurses to undertake (as occurs in Southland and other DHBs with a very positive impact on efficiency and patient satisfaction). The adequacy of secretarial support in Dunedin also needs to be sized as the volume of work appears large, and important areas such as operation notes are reportedly three months behind in being typed. The expectation around booking staff taking turns to man reception needs to be reconsidered to ensure workflow is as efficient as necessary.

2. Standardise protocols and policies across the whole DHB, including but not restricted to:
   a. Job sizing and remuneration of SMO staff
   b. GP referral triaging and referral pathways
   c. Healthcare information/pamphlets
   d. Thresholds for access to surgical waitlists
   e. Waiting times for outpatients and surgical procedures
   f. Standardisation of nursing policies/protocols/patient information
a. SMO Job Sizing and Remuneration

In Southland, job sizing is calculated by sessions. A 1.0 FTE clinician does 10 sessions made up of 7 clinical sessions and 3 non-clinical sessions. Additional to this is an on-call component 1:2, remunerated with 5 hours pay per week and 15% availability allowance.

In Dunedin neither the clinicians nor management were able to tell us how job size is calculated. The only information we were told was that one of the clinicians stated he is employed to do 1:4 on-call, is paid for 4 hours per week for this, and gets 7% availability allowance.

The review committee strongly believes clinicians doing the same job in the same DHB should be remunerated in a standardised and equivalent manner. We believe the Southland model is too simplistic and does not account for actual hours worked. For example, all day operating lists go for 8 hours but additional to that the clinician will need to review patients before and after surgery and also do a ward round for any other inpatients. Thus, there is at least 9 hours of clinical work on those days.

There are many formulas for how job sizing can be done and Southern DHB needs to have a single transparent calculation for all its SMO urologists. Included in Appendix 5 is a document outlining how FTE for urologists is calculated at Auckland and Counties Manukau DHBs which may be a useful resource.

b. GP Referral Triaging and Referral Pathways

GP referral triaging and referral pathways need to be standardised. There are pathways that have been agreed South Island wide and these should be utilised. Criteria should be strictly adhered to. GP education will be required so that GPs know what the pathways say and require so their patients are worked up appropriately prior to referral. This type of system is working well in Southland. In Dunedin it seems to be working poorly, with clinicians reporting that patients come to clinic only to be sent off for investigations before clinical decisions can be made. One reason given for this was that radiology would not allow GPs direct access to scans. Most DHBs in NZ have systems that allow GPs to access investigations, especially if they are within agreed pathways. We understand from the radiologists that there is now much improved access to radiology directly by GPs.

The committee feels strongly that ALL referrals within the DHB should go to a single place for processing before being sent to the triage nurse in either location. The triaging process needs to be the same. Without this, standardisation will be difficult.

c. Healthcare information/pamphlets

The committee did not formally assess this but within a single DHB, information given to patients should be standardised. Access to an electronic version of information, such as HealthInfo in Canterbury DHB, could be considered.

d. Thresholds for access to surgical waitlists

Clinicians need to have consistency on what cases they put on the surgical waitlists and also what acuity cases are given. This is particularly important in departments that are
running ‘pooled’ waiting lists. Without standardisation patients may be advantaged or disadvantaged depending on which clinician they have seen. Also, without standardisation one clinician may not agree with another’s assessment leading to short notice cancellations which impacts on theatre utilisation and efficiency.

e. Waiting times for outpatients and surgical procedures
Regular review of waiting times on both sites, should be undertaken. It is conceivable that there are areas within the DHB (e.g. Central Otago) where the site the patient is referred to could be based on waiting times at either site, as travel distances are similar. This is only possible with far greater visibility of waiting times. A single point of entry into the system for both sites will also help with this visibility.

f. Standardise nursing policies, protocols
Nursing policies and protocols should be standardised across both sites [see Recommendation 1.a. above, and Appendix 4 below].

3 Establish a collaborative approach across the whole service
   a. At managerial levels – service and senior management
   b. At clinician levels, both SMO and nursing
   c. At administration levels

This has been discussed extensively already in this document. It is essential that both sites realise they are working for the same DHB and so are effectively 1 department not 2 departments.

4 Review after hours care provision
The review committee was presented with three models for afterhours care, which were considered carefully.

The review committee strongly feels that the only sustainable model for future delivery of urology after hours care would be in the form of a single, district-wide on-call roster across both sites.

There are two ways this could be delivered:
   c. All SMOs within Southern DHB participate in a single on-call roster and do their on-call from where they live. This would mean 2:5 cover would be in Invercargill and 3:5 in Dunedin. This assumes the current 2:3 split of SMO staff at each site, but could shift if this split changed.
   d. On-call is delivered from a single site, most likely Dunedin given it has the larger referral base and easier access to afterhours interventional radiology and vascular or other tertiary services. If this model was adopted, then careful consideration would need to be given about how elective urology care was delivered at the other site.

There are difficulties with either model. Both would require a lot of discussion with general surgeons to provide a skeleton service before patient transfer occurs and to be
willing to provide some basic urological care (e.g. scrotal exploration for testicular torsion).

Models exist in other DHBs where urology protocols have been agreed between general surgeons and urologists and these could be utilised. The review committee understands that general surgeons have been satisfied with the model of care and protocols adopted.

As the acute admission numbers are virtually identical on each site, with either model there may be significant numbers of patient transfers, unless further analysis shows a different picture for reasons for acute admissions, or inclusion of planned patients who are seen in under 7 days.

5 Dunedin Site-Specific Recommendations

The review committee makes a number of recommendations specific to the Dunedin site. The review committee was very concerned at the waiting times and care provided on the Dunedin site. Urgent action is required to manage the situation to avoid serious sentinel events and complaints related to patient care.

a. Recovery Plan
An immediate plan must be developed and agreed for managing the backlog of work, quantifying the clinical risk to the patient population and addressing it as an immediate priority.

b. Outpatients Environment and Throughput
Urgent changes to Outpatients environment and throughput are needed:
   i. Physical space is restrictive
   ii. The ‘flow rate’ cupboard is unacceptable
   iii. Inefficient clinic booking process
   iv. Improve throughput
   v. Ability to perform outpatient procedures in outpatients
   vi. Virtual clinics and database utilisation
   vii. Streamlined use of CNS time.

The outpatients physical environment is poorly laid out and under-resourced, contributing to significant inefficiency. The contrast with the environment in outpatients at Southland Hospital was staggering.

There is a disparity in throughputs between the sites. In Dunedin the usual Tuesday clinic has 2 SMOs and a registrar for the whole day (2 sessions), plus the Clinical Nurse Specialist, with a Registered Nurse and Enrolled Nurse available in the area (although it was unclear that they were dedicated to urology). Forty eight patients are booked into this clinic which represents 8 patients per clinician per session. Clinics are usually overbooked to accommodate urgent cases, with no definition provided of what constitutes an urgent case and apparently no cap on numbers of urgent cases. On the day we visited 53 patients total were booked into clinic and we were told this would be a typical number. There are no outpatient procedures performed during this clinic.
In Southland, a usual clinic has 12 patients booked into it for a half day (single session) and these 12 patients are seen by a single SMO, without a registrar and with the Clinical Nurse Specialist assisting. It would be typical for 6 of those 12 patients to undergo a procedure, mostly a cystoscopy, in the same clinic. If a registrar is rostered to attend the clinic then an additional 8 patients are added to the list but no further procedures. To translate these numbers to compare to a Dunedin clinic model; 64 patients and 12 procedures would be performed across 2 sessions if 2 SMOs and 1 registrar were present in Southland for the day. Across the last 12 months there were as many patients seen in the Southland Outpatients Department as were seen in Dunedin, despite there being fewer clinics, fewer clinicians, and less FTE.

To give another comparison, the review committee chairman works in 2 outpatient environments, at Greenlane Hospital (ADHB) and Manukau Super Clinic (CMDHB). At Greenlane in a single session he, a senior registrar (SET 4-6) and a non-trainee registrar collectively see 22 outpatients and do 8 procedures (mostly cystoscopies). At Manukau Super Clinic in a single session with a non-training registrar he sees either 21 patients (13 for SMO and 8 for registrar) or sees 15 patients and does 6 procedures.

The Nurse Manager on the review committee oversees outpatient clinics in 3 DHBs and 2 private outpatient clinics. In these 3 DHBs 1 SMO will see a minimum of 32 patients in a full day and of these, approximately 6 will have a cystoscopy and 4 TRUS biopsy. In private 1 SMO will see 24 patients in a full day with a similar number of cystoscopies and TRUS biopsies.

These examples show that Dunedin outpatients is not working in an optimal fashion. This is not to imply that staff are not working hard. We have no doubt they do. Complaint letters sent to us had a few common themes, but one theme was that outpatients always ran behind time and this was true on the day we visited when theatre and ED calls occurred. This suggests outpatients is working to the capacity achievable under the current model.

The committee sees a number of important changes that should be made to outpatients that will produce a more efficient throughput and a better patient experience.

i. First we would recommend splitting clinics into single consultant clinics. Having 1 CNS look after a clinic for 2 SMOs and 1 registrar is insufficient, especially if other nurses in the outpatients area are not dedicated to urology patients. Most OPD environments would have a 1:1 clinician to nurse ratio. There are also not enough rooms to see patients if there are 3 clinicians in clinic. This change would allow SMOs to have a consistent work plan rather than the 2:3 weeks at work model they currently do.

ii. Second, procedures must be incorporated into outpatient clinics. This is a very standard practice in most urology units in New Zealand. The committee has been told, and was provided with email dialogue, that the clinicians have been pushing to have this change made. The apparent barrier is lack of space and an unsuitable
environment to be able to clean scopes and provide necessary sterility. There are short turn around cleaning solutions, such as Tristel, suitable for cystoscopy, which could make outpatient cystoscopy clinics possible. The cleaning of the ultrasound probes is handled differently in each location. The Tristel brand also has a 3 step wipe system for cleaning ultrasound probes. However, we understand the Infection Control team at Dunedin stated this was not an acceptable standard. Interestingly, this is the process undertaken in Southland so it seems odd there are different standards within the same DHB. These types of scope and ultrasound cleaning methods are used in several centres in NZ so the review committee does not believe this should be the barrier to changing how clinics are done. It is absolutely essential that urologists can do flexible cystoscopies and transrectal USS guided biopsies of prostate in an outpatient environment. The increased throughput and shortening of ‘patient journeys’ from referral to diagnosis make this essential. This should not be difficult to deliver but requires a shift in attitude from “it’s too hard so we’ll keep doing it how we have always done it”.

iii. Third, Dunedin must embrace the concept of virtual follow-ups and virtual FSAs. The clinicians all expressed a desire to have this incorporated into the work environment. It requires the clinicians are allocated clinical time to perform this task. It also requires resource, particularly IT and administration, to set-up and run follow-up databases (but a SI model is available for sharing). Once set-up though the efficiency gains will offset any additional resource put into it. As an example, Canterbury DHB’s urology department has nearly 1,000 virtual follow-up appointments per annum, which frees up enormous numbers of outpatient appointments to sees FSA patients. The SMO can then see virtual FSAs and/or follow ups at the end of an outpatient clinic if the nurse has prepared these for review beforehand. If they are more urgent, then they can be done on an ad hoc basis.

iv. Fourth, a “one stop” approach must be undertaken for haematuria referrals and elevated PSA referrals. There are large numbers of patients travelling from around Otago to come to Dunedin. Some may drive more than 2 hours. It is an injustice to these patients to drive those distances for an initial consultation only to be told they need to come back at another time for an investigation. A “one stop” approach can only happen if referral pathways are tightened up and strictly adhered to AND there is the ability to do procedures in outpatients. Creating this one stop approach would reduce the time from referral to diagnosis by several months for patients with either prostate cancer or bladder cancer. Southland, as stated, already operates a “one stop” approach.

v. Fifth, the flow rate room must be upgraded. It is too small, it smelt, and it has 2 significant steps which must make it very difficult for some elderly, or poor mobility, patients to get into it. Most outpatient environments the committee has seen, or worked in, have the flow rate machine housed in a toilet cubicle which is usually the size of a disabled toilet cubicle so there is plenty of room and no steps or other hazards.
vi. Sixth, the clinic booking process must improve to allow short notice urgent cases to be accommodated without overbooking clinic numbers. Clinics should have spaces reserved for urgent cases and these spaces should only be filled in last 2 weeks before clinic. In other DHBs review committee members are associated with, around 5 slots for urgent cases will be held until nearer the clinic date, and as with Southland, the CNSs are closely involved with the booking process.

vii. Seventh, the cystoscopy clinic in its current state is very inefficient. Approximately 10 cystoscopies are performed per clinic with the registrar and an SMO present at this clinic. No other patients are seen at same time. If these clinics were conducted in a space where other outpatients could be seen at the same time then the registrar could be doing the cystoscopies while the SMO sees some patients and provides oversight. It would be easily achievable to do 8-10 cystoscopies and see 8-10 outpatients in the same clinic. The current SET trainee registrar in Dunedin has previously been a non-training registrar at ADHB and performed cystoscopies independently while the SMO (chairman of this review committee) consulted general outpatients in a separate office at the same time. The non-training registrar would ask for assistance, or for a cystoscopic finding to be validated as necessary. This model is common in urology outpatients around the country. There should be no reason why this model can’t be emulated in Dunedin, especially as all SET trainees will have done at least 6 months of urology prior to entry onto the training programme. They are therefore likely to already have had exposure to performing outpatient cystoscopies.

viii. Finally, the CNS is an excellent resource. However, the role needs more precise, manageable definition to mirror the Southland site role.

The suggested outpatient changes and improved throughput could be achieved without an increase in FTE by:

I. Increasing outpatient numbers to 20 patients per session: 12 patients for SMO and 8 for registrar. This would mean 60 patients would be seen in 2 sessions, an increase of 7 patients per week.

II. If the current cystoscopy clinic was moved to allow outpatients to be seen at same time then probably 8 outpatients per week could be seen in addition to current numbers.

III. These 2 efficiencies would improve output by 15 patients per week, and multiplied by 40 weeks per SMO (conservative estimate to allow for SMO leave) then 600 more patients could be seen per year. This is a >25% increase in output over current levels with no change in FTE devoted to outpatients.

c. Theatre
Theatre lists are the most scarce resource for any department. It is imperative that all theatre lists are used and that they are used efficiently. With 3 SMOs in Dunedin it should be possible to cover virtually every list; someone must always be in town to cover the on-call so there should always be an SMO available. However, if an SMO covers a colleague’s theatre list because the other SMO is away then this needs to be compensated by that SMO dropping other clinical work. For example, if an all-day list is covered then 2 outpatient clinic sessions should be dropped from that SMO’s roster
either that week or in adjacent weeks to compensate for the additional work done. It should be possible to approximate how often this would be necessary (SMOs get 6 weeks annual leave, + 2 weeks CME leave + approximately 1 week travel leave, sickness leave and so on, i.e. about 9 weeks per year, so there would be 27 weeks of expected vacant theatre lists). This approximation could then be factored into numbers of clinics needed per year expecting that clinicians will miss clinics when their colleagues are on leave so that theatre lists are always covered.

Even if 100% of currently allocated theatre lists are utilised by urology the review committee doubts that 2 days per week is sufficient time to provide a reasonable service. We would estimate at least 2.5 operating lists per week would be necessary to cover the work particularly if SMO numbers need to increase to fit with the DHB’s population.

d. Staff Roles and Responsibilities
Non-clinical staff roles need more precise definition. It seemed that staff roles have grown to cover areas where resource/personnel have been stripped out. This situation has led to staff who are over worked, stressed out, frustrated and feeling as if they are working beyond their levels of knowledge and competence, at times straying into clinical areas, with little support and guidance. Currently non-clinical staff are, for example, fielding complaints calls, covering outpatients’ reception which diverts focus from booking responsibilities and requires catch up work, and holding routine patient referrals without clarity about whether these patients will be seen by the DHB.

Without defined roles with clear boundaries, it is hard for the staff to be efficient and feel effective and confident in their roles.

e. SMO Job Sizing and Job Plans
SMO job sizing has been discussed previously. The committee recommends that the SMO do not continue on a 2 week on, 1 week off job plan.

This system seems to cause confusion with clinic bookings and with knowing who is covering which clinical activity. It also creates an imbalance of when leave is taken. For example, if an SMO only used his leave during the 2 weeks he is due to work in the schedule, but never during the week he is due to be off, then those 2 weeks will mean 2.0 FTE clinical work is not done but only 1.4 FTE annual leave is actually taken as SMOs are employed on 0.7 FTE agreement. Of course, if SMOs take leave during the week they are on, the “week off” 0.7 FTE leave is docked, but no actual clinical work is missed, effectively reversing the previous scenario. This potential imbalance would be very difficult to track and hence it is important that SMOs have a regular job plan to avoid these anomalies. The committee has received clarification that there is a system in place to ensure that leave is taken appropriately and any imbalance as above is avoided.

A regular SMO job plan and departmental schedule would have benefits to production planning and managing waiting lists. Appendix 5 contains a model used in another DHB that might be useful to consider further.
Review Outputs
The committee was asked to provide the following review outputs:

- An agreed plan for overall service delivery volumes
- An agreed triage prioritization process consistent across the district
- A future workforce plan
- A contribution to the facilities design
- A process to agree guidelines for treatment and management of urological conditions across the SDHB
  - Within the specialist service
  - Across the hospital and primary care providers using HealthPathways.

The committee has endeavoured to address the required outputs, either directly as in the contribution to the facilities design required, or as recommendations to be considered by service staff and management working together, with facilitated change management support if necessary, towards a district-wide urology plan. It is essential that the next steps are taken within Southern DHB.

Most people that were interviewed during this review were asked if they would be committed to undertaking changes recommended in this review. They all said they would.

The review committee hopes that this review will lead to significant change in the delivery of health care to the urology patients in Southern DHB. Change is necessary because currently not all urology patients in Southern DHB are being adequately cared for.

Review Committee
The review committee selected comprised:

- Mr Andrew Lienert, MBChB FRACS Urology; Clinical Director Urology Counties Manukau DHB
- Mrs Rosemary Benfield, MN; Clinical Nurse Specialist, Nurse Manager Urology Associates
- Ms Janice Donaldson, LLB (Hons); Diploma Social Work; Programme Manager SI Alliance Programme Office.
Appendix 1  Review Brief

Review of Southern District Health Board Urology Service

Terms of Reference

Background
Urology services are primarily provided to a population of 300,000 by the Southern District Health Board (SDHB) in two sites: Southland Hospital and Dunedin Hospital with some outlying clinics. These elements were originally in separate DHBs but should now work as one service.
SDHB covers a large geographical area with a significant population away from the main centres including a relative concentration in the Queenstown Lakes area.

Both Southland and Dunedin Hospitals provide secondary services and Dunedin some tertiary services including the Intensive Care Service (Southland has a limited ICU capacity at the level of HDU with capacity to ventilate for short periods).

SDHB has an older population compared to other DHBs and an ageing trajectory that will see significant increases in patients requiring Urology services.

There is private surgical capacity in both centres that can provide in-patient beds, theatre and perioperative care for low to medium risk Urology surgical interventions as well as out-patient services.

There are CT and MRI imaging services in both centres and CT capacity in some of the rural areas.

There is a single electronic clinical workstation providing an integrated view of the majority of health information required for clinical care. It is accessible to GPs and includes a GP summary record and community pharmacy.

SDHB is currently planning a redevelopment of the hospital facilities in Dunedin, the current extent of which is not yet finalised but will certainly include theatres and out-patient space and quite possibly in-patient facilities.

Problem statement
The Urology service in SDHB is experiencing a number of issues that need an expert and reasoned investigation. They have been expressed as:
- Difficulties in meeting ESPI targets
- Difficulties in agreeing the prioritisation of available service delivery
- Two sites that are not integrated
- Inequity of service, and possibly outcome, across sites
- Perceived lack of SMO FTE to meet service requirement
- No clear future workforce plan
- Apparent constraint in available theater time – acute and elective

Currently these actual or perceived problems are affecting the relationship between the DHB and the Urologists. The consequent effects for patients are potentially serious in that there is a risk of delays to assessment and intervention and provision of a service below an acceptable standard.

Goals of a review
A review is an opportunity to gain an external perspective on what has become a challenging situation – and thence a consensus on a future plan plus resolution of urgent issues.

These include:
- An agreed plan for overall service delivery volumes
- An agree triage prioritization process consistent across the district
- A future workforce plan
- A contribution to the facilities design
- A process to agree guidelines for treatment and management of urological conditions across the SDHB
  - Within the specialist service
  - Across the hospital and primary care providers using HealthPathways

Content of Review
The reviewers will be asked to consider the following matters, seek information on them (in addition to that provided) and the performance of:-
- The triage process
- The prioritisation process
- Management of patients with suspected cancer
- Theatre booking and usage
- Outpatient bookings and appointment management
- Surveillance and follow up of cancer patients
- Process to create timely discharge summaries, clinic letters and operation records
- Mortality and Morbidity review
- Training of RMOs
- Training of Advanced Trainees
- Rostering of SMOs on sites and across the district
- Appropriate use of CME
- Leave planning
- Internal relationships and behaviour of SMOs
- Integration with Nursing and Allied Health Practitioners
- Integration with cancer and imaging services
- Integration with Primary Care Services
- Clinical Leadership within Urology and the Surgical Directorate

Proposed Reviewers
The SDHB will propose reviewers and consult with the Urologists before making a final decision.

Timeframe for review
The SDHB will agree a reasonable time for completion of the review – this is expected to be within the order of 8 weeks.

Report process
The reviewers will be provided with a set of information relevant to the review and further information upon their request.

The reviewers will visit both sites and interview all parties they deem relevant including;
- Urologists
- Clinical Leaders of Radiation and Medical Oncology
- Medical Director of Surgery
- Nurses including specialist Nurses and Nursing Leadership
- General Manager of Surgical Services
- Service Manager
- Allied Health Practitioners
- Patient representatives if available and relevant

The reviewers will be provided with admin and clerical support, which will cover:
- Note taking during interviews and discussions between the reviewers
- Venues
- Catering
- Making appointments
- Communication between the reviewers, the Urology Service and the SDHB
- Other as necessary

Process of producing the report and recommendations
The reviewers will produce a draft report, which will be circulated to all participants in the process for a review of accuracy.

The final draft will then be submitted to the nominated person in the SDHB who will provide final feedback to the reviewers.

The reviewers will then produce a final version with recommendations.

Commitment of the Southern DHB in respect of recommendations
The SDHB will consider the recommendations and take all reasonable and practical steps to either implement them or make it clear where recommendations are not possible or impractical.

Confidentiality and privacy:
People interviewed in the process will not be named in the report but their role may be included where it is necessary for clarity.

Costs
The SDHB will agree remuneration and/or cover of costs for the reviewers.
Appendix 2   Qualitative and Quantitative Information Request

The Review team requested the following documentation from Southern DHB (by 26 May 2017) to help in their preparation for the meeting. Where this information is currently site-specific both sets of documentation should be provided:

1. Community HealthPathways
2. Triage process and protocols
3. Management protocols for patients with suspected cancer
4. Theatre data
   o booking schedules from 1 July 2016 to 31 May 2017, including cancelled theatres
   o Summary of theatre utilisation for urology
   o Summary of any volumes of outsourcing/insourcing
   o Summary of adhoc / additional lists that have been required to achieve volumes
5. Summary of Outpatient bookings, booking schedules and appointment management processes
6. FSA: Follow Up ratios, by site and practitioner
7. ESPI 1, 2, 5: volumes and compliance summary from 1 July 2016 to 30 April 2017 (and an indicative performance to 31 May 2017 if available)
8. Follow up management protocols for patients
9. Surveillance and follow up of cancer patients: protocols and screenshot of any surveillance database used
10. Templates: discharge summaries, clinic letters and operation records
11. Mortality and Morbidity review: templates, examples
12. Training programme outline: RMOs, Advanced Trainees
13. Summary of rostering of SMOs on sites and across the district, 1 July 2016 to 31 May 2017
14. Summary of CME/Professional Development by SMO and Nurse, 1 July 2016 to 31 May 2017
15. Leave planning process, and summary of conformance
16. Waiting times for imaging services by site: Ultrasound, X-Ray, CT, MRI.

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<td>Preadmission Clinics: requirements, investigation, Informed Consent</td>
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<td>CNS Monthly Report</td>
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Information Provided

<table>
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<td>Community HealthPathways</td>
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<td>Management protocols for patients with suspected cancer</td>
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<td>Clinic data</td>
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<td>Theatre data</td>
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<tr>
<td>Consultant schedule</td>
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<td>ESPI 1, 2 &amp; 5 performance, procedures + follow-ups (by site, team)</td>
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<td>Urology discharges, by site</td>
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<td>Outsourced discharges, by site</td>
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<td>Weekly Costweight Summary cumulative against target, by site</td>
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<td>Discharge documentation</td>
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<tr>
<td>GU MDM</td>
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<tr>
<td>Urology on-call roster, by site</td>
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<td>Professional development record [CNS]</td>
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<td>Management of planned leave</td>
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<tr>
<td>Department Structure Chart</td>
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<td>Complaints</td>
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</tbody>
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The review committee also considered:

- SMO MECA
- RACS 2013 *Appropriate Working Hours for Surgical Training in Australia and New Zealand*
- RACS 2014 *Access to Elective Surgery*
- RACS 2017 *Clinical Governance Frameworks*
- NZMC 2008 *Safe Practice in an Environment of Resource Limitation*
- NZMC 2016 *Good Medical Practice Statement*
Appendix 3 removed as per terms of reference to protect the identity of persons.
Appendix 4  

Overview of Nurses Role

This information has been provided by Mrs Rosemary Benfield, nursing member of the review committee.

OVERVIEW OF NURSES ROLE

Outpatients

- Organise outpatients clinic
- Organise pre clinic diagnostics
- Organise minor procedures
- Triage referrals
- Assist with minor procedures on clinic day
- Assist with follow up arrangement

Inpatients

- Review theatre list, aware of surgeon/patient mix
- Organise preadmission clinic
- Occasionally attend theatre
- Post op ward round
- Daily ward round for inpatients
- Resource for surgical nurses
- Review patient prior to discharge
- Organise post op follow up

Other

- Day to day phone calls, enquiries, advice.
- Pick up and follow up laboratory/radiology results.
- Pick up and triaging of referrals (including ED referrals). Appropriate investigations requested at time of triage. Referral letters are triaged within a week
- Maintaining awareness of waiting list numbers, priorities and compliance.
- Notification to Manager and/or urologists of any actual/potential problems, complaints, re-admissions etc.
- Documentation, (letters, reports, results etc) sent to medical records in a timely manner.
- Clearing of OPD rooms and minor ops theatre after clinic.
- Surgical round day after theatre.
- Post void residuals requested by ward staff.
- Ensure appropriate follow up has been arranged post outpatient clinic.
- Maintenance of accurate and timely records on profile.
- Urologist clinic (includes sending list of patients to be booked to Central Booking Unit (CBU) with appointment times, posting out letters with appropriate blood/radiology request forms and procedure information. Preparation of patient charts prior to clinic. Set up of OPD rooms and minor ops theatre prior to clinic).
- Post clinic phone calls as necessary, e.g. Post botox, MSUs etc.
- Follow up phone calls to all DNAs and cancellations to discuss re-scheduling.
- Follow up of clinic and surgical histology reports and other investigations. Notification of results to patient, GP, urologist. Rebook clinic if necessary, discharge to GP if appropriate with letter.
- Liaison with ward medical and nursing staff on daily basis while surgical patients remain in hospital. Daily update to urologist.
- Flow and Residual clinic x 1 per month. (includes sending list of patients to be booked to CBU, posting out letters, seeing patients, inputting data into patient management system)
- Follow up clinic on the same day as the urologist clinic, (those patients who potentially may require some urologist input on the day).
- Maintenance of prostate and renal databases.
- 1 week post-op follow up phone calls.
- Liaison with MMT and CBU to arrange ESWL list
- Preparation of draft surgical list each month. Once approved, notification to CBU, Theatre, Surgical ward and Day unit.
- Follow up and pre-op nurse clinics x 3 per month (includes sending list of patients to be booked to CBU, posting out letters with appropriate blood/radiology request forms, seeing patients and dictating letters to their GPs).
WORK FLOW

REFERRALS

- Booking for FSA (First Specialist Appointments)

Other Specialists  
GP  
Other  
Emergency Dept

Referral letter OR electronic (ERMS)

Letters sorted by central bookings and entered onto DBH system. Nurse collects referrals from central bookings for triaging. Once letter is triaged, send back to central bookings. Patients will go on the waitlist OR are pending to be triaged by urologist if a difficult referral. If referral is urgent, then the nurse decides what clinic is appropriate for the patient. If semi-urgent, nurse will decide and book across three months.

TRIAGING

- Performed 1 or 2 / week by Urology Nurse and will have one of the following outcomes.

<table>
<thead>
<tr>
<th>Referred back to GP</th>
<th>Referred to SMO clinic</th>
<th>Ordered diagnostics</th>
<th>Referred for minor procedure before SMO clinic</th>
</tr>
</thead>
</table>
| • Written response from urology nurse (use standardised decline letter)  
• Occasionally discuss with GP | • Triaged into urgent, semi urgent & planned  
• Patient contacted by mail  
• OPD clerical staff does mail out for upcoming clinic | • Diagnostics requirements identified & forms included in letter  
• If urgent diagnostics – take directly to Radiology  
• AIM IS TO HAVE ALL DIAGNOSTIC RESULTS REVIEWED & AVAILABLE FOR CLINIC | • Flow & Residuals  
• Decision made by Urology Nurse from the referral letter  
• OP clerk contacts patient  
• Urology nurse & OP clerk organise appt dates & times  
• Flow & Residuals done close to clinic day |
Appendix 5  Job Sizing Principles for Urology, Counties Manukau DHB

This information has been provided by Mr Andrew Lienert, Chairman of the Review Committee.

Aim
To generate principles of what constitutes a balanced job plan and reasonable job sizing calculation for urologists at CMDHB.

Balanced job plan
A balanced job plan should have:
1. approximately 1:1 clinic : theatre list ratio. This may vary a little between clinicians depending on sub-specialisation interests but at most should be 0.75:1 – 1.25:1
2. adequate non-clinical time; suggested as 30% in the MECA
3. ability to attend MDM, audit, and other meetings
4. on-call time allowance if urologist participates on the on-call roster; currently this is set at 3 hours.

Calculating Job Size
To calculate a job size the following assumptions are made:
1. theatre lists are 5 hours per half day / 10 hours per full day; that is 4 hours of operating and 1 hour to see patients pre and post-op
2. clinics are 4 hours per half day.
   a. Generally it would be expected that a urologist would see 12 patients in a half day clinic but variation may occur dependent on case mix
   b. FSA: follow-ups should be around 1:1.5; there will be variability based on subspeciality etc
3. ESWL is considered a theatre list
4. Urodynamics / TRUS biopsy / flexible cystoscopy is considered a clinic
5. MDM on Wednesday morning is a clinical meeting and goes for 2 hours
6. Post-operative ward rounds are expected as we are a consultant led service. These will be 1 hour clinical time per round and generally a clinician would be remunerated for 3 days of ward rounds after an all day list and 2 hours after a half day list. Saturday ward rounds may attract more time due to travel / hassle factor. Sunday round is done by acute consultant and this time is part of their on-call allowance.
   a. This applies to ward rounds after ADHB theatre lists
   b. Ward rounds after MSC lists will be performed by 'consultant of the day' and exact remuneration for this not determined
7. Non-clinical time:
The MECA states “The parties note that the Council of Medical Colleges of New Zealand endorses that these non-clinical or Section Four activities should make up at least 30% of the total job size, not counting the average hours worked on the after-hours on-call rosters.”
So for a 1.0 FTE urologist there is 37 hours of work + 3 hours on-call. 30% of 37 hours is about 12 hours. 10-12 hours should be the approximate amount for a 1.0 FTE
consultant. For those who are on less than 1.0 FTE then non-clinical can be approximated by taking the total hours worked and subtracting 3 hours for on-call then working out what 25-30% will be.

a. Non-clinical time has 3 components:
   i. time for personal study / research / reading; time for responding to emails, liaising with colleagues etc
   ii. time for audit, planning or departmental meetings, i.e. has a component of non-clinical duties within the DHB
   iii. time for GP teaching or other teaching, health advocacy, college positions; i.e. has a component beyond the DHB

b. Component ‘i’ would be similar for all urologists. This component from a practical point of view would mostly be done at home out of hours, e.g. emails need responding to in a timely manner so can’t be ‘rostered’ time; reading about an operation you are going to be performing can’t be done 5 days earlier, it needs to be the night before; journal clubs and GP teaching session often occur in evening

c. Components ‘ii’ and ‘iii’ are variable depending on how involved urologists are in planning / teaching etc. i.e. when job sizing is done we would need to justify how much time we should have for those.

8. GP grading is clinical activity. It is estimated that there is about 6 hours / week at CMDHB, which should be split between those consultants that do this activity.

9. Clinical directors are allocated additional time to perform that duty; in addition to usual non-clinical time allowance - 3 hours per week. (clause 48.2 section 5 in the MECA)

10. Travel between DHBs needs to be factored into job plans. This may either be by reducing clinic numbers / shortening lists or by adding it as time on the job plan.

What would a ‘normal’ 1.0 FTE urologist job look like each week?

1. all day operating list: 10 hours
2. 3 post-operative ward rounds: 3 hours
3. all day clinic: 8 hours
4. MDM clinical meeting: 2 hours
5. Other clinical activity: grading, ESWL, urodynamics, day surgery: 4 hours approximately.
6. On-call: 3 hours
7. Non-clinical time: 10-12 hours.

CMDHB has a 4 day working week at 10 hours / day so the structure would be like this:

Monday: 10 hours operating
Tuesday: 1 hour ward round + 8 hours clinic + 1 hour GP grading
Wednesday: 1 hour ward round + 2hours MDM meet + 4 hours ESWL / day surgery etc + 3 hours non-clinical
Thursday: 1 hour ward round + 4 hours non-clinical + half day off
Friday: day off
Additional 3 hours of non-clinical time is ‘category a’ time to be done out of hours.
Appendix 6 2016/17 Costweighted Discharges

Full year position

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<th>Site</th>
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<th>Costweights</th>
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</tr>
<tr>
<td></td>
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</table>

To 21/5/17 (provided to Review Committee at time of site visit)