

Provision of
out of hours
and emergency
urological care:
guiding
principles for
clinicians

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Foreword

The provision of out of hours and emergency urological care is an important and challenging issue for those of us involved in delivering it.

It became apparent that BAUS needed to look at the many complex and varied issues integral to the delivery of safe, appropriate and timely care to our increasingly elderly and complex patients within the challenging working environment of today's NHS. The problems are more noticeable in smaller units without a full complement of consultants and patchy or absent mid-grade urological cover.

We therefore gathered information on the current emergency urology service provision across the UK by asking for specific feedback from all BAUS members, via their Regional Representatives, and met in late 2018 with the aim of producing a document to assist in organising emergency UK urological care.

At the same time, Simon Harrison and the GIRFT team were looking at emergency care provision as part of the review of the totality of urological care in England and so it seemed natural and sensible to join forces to produce a document to address how this care might be organised and delivered most effectively. There has been close co-operation and collaboration between BAUS and GIRFT which, I feel, has resulted in something much stronger than by the two organisations working separately. I am grateful to Simon for this.

There is obviously a huge variation in the geography and size of units, working patterns and practices in how out of hours care is organised. A "one size fits all" solution would be impractical and this is not what is suggested. It is hoped, however, that this document provides clinicians with some guiding principles, possible solutions and that it will encourage discussion not only within individual departments, but also between them.

I would like to thank all who have contributed to this work, in particular BAUS Regional Representatives, Council, Trustees, and especially Matt Hayes, Simon Williams and Sri Sriprasad for their help in writing the first draft and several subsequent iterations. I hope that this document will help to ensure sustainable, safe, compassionate, efficient and cost-effective emergency care into the future.



Duncan Summerton

President, BAUS

Statement of Support

The publication of BAUS recommendations for the provision of urological care to patients who present as emergencies is an important milestone in the journey that has seen emergency urological services move into the limelight, having been overshadowed by other priorities, such as the development of greater subspecialisation. In doing so, BAUS is fully in tune with its primary objective “to promote the highest standard in the practice of Urology for the benefit of patients”.

The GIRFT National Report, published in July 2018, included a number of recommendations in relation to emergency urology care; they are summarised in the early paragraphs of this document. It is encouraging to find that BAUS is fully supportive of a direction of travel that sees more “hands-on” consultant involvement in the care of emergency patient. From a patient’s perspective, the personal contact with a senior clinician is a source of considerable reassurance, particularly if there is continuity of that care. BAUS is also supporting working arrangements that facilitate such continuity.

However, this set of BAUS recommendations rightly emphasises that improvements in the quality and cost-effectiveness of care for emergency urology patients is dependent on Trusts working with clinicians in order to develop new pathways of care. Optimised care can only be delivered if the necessary supporting infrastructure is present, including timely access to imaging investigations and properly equipped emergency urology operating theatres.

Importantly, this document also signposts issues that remain work-in-progress. There is an urgent need to develop models of care that ensure that consultants who don’t have the benefit of a tier of middle-grade urology cover at night and at weekends, are supported in a way which avoids them providing out of hours care which could be delivered by the generic surgical team that is on-call, or by other members of the hospital’s out of hours team. Secondly, there is a need to look at the way in which patients who require complex emergency urological surgery are able to access such care, given that not all consultant urologists will be able to perform this type of surgery due to their lack of day to day involvement in open or reconstructive operations. The commitment that BAUS makes in this document to look at this issue in the near future is important.



Simon Harrison

Getting It Right First Time Clinical Lead for Urology

Introduction

The provision of out of hours and emergency (OOH/E) urological services has become increasingly challenging in volume, intensity and complexity in recent years - approximately 20-25% of all acute surgical hospital admissions are accounted for by urological emergencies¹.

This has arisen for a multiplicity of reasons including:

- Rising population demand and demographics
- Recruitment and retention pressures
- Workforce planning
- Increasing sub-specialisation
- Reduction in the availability of middle grade support
- Developments in specialist urological training

BAUS published 'A Guide to Job Planning for Consultant Urologists' in 2016¹ which helpfully addresses some specific issues in regard to OOH/E working – consultant urologists may wish to avail themselves of this when embarking on the job planning process within their own organisations.

The recent (2018) publication of 'Urology: GIRFT programme national report'² (<https://gettingitrightfirsttime.co.uk/wp-content/uploads/2018/07/GIRFT-Urology.pdf>) drew attention to a number of recommendations, several of which are pertinent to OOH/E service provision. It is suggested that NHS provider Trusts should:

- Provide consultant-delivered emergency urology care in every trust by reducing elective commitments for consultants on call.
- Review workloads of on-call consultants to ensure the sustainability of on-call arrangements.
- Ensure high-quality emergency urological care is available in all areas, seven days a week, by focusing available resources at weekends on a smaller number of departments, while allowing some departments to operate on a five-day basis.
- Review the approach to providing care for patients who require urgent surgery for urinary tract trauma and related conditions.

- Establish [urology area networks](#) (UANs), comprising several urology departments which would provide comprehensive coverage of urological services, beyond existing network arrangements, to optimise quality and efficiency.

In response to these challenges many UK urology departments are seeking further, more detailed guidance to enable them to plan OOH/E service developments. The size, configuration and clinical practice of urology departments vary significantly across the UK, making a 'one size fits all' solution impractical. It is unlikely that a smaller or more remote clinical service will be able to put in place the same measures to ensure resilience as a large teaching hospital in an urban environment.

Smaller, geographically remote urology departments have different requirements for on-call arrangements, including:

- Cross-cover by non-urologists, which should only be provided by clinicians who have received specific training in the management of urological emergencies. This could be put in place through a training course, run nationally, under the aegis of BAUS.
- Clear arrangements for provision of urology advice for on-call non-urologists. There should be a named urologist available for discussion of such cases. Urologists available for such advice provision must have readily accessible remote access for viewing imaging and investigation results.

This document is the result of feedback sought from BAUS members through their Regional Council Representatives. It is hoped it will provide clinicians with some guiding principles not only to encourage discussion within individual departments but also between them. In so doing it is the expectation of BAUS that departments will thereby ensure sustainable, safe, compassionate, efficient and cost-effective emergency care into the future.

1 On call rota

In many units, experienced non-medical staff, such as advanced care practitioners (ACPs) or Clinical Nurse Specialists (CNSs) assist in the management of urological emergencies. Emergency admissions are avoided by these members of the team who resolve mechanical problems with catheters and nephrostomies as well as dealing with other non-complex urological issues.

BAUS supports the recommendation that all other emergency surgical admissions should be discussed with the responsible consultant urologist within 12 hours of admission³. Where practical, BAUS continues to recommend a daily consultant-supervised ward round/review, 7 days a week, to support ongoing decision making and patient care¹. BAUS expects that all patients admitted as an emergency, or requiring emergency specialist urology assessment, will be seen by the on-call consultant urologist within 24 hours, 7 days a week¹.

Many urology departments now operate a 'consultant of the week/day' (COW/COD) model whereby elective work is significantly reduced to allow this pattern of working. Such a model is only likely to be feasible in units configured to allow a 1 in 8 or less frequency of COW/COD activity.

BAUS would strongly encourage smaller units to work in collaboration with other nearby urology departments within their [urology area network](#) to move towards this model of care where possible. It would not be anticipated that such arrangements would necessitate formal commissioner approval but BAUS would encourage appropriate dialogue with Clinical Commissioning Groups (CCGs) where necessary.

Urologists working in smaller more isolated units should continue to work closely with their general surgical colleagues where feasible and appropriate.

It is accepted that the co-location of other clinical services (critical care, colorectal surgery, obstetrics and gynaecology, interventional radiology etc) will need to be taken into account when considering closer working/merger of departments. Such planning will need to incorporate discussions with all appropriate stakeholders at an early stage, including agencies such as ambulance services where patient transfers will be affected.

Specified arrangements will need to be established for the provision of supporting services, including laboratory, radiology, interventional radiology, paediatric anaesthesia, critical care and specialist (tertiary) urological care. BAUS strongly encourages urologists to use their local GIRFT reports in evidence for this purpose.

As a consequence of a trend towards greater sub-specialisation in UK practice, some consultants are less confident to provide considered opinion and surgical expertise in certain rarer emergency conditions such as iatrogenic ureteric injury, trauma nephrectomy or the complications of pelvic surgery. Members of the developing GIRFT urology area networks will need to prioritise the development of appropriate mechanisms to deliver such care across each network.

Urologists who attend a hospital emergency after midnight should not be expected to attend for regular elective work on the following morning. On the

rare occasion that the consultant has to work through the night he/she should not be expected to work the following day¹.

Consultant job plans should take account of both predictable (e.g. daily and weekend ward rounds) and unpredictable (e.g. recall to hospital) activity by consensual departmental negotiation, on an annualised basis where appropriate¹.

2 On call availability supplement

As set out in 'A Guide to Job Planning for Consultant Urologists', all job plans describing an OOH/E commitment will include an appropriate combination of predictable and unpredictable PA activity.

Category A on call availability supplement should apply to all urologists providing NHS OOH/E services.

The value of the availability supplement is dependent on rota frequency as indicated below (% = percentage of full time basic salary for category A duties).

1 in 1 to 1 in 4	8%
1 in 5 to 1 in 8	5%
1 in 9 or less	3%

Consultants employed on a less-than-full-time basis, whose contribution when on call is the same as that of full time consultants on the same rota, should receive the appropriate percentage of the equivalent full-time salary.

There are few, if any, urological emergencies where the presence of a resident consultant urologist will improve patient outcomes. Non-resident urological consultant OOH/E cover is the norm in the UK and it is unlikely that resident consultant cover could ever be justified on a risk benefit basis.

Whilst some urologists may wish to provide on call availability for the entirety of their careers, BAUS would support those wishing to withdraw from on call rotas from the age of 60 unless extenuating circumstances dictate otherwise.

3 Elective working in COW/COD

BAUS recommends that consultants should be freed up from all time-critical elective activity when providing daytime emergency work. Pressures to reduce hospital admissions are dependent on high level decision making, increasingly

at the 'front door' of the hospital. This is not possible if on-call consultants are unable to leave a pre-existing clinical commitment. There is no doubt that patient pathways and onward transfer/discharge are enhanced when overseen/directed by senior clinicians.

Departments with low numbers of urological emergencies will need to ensure that the on-call urologist is providing an appropriate overall volume of work while on-call, necessitating a more flexible approach to job planning.

On call work provides essential training opportunities for trainees which are also maximised by readily available consultant oversight.

4 Middle grade cover

Currently only the largest (usually teaching) hospitals are able to provide a fully staffed 'middle grade' rota. The majority of urology departments run services configured around a variety of 'partial cover' options especially overnight and at weekends.

BAUS takes the view that the management of emergencies is a critical component of specialist training in any craft surgical specialty, and fully endorses the requirements of the SAC in Urology in respect of required clinical competencies in this area. Whilst it is acknowledged that significant emergency care experience can be obtained 'in hours' where configured and supported appropriately, it is also recognised that with reduced working hours, and a potentially foreshortened training period, OOH experience remains of significant training value.

On call consultant urologists should be supported either by CT/ST level urology trainees or Trust grade doctors, with additional support by appropriately trained and accredited advanced clinical practitioners where necessary. The latter are a common and important component of many 'hospital at night' models. Such 'middle grade' support, however provided, will require the acquisition of a number of specific competencies. The definition of and training requirement for these will require appropriate oversight.

Hospitals in some regions have actively promoted the appointment and retention of middle grade doctors and fellows by supporting them in pursuing higher degrees and diplomas on a day/block release basis. This approach to the personal development of current and future urological trainees is to be encouraged.

5 Paediatric urological emergencies

Suspected acute testicular torsion in children is a time-critical emergency, necessitating potentially organ-saving surgery. It is clear that, to be timely, this is best delivered as locally as possible. Inter-hospital transfers should not usually be considered and should only take place when the extra transfer time is very short and can be justified - for example, transfer to a hospital in the same city with paediatric surgical expertise and an available theatre. If such transfers do take place as part of a locally agreed practice, the time from the decision to surgically explore to arrival in the paediatric surgical unit and outcomes should be audited.

It is the view of BAUS that urologists who are required to provide such surgery should be fully supported in pursuing any appropriate personal development needs that are required to fulfil this obligation. On call responsibilities should be shared with general surgical colleagues in the best interests of patients, as agreed by the FSSA and RCS in 2015^{4,5}.

Surgery in the under 5's may necessitate referral to a specialist centre depending on local agreement – urologists should seek the advice of their employing Trust's Medical Director where uncertainty exists regarding agreed pathways of care, and have an agreement in place in anticipation of such a situation arising. It is expected that, although they will vary according to geography, such arrangements will be made in order to ensure patient outcomes are not compromised by delays caused by these patient transfers.

6 Interventional radiology (IR) service provision

Not uncommonly the OOH/E availability of IR expertise is limited by service capacity constraints, particularly in smaller units. In addition, some urologists report that their ability to accept inter-hospital referrals may be limited by contractual constraints between Trusts.

Clinical lead urologists should work with their BAUS regional representative and Trusts to ensure across their urology area networks that priority is given to developing wider networks of IR provision, including appropriate contractual and governance relationships between providers. Any patients requiring time-critical IR procedures should be transferred, if fit and stable enough, to the nearest provider of such services following locally agreed care pathways in order to reduce the risk of delays impacting on outcome.

7 Theatre access

Many urologists report difficulty in readily accessing operating theatres (including CEPOD theatres) for OOH/E work, a situation exacerbated when the on call urologist is also committed to other elective work during COW/COD activity.

BAUS advises that clinical leads for urology ensure regular close working with operational management and clinical colleagues in prioritising emergency surgical interventions, for example with the provision of dedicated daily early morning urology slots in emergency theatres.

Some hospitals will have established sessional theatre capacity set aside for urological emergencies for use by the on-call urologist which can, if necessary, be back-filled with urgent elective patients to ensure appropriate theatre utilisation.

BAUS recommends that consultants should be freed up from elective activity when providing daytime emergency work in order to maximise their ability to access emergency theatre capacity at any opportunity.

8 Maintaining skills in emergency surgery

It is acknowledged that issues remain in relation to the provision of complex urological emergency surgery by consultants for whom the required surgical skill set may be less familiar (including trauma, complications of pelvic surgery etc).

A different approach to the future provision of CPD training opportunities in emergency surgery is required to support consultant and trainee urological surgeons in this regard. BAUS will seek to address this in consultation with its membership in the near future.

References

1. *'A guide to job planning for consultant urologists,'* BAUS, 2016.
2. *'Urology: GIRFT programme national report,'* GIRFT, 2018.
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4. *'Position statement on the management of emergency surgery at the general, paediatric and urological interface,'* ASGBI, BAPS, BAUS, SACs in General Surgery, Paediatric Surgery & Urology, Federation of Surgical Specialty Associations, 2015.
5. *'Standards for non-specialist emergency surgical care of children,'* Royal College of Surgeons of England (on behalf of the Children's Surgical Forum), 2015.

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