NHS

Primary Care Contracting

Providing care for patients with urological conditions: guidance and resources for commissioners

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Authorship

1. This guidance was developed by members of the Care Closer to Home Urology Sub-group. Advice and help was given by others as acknowledged in **Appendix 1**.

Foreword

2. Due to increases in the male population over 50, and increasing medicalisation of urology, a large proportion of referrals into Secondary Care do not 'convert' to inpatient or day case operative procedures, giving the opportunity to redesign some urological pathways and services.
3. The White Paper, 'Our Health, our care our say: a new direction for community services' stated that the Department of Health would work with six specialities (ENT, gynaecology, orthopaedics, dermatology, urology and general surgery) in demonstration sites to 'define clinically safe pathways that provide the right care, in the right setting, with the right equipment, performed by the appropriately skilled person'.
4. The urology sub group identified examples of existing innovative practice in delivering care in more convenient settings for patients. An independent evaluation of this good practice was carried out by the National Primary Care Research and Development Centre at Manchester University, providing an insight into the experiences of the 30 demonstration sites, including the 5 urology sites. The sub-group learnt more about the demonstration sites and about shifting care more generally in their specialities and this work has culminated in the production of the 'Shifting Care Closer to Home Demonstration Sites - report of the speciality sub-group's report' [DH, 2007].
5. The report included a number of key recommendations including:
   - New services may be fragile and therefore initially subject to intense clinical scrutiny.
   - Involvement of all stakeholders, including the local department of urology, is essential.
   - The need for greater clinical input from specialty teams to inform the commissioning cycle.

This guide has been produced as a result of these recommendations and is intended for both commissioners and clinicians. It aims to facilitate the process of providing appropriate, safe and sustainable, cost-effective care closer to home, so that urology services are delivered 'in the right setting, with the right equipment, performed by the appropriately skilled person'.

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Introduction

6. This resource builds on a report, 'Shifting Care Closer to Home demonstration sites - report of the speciality sub-groups' (DH, 2007). The urology report contained a number of recommendations, including:

- Providers should start planning how to make best use of those urology CCT holders who have recently completed their training. They will be equipped to work both in the community and the acute sector, and could form the backbone of a new seamless urology service.
- New services may be fragile and initially subject to intense clinical scrutiny. Involvement of all stakeholders, including the local department of urology, is essential.
- Service models must be tailored to different settings, for example urban and rural, and to the resources (in the form of facilities, staff and service leads) available.
- Services must make use of local strengths and expertise, involve the local urology department and be 'seamless' across the sectors.
- Providers should appoint staff who can work across the whole health economy.
- Systems should be put in place to enable telephone/email follow-up where appropriate.
- Hospital trusts should encourage their staff to provide training, mentoring and assessment. This will not always be comfortable, particularly where trust income is falling as a result of services moving into the community. However, it will benefit both patients and the service as a whole.

7. This resource has been developed in response to the recommendations from this report.

Aim

8. This guidance is aimed at facilitating the process of providing appropriate, safe and sustainable cost effective care closer to home.

9. This resource aims to provide guidance and information for commissioners to consider and use when commissioning services for people with urological conditions, in the community. It is also intended to provide information for clinicians and others who are exploring providing urology services in the community.

The Case for Change

10. The specialty of urology predominantly covers the care of urogenital conditions involving diseases of the kidneys, bladder, prostate, penis, testes and scrotum. Bladder dysfunction, male and female continence surgery and paediatric peno-scrotal conditions make up the rest.

11. The proportion of the male population over 50 years has risen by 20% over the last 20 years and referrals to secondary care have been rising at 5-10% per year. In addition there has been an increasing 'medicalisation' of urology as the pharmacology of the urinary tract has become better understood with the increasing availability and ever improving drug armamentarium. As a result, over 80% of referrals into secondary care do not 'convert' to inpatient or daycase operative procedures.

12. Therefore there is an opportunity to redesign some urological pathways and services and this has been recognised in the published 18 week pathways [haematuria, incontinence, scrotal lumps and vasectomy]. Other areas as discussed later are open for service redesign.

Principles

13. In creating the changed delivery of a proportion of urological care we believe there are some important principles that should be observed in commissioning these new pathways:

- No specialist practitioner should work in isolation:
  - The implication of this is that a specialist [however defined] working in primary care must be part of, or affiliated to, the local Urology team for governance purposes [appraisal, CPD, recertification and revalidation].
- The leader of the Urology team must be a certificated Urologist [CCT or CESR holder] and on the specialist register of the GMC.
- GPwSI and extended role [nurse] practitioners [AHP] etc providing expert Urological care in the primary sector must be affiliated to the Urological team and have achieved proven urological competencies in their areas of practice.
- The Urological service in primary care must be Improving Outcomes Guidance (IOG) compliant (Improving Outcomes in Urological Cancers - The Manual (NICE 2002)).

14. A possible undesirable outcome of this move to provide care more conveniently for patients is that the new services may be under-resourced and poorly thought through. As a result they may be unsustainable and lead to a fragmented service with expensive duplication, poor governance, little training and service development.

Principles of commissioning

15. Effective commissioning makes the best use of allocated resources to:

- Improve health and well-being.
- Reduce health inequalities.
- Reduce social exclusion.
- Secure access to a comprehensive range of services.
- Improve the quality, effectiveness and efficiency of services.
- Increase choice for patients.
- Ensure a better experience of care through greater responsiveness to people's needs.

16. This guide and resource builds on other commissioning guidance available, which should be considered alongside it, such as The Commissioning Cycle [Health reform in England - update and commissioning framework: annex - the commissioning framework, DH, 2006] and World Class Commissioning: vision [DH, 2007]. In addition, The NHS Institute for Innovation and Improvement has refreshed its suite of approaches designed to help PCTs as commissioners to meet the challenges of shifting care, which include:

- **Prioritising Commissioning Opportunities** is aimed at strategic decision making and provides a guide to prioritising opportunities.
- **Project Delivery for Commissioners** is a guide to the steps to success in project management in pathway redesign.
- **Commissioning Patient Pathways Guide** takes a broad overview of commissioning for patient pathways exploring the commissioning functions and the activities involved in pathway redesign through a simple matrix with hints and tips.

17. They are all available through the website at *www.institute.nhs.uk/commissioning*

18. **The Opportunity Locator** helps PCTs analyse their local data to identify millions of pounds worth of activity currently undertaken in an acute setting (that could be delivered in the community, highlighting those areas likely to bring the greatest benefit to patients) and this is available at *www.institute.nhs.uk/opportunitylocator*.

19. The commissioning cycle is used as the framework for commissioners to commission urology services for their population. The 'Shifting Care Closer to Home demonstration sites - report of the speciality sub-groups' [DH, 2007] recommended that service models must be tailored to different settings. Commissioners should understand and use the drivers available to them to commission services that allow patients to choose where and how they access urology services.

Financial Flows

20. The aim of redesigning clinical pathways and services is to provide a more convenient and timely service closer to home for the patient. To make this cost effective it is necessary to have a clear understanding of the current patient pathways. This must include an accurate appreciation of what is being 'bought' for a current patient/hospital episode of care; an example would be the ultrasound examinations that occur in the urology clinic that are not recorded. In relocating the service in the community the provision of ultrasound will need to be funded. While the competition of willing providers may drive down costs in these redesigned services and be more convenient for patients, it is unlikely that the overall costs will be markedly cheaper.

Commissioning Services for Patients with Common Urological Diseases - Using the Commissioning Cycle

i) Seeking Patient and Public Views

21. It is essential that patients and local people are involved in every step of the commissioning process, from developing any commissioning proposal, through to selecting any new provider. The first key question for any commissioner is:

- How, and in what ways can patients lead and be part of commissioning urology services?

22. **Appendix 2** provides some information to help commissioners answer this question. The National Centre for Involvement is an excellent source of information and resources to guide commissioners on how to involve patients and the public successfully. More information is available at: *www.nhscentreforinvolvement.nhs.uk*.

23. One active way to involve patients and the public is to invite them to be part of a local urological stakeholder group which should also include all local urological providers from primary, community and secondary care.

24. This group should be led by a commissioner and should be responsible for assisting the commissioner to review and commission urological services providing the full range of clinical expertise from prevention and self care through the surgical intervention and follow up care. **Appendix 2** provides information on setting up a stakeholder group and sets out general Terms of Reference.

ii) Assess Needs

- What are the needs of the local health community in relation to urological conditions?

25. Commissioners must assess local need to ensure future services are commissioned to improve health outcomes. The National Institute for Clinical Excellence (NICE) has published a five step process to completing a health needs assessment, which complements the commissioning cycle, and is replicable to any commissioning process, available at: *www.nice.org.uk*.

26. Working with the public health team, commissioners/ the stakeholder group need to build up a picture of the local demographics; geographical mapping; age, gender and ethnic distribution, as well as levels/areas of deprivation and transport links. In assessing the need commissioners should then identify the following areas of need.

27. **Health need** - obtain information about incidence and prevalence of urological conditions locally and nationally. As a minimum, commissioners/the stakeholder group should obtain information on each of these services depending on local priorities and other needs as appropriate:

- Haematuria.
- Scrotal swellings.
- Incontinence.
- Erectile dysfunction.
- Prostatic disease (benign enlargement and lower urinary tract symptoms) (LUTS).
- Prostate Specific Antigen (PSA) monitoring and follow up.

28. Consider local health needs and whether promotion of male health would be beneficial, bearing in mind the effect of obesity, diabetes, smoking and cardiac disease, all of which influence the prevalence and severity of urological disease in the locality.

29. Possible data sources include:

Public Health Observatories;
QOF/QMAS;
Practice level estimates;
Hospital Episode Statistics (HES);
Dr Foster Intelligence;
Prescribing (PACT) data;
Audits of local continence services;
Secondary Uses Services (SUS);
NICE commissioning urology toolkit.

30. The data can be analysed by PBC cluster, GP practice, ICD 10, HRG codes or by provider.

31. In reviewing the data, commissioners should identify the specific health needs of children, adolescents and the elderly.

32. When re-designing pathways, commissioners/the stakeholder group also need to be aware of the nationally agreed urological standards and guidance for urological cancers (Improving Outcomes Guidance (IOG)) bearing in mind the risk of malignancy.

33. Using data from the sources above commissioners/the stakeholder group will be able to benchmark against similar health communities for:

- Primary care consultations for urological conditions.
- Referral rates for continence assessment and services.
- Suspected urological cancer referrals.
- Referral rates for specialist assessment.
- Reasons for referral (segment into children, adult and the elderly).
- Routine/urgent case-mix.
- Outcome of referral to specialist services.
- Length of stay, 18 week referral to treatment times and New:FU ratios.

34. Reviewing activity data will only provide information on what work is being done rather than the demand. Action on Urology and the NHS Institute Demand & Capacity Toolkits are both widely available resources providing detailed information on how to complete a service level mapping, and demand and activity audit.

35. The stakeholder group should consider completing simple scoping exercises to have a greater understanding of needs of the health community for both the generalist and specialist urological services.

36. **Training and education need** - Commissioners/the stakeholder group need to consider the needs of the local health community including prevention, self care, and expert patient programmes, generalist and specialist training and education needs of health care professionals.

37. Commissioners/the stakeholder group need to have mapped:

- What patient focused teaching and training is currently provided and by whom?
- What professional teaching and training is currently provided and by whom?
- How does this sit with the requirements within national guidance?
- What are the gaps or opportunities that need to be built into the commissioning specification?

iii) Review current service provision

38. **Appendix 3** shows examples of information that it might be useful to collect to aid the review process and a useful checklist for doing so.

39. Start by identifying the current providers for these six areas of urological care. Relate this provision to the geography and the urological healthcare needs of the population and the transport facilities available.

- Haematuria.
- Scrotal swellings.
- Incontinence.
- Erectile dysfunction.
- Prostatic disease (benign enlargement and lower urinary tract symptoms) (LUTS).
- PSA monitoring and follow up.

40. Depending on priorities, assess where each part of the care pathway is delivered and by whom.

41. Make an inventory of the current workforce available across the sectors taking into account GPs, GP with a Specialist Interest (GPwSIs), Allied Health Professions (AHPs), ultrasonographers, community continence nurses, Department of Urology specialist urology nurses, urological trainees, trust specialist doctors and consultants and any willing providers in the private and state maintained sectors.

42. Separately assess the diagnostic imaging facilities available and see if there is currently adequate timely and accessible capacity. If additional ultrasound services are to be provided, are there trained operators available to deliver the service?

43. Explore what quality standards and measurements are available (these could be Patient Reported Outcome Measure (PROMS), Quality of Life (QoL) indicators and patient / public surveys). Enquire from as many sources as possible as to what works well and what is not so useful.

44. Critically review what urological care is provided outside the PCT locality and assess the necessity for this. Can it be and should it be 'repatriated'?

iv) Decide priorities

45. There will be national, regional and local 'directives' that will influence the shape of the commissioning and provision of urological care closer to home. Clearly NICE guidance will be considered by most to be "must do's". Currently those affecting urology cover urological cancer care (IOG guidance) [1], specifically the management of prostate cancer [2], multi-disciplinary incontinence care [3], commissioning toolkit guidance [4], the multiple sclerosis guidance which is an example of the multi-disciplinary care of the chronically sick [5]. The urgent referral guidance (two-week cancer pathway) defines the referral protocols into secondary care for urological cancer [6].
Please see table on next page for more information.

[1[YUN2]] Improving Outcomes in Urological cancer [NICE, 2002]
www.nice.org.uk/csguc

[2] Prostate cancer: diagnosis and treatment [NICE, 2008]
www.nice.org.uk/guidance/index.jsp?action=byID&o=11924

[3] Urinary Incontinence: the management of Urinary Incontinence in women [NICE, 2006]
www.nice.org.uk/guidance/index.jsp?action=byID&o=10996

[4] Urinary continence service commissioning tool [commissioners only - login required] [NICE]
www.nice.org.uk/usingguidance/commissioningguides/uiwomen/determininglocalservicelevels/CommissioningTool.jsp

[5] 2003/63 New guidelines for the NHS on the management of multiple sclerosis in primary and secondary care set to improve services for patients [NICE, 2003]
www.nice.org.uk/guidance/index.jsp?action=download&o=29204

[6] (Urological) Referral guidelines for suspected cancer [NICE, 2005] [pages 14-15]
www.nice.org.uk/nicemedia/pdf/CG027quickrefguide.pdf

46. Seek advice from PCT and SHA Departments of Public Health for their opinions of the priorities. Local stakeholders will have views about areas of the service that are important, and better 'shifted' as well as those that are underprovided.

47. In some areas there will be mechanisms for defining Low Priority Procedures and a joint PCT/Providers/GP committee for reviewing Service Provision and Clinical Effectiveness. These are valuable in deciding local priorities [further information at *www.westsussexpct.nhs.uk*]

48. It is important to understand that one of the key underlying principles of integrated pathways is that services should be defined by the needs of individual patients and the staff and equipment required, rather than by whether they are being delivered in the acute or community sectors.

v) Design Services

49. Consider which outcomes could be improved by better resourcing of prevention and education. Male Health services, including the reduction of smoking, obesity, and diabetes, are all beneficial.

50. Any new service is fragile and liable to intense clinical scrutiny. In prioritising which part of urological care is to be shifted closer to home, it is worthwhile starting with areas that have widespread stakeholder agreement, the availability of the appropriate 'governanced' workforce and diagnostic facilities.

51. The 18-week integrated pathways were designed to facilitate the patient's journey throughout the various stages of investigation and treatment. These covered haematuria, scrotal lumps, incontinence and vasectomy (available at *www.18weeks.nhs.uk/Content.aspx?path=/achieve-and-sustain/Commissioning-pathways/18-weeks-commissioning-pathways*). There are also pathways for incontinence and erectile dysfunction on the Map of Medicine (*www.mapofmedicine.com*). In the majority of areas, vasectomy services are now delivered solely in primary care.

52. In general terms the care of the patient should be seamless and clinically effective thereby producing the best cost effective outcomes for the benefit of the patient. These outcomes can be measured in terms of:

- Mortality.
- Morbidity.
- Quality of Life [QoL].
- Patient satisfaction.

53. The following principles for commissioning the overall urological service are likely to produce the best and most cost effective outcomes. This is likely to be particularly true for services shifted to closer home because of the risks of fragmentation, over-investigation, including duplication of investigative imaging, and invasive 'office' procedures. A common theme running through the report of the closer to home pilot sites was the danger that even good services were not sustainable due to practitioners working in relative isolation. As noted in the introduction, these principles are:

- No specialist practitioner should work in isolation.
  - The implication of this is that a specialist [however defined] working in primary care must be part of, or affiliated to, the local Urology team for governance purposes [appraisal, CPD, recertification etc].
- The leader of the Urology team must be a certificated Urologist [CCT or CESR holder] and on the specialist register of the GMC to provide clinical leadership and governance.
- GPwSI and extended role [nurse] practitioners [AHP] etc providing expert Urological care in the primary sector must be affiliated to the Urological team and have achieved proven urological competencies in their areas of practice.
- The Urological service in primary care must be Improving Outcomes Guidance (IOG) compliant (Improving Outcomes in Urological Cancers - The Manual (NICE 2002)).

54. It may be appropriate to commission a service level agreement [SLA] between the PCT and the local Urology team to support the monitoring, governance and training of GPwSI and AHPs providing specialist urological services in primary care.

55. As identified previously, there are six areas of high volume urological care that are suitable for shifting closer to home. These are explored in more detail below.

Haematuria

56. Patients presenting with haematuria [visible (frank) and invisible (microscopic)] are for the most part managed within the two-week IOG cancer pathways. If some part of this service is shifted for reasons of access the following are necessary:

- Ideally should be one stop.
- Include clinical assessment, imaging of urinary tract, & flexible cystoscopy.
- Provide immediate access to health care professional to discuss results of investigation and likely subsequent management plan.
- Have immediate access to the locality IOG cancer care pathways.
- Have immediate access to specialist urological imaging. The practicality and governance of this is important to reduce the risk of duplication of imaging because of the need to share the images via the Picture Archiving and Communications System (PACS) system for the Cancer Network specialist multi-disciplinary team meeting.

57. In reality, the referral pathways for frank haematuria are best left to secondary care because of the high risk of malignancy. Asymptomatic invisible / microscopic haematuria has a lower incidence of malignancy and could be considered for shifting more conveniently closer to home. If this re-design is to be considered, it probably needs to be co-located with other flexible endoscopy services due to the cost of equipment and decontamination facilities. The presence of asymptomatic invisible haematuria as a possible nephrological marker should be recognised in the pathway of care [18-week haematuria pathway, BAUS and Renal Association draft consensus statement 2008)

Flexible cystoscopy

58. The follow up of bladder cancer by flexible cystoscopy in patients with low risk of recurrence could also be done in this shifted service provided that the endoscopist is an extended member of the local Multi-Disciplinary Team (MDT) and the service subject to the appropriate governance. A checklist for flexible cystoscopy is given below:

Checklist	✔
Due to cost of flexi endoscopes and decontamination equipment and regulations, a shifted service is only viable when combined with endoscopy services of other specialties.	
Ideal arrangement is for specialist nurse practitioner working alongside urologist who is doing outpatient clinic, TRUS list or training daycase list.	
If covering urologist is not immediately available then there should be video recording available and urgent access to urology team for help and support.	
If cancer follow up flexible cystoscopies are planned in the community the endoscopist should be an extended member of the IOG multidisciplinary team and be IOG compliant.	

59. Guidance for the training and competencies of the urological endoscopist can be found in the North East Essex Community Urology Service Nurse Cystoscopy Training: NMC and Scope of Professional Practice Dec 2004. *www.innovationinurology.nhs.uk/pathways/renal_cancer/referral/colchester_cystoscopy/cystoscopy_training_guidelines.pdf* and the BAUS publication Nurse Cystoscopy (2000)

Scrotal lumps/pain

Background and Needs

60. Testicular and scrotal problems are common, typically comprising 10-15% of urology outpatient (OPD) referrals[1]. Whilst the vast majority of these are for benign disease, testicular cancer remains an underlying fear for patients and a diagnostic concern for clinicians. Consequently the majority of such referrals should be referred for diagnostic ultrasonography (US)[2].

61. In designing clinical pathways it is essential to ensure not only that testicular cancers are detected quickly but also that inappropriate referrals of benign disease do not overburden the two week cancer pathway[3]. The increasing transportability and accessibility of US can be used to mitigate this problem.

Priority of Service Provision

62. This is high, due to anxieties around the diagnosis of testicular cancer (incidence approx 5 per 100,000 men/year). US is the mandatory diagnostic investigation for intrascrotal masses[4]. Though very uncommon, pain may also be a presenting symptom of testicular cancer.

Service Design

63. This should be based on a patient centred pathway designed to the following criteria:

- Local access.
- Rapid access to accurate diagnostics.
- Safe, ie 100% diagnostic accuracy (to remove the risk of missed malignancy).
- Sufficiently resourced to sustain local demand.

64. The ultra-sound service may be provided by the ultra-sound community or the hospital urology department.

65. The performer of US must be trained to a minimum of 'Level 1' according to the British Association of Radiologists criteria[8] (*www.rcr.ac.uk/docs/radiology/pdf/ultrasound.pdf*). This may be a urologist, radiologist, ultrasonographer or GPwSI.

66. Ideally the service should be '1-stop' and provided by a GPSI/Urologist with Level 1 US training or a radiologist/ultrasonographer trained urologically to operate a clinical pathway algorithm. Further information on the sources used is available in the references.

Continence Services

67. Commissioning best practice continence services relies upon recognition of potential problems in current services such as:

- Lack of recognition by both patients and professionals of an unmet need.
- Poor access to services.
- Lack of appropriate expertise and diagnostic support, especially in primary care.
- Over reliance on pads.

68. Since 90% of continence problems can be managed without surgical intervention, access to continence services is best built up in primary care, either by primary care based clinicians and AHPs or through secondary care outreach clinics.

69. A comprehensive service should provide expertise in:

- Adult female and male continence.
- Paediatric and adolescent incontinence.
- Neuropathic diseases leading to incontinence.
- Geriatric incontinence.
- Psychiatric and mental disability incontinence.
- Faecal incontinence.

70. The service should ideally work as a multidisciplinary, cross-boundary team essentially encompassing the expertise of urologist, urogynaecologist, colo-proctologist, continence advisors, clinical nurse specialists and physiotherapists (Incontinence 2006 guidance, further information at NICE, *www.nice.org.uk/guidance/index.jsp?action=byID&o=10996*)

71. For adult urinary incontinence assessment the service should provide:

- Joint referral protocols agreed between primary care professionals and the pelvic floor dysfunction MDT.
- Access to primary care continence clinics (PCCCs).
- PCCC access to basic urodynamics.
- Joint referral protocols to urologists/urogynaecologists.
- Guidelines to separate incontinence pathways from prolapse referral pathways.
- Pathways compliant with the joint WHO/International Continence Society guidelines.
- Public/professional awareness campaigns.

72. Evidence exists from the community services provided in Manchester and Cambridge that 60 - 80% can be managed without referral into secondary care (Mr Tony Smith and Mr Ian Pearce - Manchester Royal Infirmary, BAUS Annual meeting 2006, Action on Urology peer review Continence services, Cambridge). *[www.innovationinurology.nhs.uk/pathways/continence/referral/addenbrookes_continence/peer_review.pdf]*

Erectile dysfunction

73. Most ED has been managed in the community by GPs. However, recent recognition that ED is an early marker for cardiovascular disease means that wherever the service is provided or a new service is commissioned, risk profiling is mandatory and referral pathways for appropriate cardiovascular investigation are provided. (*www.mapofmedicine.com*).

74. Pathways need to be formulated for the onward referral to the local specialist service, which may be situated away from the acute Trust, for those refractory to PDE-5 inhibitors and for those who have severe distress [NHS drug prescription]. Similarly, care pathways need to be identified and made overt for those cardiac and diabetic patients who also have ED.

Lower Urinary Tract Symptoms (LUTS)

75. The following describe the characteristics of a good LUTS service and should be incorporated in the commissioned pathways:

- Investigative pathways that acknowledge LUTS as a presenting symptom of both benign and malignant bladder and prostatic pathology.

- Access to flow rate and residual urine estimations including an assessment of renal risk.
- Availability of simple, video, and ambulatory urodynamics as per clinical indication.
- A detailed understanding of the physiology and pharmacology of bladder, urethral and prostatic function.
- Patient information and similar tools with specialist support to allow patients to make informed decisions on their management.
- An integrated approach that recognises the relationship between patient expectation, socio-economic circumstances and the available treatment options.

PSA Follow Up

76. The follow up of men with suspected or confirmed prostate cancer uses a significant proportion of specialist care within the acute sector. Different models exist to reduce this workload. Some are managed by urology specialist nurse-led telephone follow up from the acute trust. In some areas, PSA follow up has been developed as an enhanced service in primary care. More recently, there has been a move for the follow up to be devolved purely to primary care with locally developed individualised guidance governing the frequency of follow up and the thresholds for re-referral back to specialist urological care. Commissioners need to ensure that processes are in place to ensure that no patient slips through the net. Thought needs to be given as to the financing of these re-referrals. It is important that appropriate documentation is provided for the patients, and that they are involved in the planned protocol of their care. Because of the clinical risk of missing disease progression, the commissioned pathways need to include appropriate audit and safeguards.

Vasectomy

77. The clinical pathway for the local vasectomy service is laid out in the 18-week website: *www.pathwaysforhealth.org/xpath2007/xeditor/publisher.asp?dref=B154D1F324F54044AEC37D9BC587351E&d_name=&o_mode=0*.
The majority of this is now done in the community setting using the Li 'no scalpel' technique [Li SQ, Goldstein M, Zhu J, Huber D. The no-scalpel vasectomy. J Urol 1991; 145: 341-4.]. There will be occasions where difficulty is encountered and in these relatively rare situations the pathway needs to allow referral onwards for specialist urological help.

vi) Shaping the structure of supply

78. The majority of local departments of urology function as multi-disciplinary teams, with specialist urological nurses, cancer and research nurses, specialist urological physiotherapists, and stoma[YUN3] therapists, etc. If urological care is to be shifted into the community it is critical that this highly skilled workforce are utilised in the proposed care pathways.

The urological team typically consists of:

- Urologists of all types
- Trainees
- Specialist urological nurses
- Macmillan cancer nurses
- Research nurses
- District continence nurse/advisors and nurse consultants
- Practice nurses
- Physiotherapists
- GP and GPwSI
- Pharmacists wSI

79. The exact skill mix and location of the delivery of urological care will be dependent on the locality, be it urban, suburban or rural. Adequate support networks need to be designed to eliminate the risk of practitioners being in isolation and to ensure the service is sustainable should leave or unexpected sickness occurs. In utilising the workforce cost-effectively it is important that the skill and competence of the practitioner is appropriate for the task and location (e.g. 'the right care, in the right setting, with the right equipment, performed by the appropriately skilled person' [Our Health, our care, our say, DH, 2006]).
80. It is vital to assess the local diagnostic imaging facilities and see if there is currently adequate timely and accessible capacity. If additional ultrasound services are to be provided, there will need to be trained operators available to deliver the service. There is an opportunity here to facilitate and fund urology specific training for the appropriate personnel.

vii) Ensuring Appropriateness of Care - Managing Demand

81. In providing equity and ease of access to urological care, there is the likelihood that the demand will increase. There is good evidence that there is considerable unmet demand in continence services and almost certainly with regard to men's health. Clearly this needs to be borne in

mind by commissioners who will need to balance this increase in demand with the finance available and the potential cost savings of re-located services. As the exact relationship between demand and cost reduction is not known the commissioned service needs to be carefully monitored to answer this question over time.

viii) Informed Decision Making - Referrals / Choice

82. All providers of urological care, across both primary and secondary care sectors, need to provide a clear detailed directory of services to the PCT. This will enable these services to be known to the public and included on GP choice menus [Choose and Book]. This is important so that the patient is able to choose or be directed to the appropriate service for their individual need.

83. Underpinning all of this is information. It is fundamental to choice and making informed decisions. Without information there is no choice. Information helps knowledge and understanding. It gives patients the power and confidence to engage as partners with their health service. The local stakeholder group will need to define the information required and build into the pathway the support to collect and arrange appropriate dissemination.

More information at:

www.dh.gov.uk/en/Healthcare/PatientChoice/Choice/BetterInformationChoicesHealth/DH_4123252

ix) Managing Performance (Quality, Performance, Outcomes)

84. Commissioners should manage performance using a matrix of measures of patient experience, clinically relevant clinical outcomes and quality, not process or workforce measures.

85. The 'design' section provides details on the outcome measures for the top urological conditions. Any measures agreed by commissioners/ stakeholder group must be patient focused.

a. The overall patient experience: process, timely access to services and facilities:

- Did the full range of care work well for you?
- What else would have made your care better?
- Was your problem better after treatment?
- Were you treated with respect and dignity?
- Practical issues such as parking, transport and the facilities.
- 18 week referral to definitive treatment time.
- 31/62 day cancer diagnosis and treatment times.

Patient-reported outcome measures (PROMs) provide a means of gaining an insight into the way patients perceive their health and the impact that treatments or adjustments to lifestyle have on their quality of life. These instruments can be completed by a patient or individual about themselves, or by others on their behalf. Further information is available at: *www.phi.uhce.ox.ac.uk/home.php*

b. Clinical outcome measures:

i. NICE outcome measures. Quality outcomes that reflect clinical care are included in those clinical areas that relate to NICE guidance and must be measured. For example NICE urology cancer guidance (for discussion of cases at MDT, information provision for patients *www.nice.org.uk/guidance/index.jsp?action=byID&r=true&o=10889[YUN4]*)

ii. Specific quality of life (QoL) measures are available - for example NICE's preferred measure of increase in health is likely to accrue from the increase in expenditure - the cost per quality adjusted life year (QALY) - further information is available at *www.nice.co.uk*

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Appendix 1 - Care Closer to Home Urology Sub-Group

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Appendix 2- Involving patients and the public

Inform?	Provide the public with balanced and objective information to understand the problem, alternatives and/or solutions.
Consult?	Obtain public feedback on analysis, alternatives and/or decisions.
Involve?	Work directly with the public throughout the process to ensure their concerns and aspirations are consistently understood and considered.
Collaborate?	Partner with the public in each aspect of the decision process including the developments of alternatives, and the preferred solution.
Empower?	Place the final decision making in the hands of the public.

1. Points to consider:

- Suitable numbers of participants
- Resource budget
- Length of process
- What level of involvement do you want or need?
- Who should you involve?
- What outcome do you want?

Terms of Reference for a PCT Stakeholder Commissioning Group

2. This framework is designed to be used by PCTs when establishing a stakeholder group that will influence how the PCT commissions services for patients with dermatology conditions. It can be easily adapted to commissioning urology services. The basic outline and objectives should be the same for all PCTs but amendments may need to be made for specific areas. It is important to note that representation or issues that are not possible within a PCT should be looked at as development issues for the group.

STAKEHOLDER GROUP FOR THE COMMISSIONING OF

[_____(specify condition)] SERVICES IN __________ PCT.

3. For this type of commissioning group to work effectively the PCT will have to give the group autonomy for making commissioning decisions.

OBJECTIVES

4. The stakeholder group will use accurate up-to-date national and local current _____ (specify condition) needs assessment data to ensure the best possible provision of services for patients with _____ (specify condition) for the local population. The group should also monitor and act on issues of unacceptable quality or inadequacy in service provision. Decisions for development should be an integral part of the PCT's Local Development Plan.

MEMBERSHIP

5. The group should have representation from:

- Patients and the public (with LINks support).
- PCT commissioning directorate (a commissioner with the autonomy to make decisions).
- Primary care - with a generalist's view on _____ (specify condition) services (Level 2 care).
- Primary care - with a particular interest in _____ (specify condition) services and/or Intermediate dermatology services where applicable.
- Secondary care/Specialist care - specialist clinical representation from the local acute hospital _____ (specify condition) service (Level 3 care).
- Public Health input supported by information analysts from the PCT and the acute sector.
- Nursing input: ideally representing Primary, Specialist ______ (specify condition) services and the Tissue viability/community nursing team.
- A pharmacist - preferably with a specialist interest in ______ (specify condition).
- All members should have equal representation with a democratic vote for all decisions.

OUTLINE WORK PLAN

6. The stakeholder group will use the commissioning cycle and the DH guidance for those delivering services for patients with _____ (specify condition) conditions to:

- Deliberate on all relating to service issues for patients with the whole range of _____ conditions for the PCT population.
- Commission a needs assessment for people requiring _____ (specify condition) services.
- Develop a prioritised development plan that meets as many of the needs as possible.
- Ensure services are audited and monitored effectively.
- Develop redesign plans where problems exist.
- Ensure that each person accessing any _____ (specify condition) service gets the "right person, in the right place, the first time".
- Where necessary take decisions in respect of so called ' low-priority' treatments.

CRITERIA FOR SUCCESS

7. To ensure the group works effectively the following should be monitored to prove success and validate continuation of this type of commissioning:

- Commission at least two yearly satisfaction surveys.
- Build in monitoring criteria to all service delivery contracts.
- Develop tight 3-6 monthly targets for failing services.
- Ensure inclusion in the local development plan.
- Monitor all complaints made about services and act where persistent trends exist and ensure resources are properly financed.
- Where services do not exist or money is not available, the group will need to monitor 'gaps' and re-prioritise if necessary.

Guidance about the consultation process

Principles

8. The commissioners of the service (PCT) must follow the intent of legislation which is to involve patients and public in the planning and development of services (see Appendix 2 for how to do this).
9. Proposals need good clinical support across a broad spectrum of clinicians involved in their design during the consultation period.
10. The process must be transparent and well publicised.
11. There needs to be a clear understanding of the implications of changes in care pathways on patients and on personnel providing the care for individual patients.
12. The information presented to the Overview and Scrutiny Committee after completion of the consultation process must be accurate and reliable.
13. Remember that in addition to presenting the outcome of the consultation process to the OSC you will need to provide the following information:
14. Accurate information on likely impact on referrals and wait times based on good validated information.
15. Where statements such as 'improved quality of life for patients with ______ disease' are made they should be supported by outcome measures and quality standards.
16. The stakeholder group involved in developing the model of care should be detailed against the recommended list of those that should be involved.
17. Definitions of primary and secondary vs specialist and generalist care need to be made clear.
18. The commissioners (PCT) must have clear service specifications with quality standards incorporated and a policy for procurement which is legal and fair.

Consultation process

19. Section 242 of the consolidated NHS Act 2006 places a duty on NHS trusts, PCTs and SHAs to make arrangements and involve and consult patients and the public in service planning and operation, and in the development of proposals for changes. This duty is supported by the document Strengthening Accountability - Involving Patients and the Public, Practice Guidance.
20. Statutory consultation is necessary for any major change to existing service provision; ie, relocation from a hospital setting of a significant proportion of non acute general dermatology outpatient activity out into a community based service.
21. This level of consultation should include:
    - Written consultation document explaining proposed changes.
    - 12 week minimum consultation process.
    - Full stakeholder involvement.
    - Overview and Scrutiny Committee informed.
    - LINks participation.
    - Discussion with existing users and providers.
    - Public and/or stakeholder events as appropriate.
    - Comments reviewed at end of 12 week consultation prior to decision.
    - Agreed plan and feedback made public.
22. Examples of the above mechanisms should include:
    - Locality based meetings.
    - Consultation questionnaires to users, local people and providers of the service.
    - Public meetings.
    - Comments from Patient Support Groups (local and national).
    - Information on the local PCT website.
    - Parliamentary constituency office engagement.
    - Overview and Scrutiny Committee (OSC).

    The consultation process must be detailed and specific about any proposed service change.
23. If you are relocating services from acute to community settings you should make clear where the new locations will be. The location of any new service will have an impact on the outcome of any consultation process and as such specific locations, the type of services available and their frequency must be specified.

Appendix 3- Reviewing current service provision

Clinical pathway	What is currently commissioned?	Where is it provided?	Who provides the service?	Gaps? Opportunities to shift care down stream, closer to home?
Haematuria				
Scrotal swellings				
Incontinence				
Erectile Dysfunction				
Prostatic Disease				
PSA follow up and monitoring				

Reviewing Current Service Provision - check list

Checklist	✔
Process map care pathway, as a minimum, for patients with the most common urological problems.	
Such process mapping should cross inter-professional and inter-disciplinary boundaries wherever necessary: particularly relevant for continence services.	
Look at the availability of self care, expert patient programmes, and patient support groups available.	
Identify what resources are being provided to prevent urological conditions? (Smoking, obesity, physio post child birth, active management of cardiac and vascular disease).	
Identify local resources and skills currently delivering care. Review the accreditation of those involved. Do all clinicians meet required standards of accreditation and fit into robust clinical governance frameworks?	

What works well, what could work better?	
What quality measures and quality improvement systems are there in place and do they work?	
How much psycho-social support is currently provided and is the care holistic?	
Review capacity and demand of current services (generalist and specialist).	
Review historical specialist activity data: referral rates, new patient and follow up activity. Ideally look at case mix of referrals: routines/urgents/two week wait referrals for suspected urological cancer.	
Look at settings in which care is currently delivered (acute/community, specialist/generalist) and how (face to face/telephone).	
Use the SHAPE tool to identify if current services are accessible, close to current transport links, in the right place.	
Identify if national targets have to be met and whether they are being met. These will include two week wait, 31/62 day cancer diagnosis and treatment targets, 18 week referral to definitive treatment target.	
Use of national targets should not disadvantage other patient groups who are not benefiting from a 'target' relevant to their particular urological condition. If this is the case it may be that additional capacity in other areas is needed.	
How does current service meet the 'Right person, Right place, First time' approach to care?	
What arrangements are currently in place to teach, train and provide on-going continuing professional development for those delivering the service and other health care professionals in the community?	

What good practices are being provided in other parts of the country? (Action on Urology, CCH Urology Demonstration Sites).