

# National Urology Implementation Plan



Mae'r ddogfen yma hefyd ar gael yn Gymraeg.  
This document is also available in Welsh.

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## Summary

The purpose of the National Urology Implementation Plan is to improve patient experience and deliver sustainable services. The plan builds on a series of developments in Wales to provide a balanced service change for implementation by health boards across Wales.

The plan requires health boards to understand and measure demand, capacity and activity in Urology and establish a patient experience measure for Urology services in Wales.

The three primary drivers for service change will be:

- Clinical Value Prioritisation - making sure that only the right patients are managed in secondary care.
- Integrated Care - establishing collaborative care groups (between hospital, community and primary care) and empowering patients to manage their health.
- Best in Class - measuring value for money and benchmarking against top performing organisations.

The plan has been developed by the National Planned Care Programme Board after stakeholder consultation with advice and recommendations from the planned care reference groups that involves patients and the third sector. It contains thirteen key actions for health boards to implement.

The plan is issued as a Welsh Health Circular (WHC/2016/017). Health boards' delivery against the plan will be reviewed at each meeting of the Welsh Urology Board.

A guidance framework for reporting against the Urology Implementation Plan has been developed.

## 2.0 Background

### 2.1 National Planned Care Programme

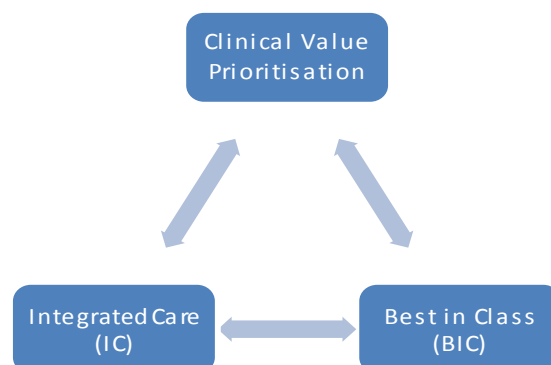
The purpose of The National Planned Care Programme is to:

- 1) Provide “sustainable” planned care services
- 2) Optimise the patient experience of using planned care services.

### 2.2 How will change be achieved?

The programme requires measurement and management of demand, capacity and activity in each of the major subspecialties.

To achieve a match between demand, capacity and activity (sustainability) the programme will employ a balanced service change approach based on three primary drivers: Clinical Value Prioritisation, Integrated Care and Best In Class.



Clinical Value Prioritisation (CVP) will include

- Identification and eradication of NICE “do not do” and “interventions not normally undertaken”
- Evidencing agreed pathways of care to ensure correct thresholds of care and management of variation
- Agreeing urgent and priority patient groups
- Taking a holistic approach to patient care including life style modification

Integrated Care (IC) will include:

- Establishing structures in health boards “care collaborative groups” (CCG) bring together primary and secondary care clinicians with management support and patient input with agreed terms of reference to ensure that the “right patient is in the right place at the right time”.
- Providing patient empowered entry into the planned care system incorporating education, decision-making aids and a supportive environment for decision-making and a range of treatment options

Best in Class (BIC) will include

- Establishing outcome measures for each planned care service
- Measuring the cost of providing services using pathway specific tools

The National Planned Care Programme will be delivered according to “managing successful programmes” protocol and will be monitored by a national programme board.

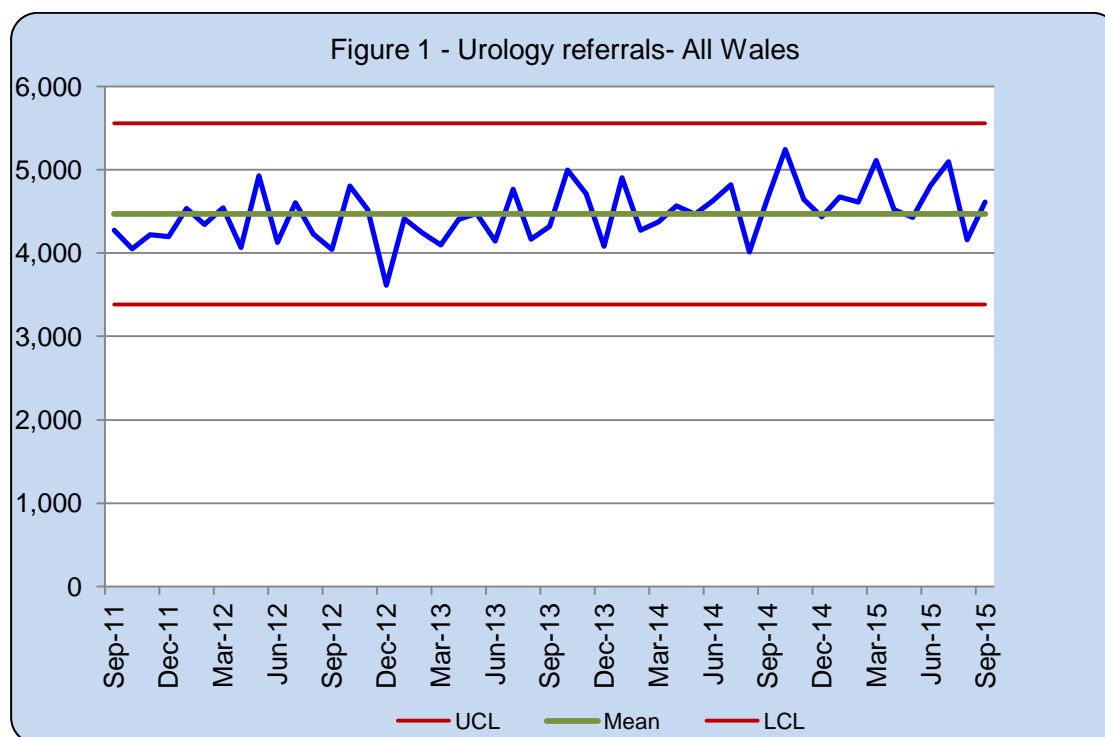
Each national service implementation plan will be delivered by individual health boards and reported through Welsh specialty boards. The programme will be supported by expert reference groups and will rely on patient involvement with contribution from third sector organisations.

## 2.3 Changes in urological services

*Our planned care system is facing challenges and there is a need for significant and urgent change<sup>1</sup>.*

Across Wales, there are approximately 53,000 new outpatient referrals per year in Urology<sup>2</sup>. The conversion rate to treatment is high (74%) with a number of patients treated suffering with cancer<sup>3</sup>.

On an All Wales basis the demand for Urology services has remained relatively stable over the past four years (Figure 1<sup>4</sup>) although three health boards<sup>5</sup> have seen an increase over the period analysed.



(LCL: Lower Control Limits / UCL: Upper Control Limits)<sup>6</sup>

<sup>1</sup> <http://gov.wales/about/cabinet/cabinetstatements/2013/plannedcare/?lang=en>

<sup>2</sup> NHS Wales Informatics Service Information Services

<sup>3</sup> NHS Wales Informatics Service Information Services (September 2011 – September 2015)

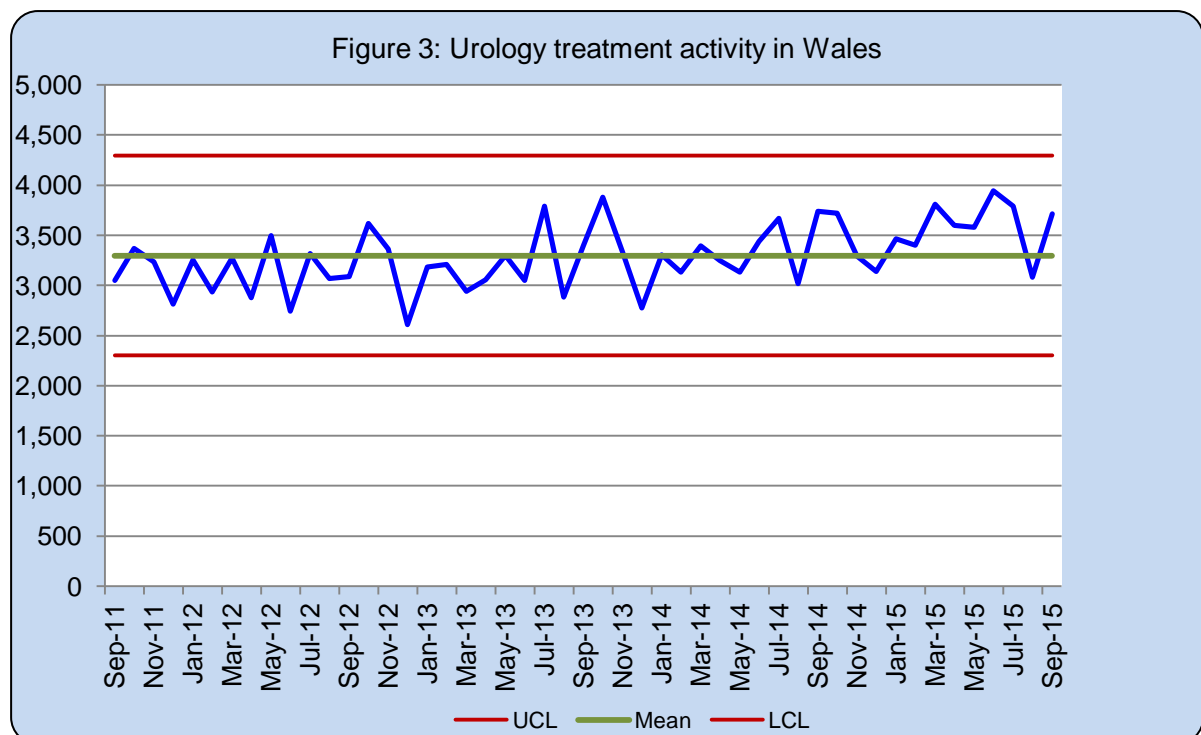
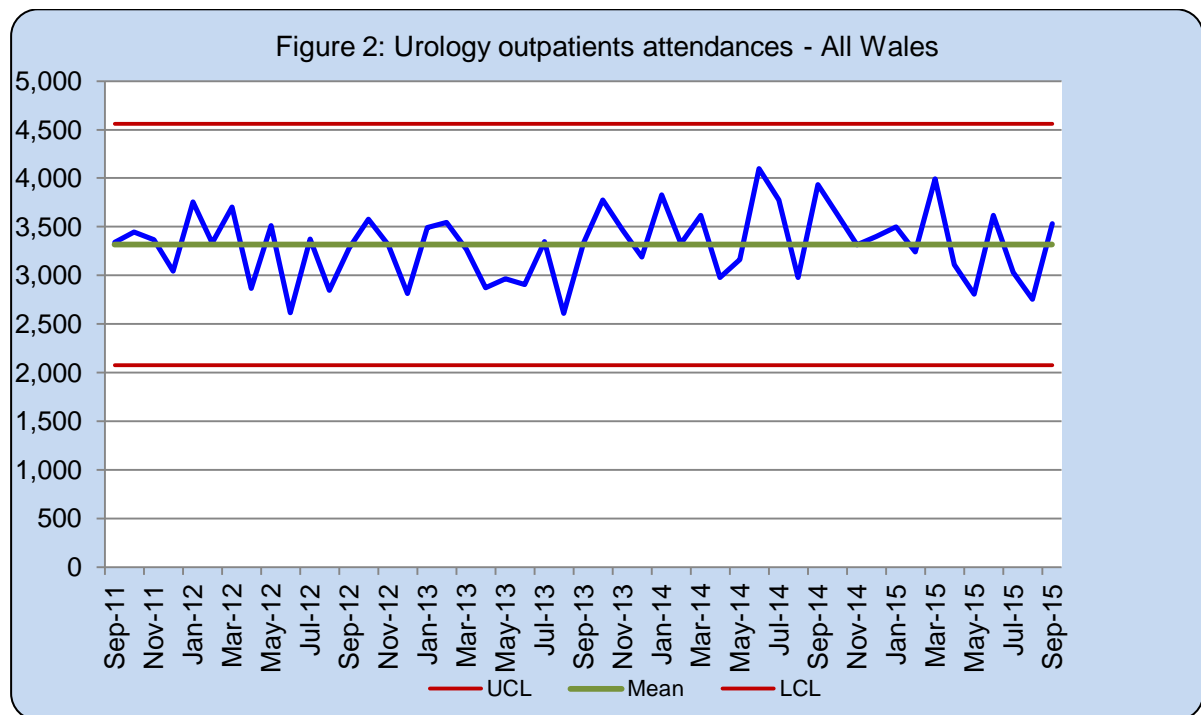
<sup>4</sup> NHS Wales Informatics Service Information Services

The Upper and Lower Control Limits show the expected boundaries of variation in the number of referrals per month.

<sup>5</sup> ABMU, BCU and C&V

<sup>6</sup> The Upper and Lower Control Limits show the expected boundaries of variation in the number of referrals per month.

During this time, Urology outpatient attendances (Figure 2<sup>7</sup>) and treatment activity (Figure 3<sup>8</sup>) has also remained relatively stable.

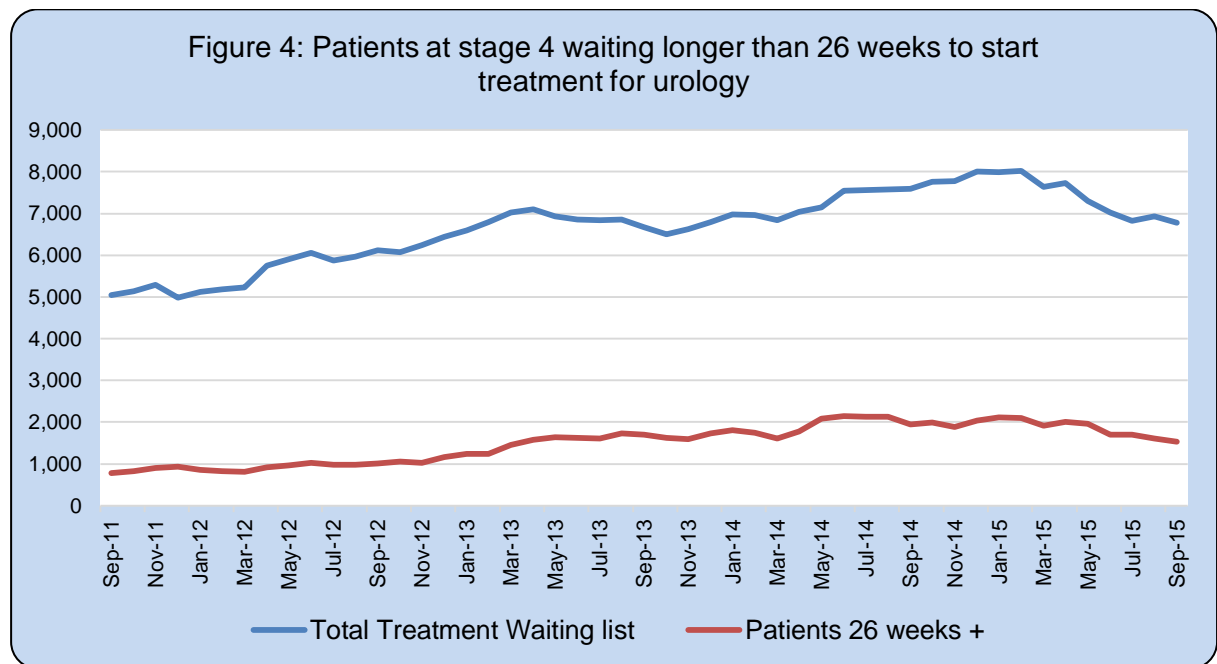


However, a gap between referrals and attendances approximately 1,000 patients per month across Wales<sup>9</sup> has resulted in a cumulative rise in the numbers of patients on

<sup>7</sup> Outpatient Minimum Data Set (OP MDS), NHS Wales Informatics Service Information Services

<sup>8</sup> Patient Episode Database Wales (PEDW), NHS Wales Informatics Service Information Services

waiting lists, causing more patients to wait longer than 26 weeks for treatment (Figure 4<sup>10</sup>)



The relationship between capacity and demand in the urology system across Wales is not balanced. Although there may be some variation between health boards, increasing waiting times are inevitable unless significant changes are applied.

The Urology Implementation Plan highlights the need for effective capacity and demand planning in each individual health board, so that productivity, capacity and service changes can be planned in a rational fashion to achieve “sustainable services”.

The plan addresses the need for service change building on recent developments in Urology and based on the prudent healthcare challenge issued by the Minister for Health and Social Services.

<sup>9</sup> NHS Wales Informatics Service Information Services

<sup>10</sup> NHS Wales Informatics Service Information Services



The prudent health care policy<sup>11</sup> is addressed by a strategic approach to changes in planned care services across Wales, which embrace the following;

Clinical Value Prioritisation is based on the prudent health care principles of:

- Achieve health and wellbeing with the public, patients and professionals as equal partners through co-production;
- Care for those with the greatest health need first, making the most effective use of all skills and resources;
- Do only what is needed, no more, no less; and do no harm;
- Reduce inappropriate variation using evidence-based practices consistently and transparently.

There is a growing consensus around using presentation with conditions such as bladder cancer as a teachable moment for modification of lifestyle factors that not only adversely affect the co-morbidity associated with surgery but also long term survival.

Integrated Care is based on the principle of achieving health and wellbeing with the patient and public as equal partners through co-production. The National Planned Care Programme aims to remodel the relationship between user and provider by empowering patients to become more knowledgeable and confident in making the correct treatment decision using a variety of related approaches including patient activation, decision support tools and peer support in a suitable supportive environment.

Finally, measurement of service quality and cost ensures the concept of value for money is real and transparent thus enabling health boards to develop actions to match top performing services and organisations.

The Urology Implementation Plan is a service change initiative that builds on new approaches to develop sustainable services with optimal patient experience.

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<sup>11</sup> [www.1000livesplus.wales.nhs.uk/prudent-healthcare](http://www.1000livesplus.wales.nhs.uk/prudent-healthcare)

### **3. The National Urology Implementation Plan**

Urology encompasses diseases of kidneys, bladder and prostate to include incontinence, impotence, infertility, cancer and reconstruction of the genito-urinary tract. It includes patients of both sexes and all ages.

Over the last 20 years, urology has become one of the most innovative surgical specialties. Urologists use traditional surgical methods but have also pioneered the most modern high-tech, fibroptic and endoscopic techniques.

The Urology Implementation Plan, through consultation has agreed that its focus will be upon addressing the key areas that will support the development of a sustainable service in Wales. It therefore focuses upon those areas where changes can be made in the most efficient and effective manner.

#### **3.1 Measuring patient experience**

The Urology Implementation Plan aims to optimise patient experience by:

- adopting a standard measure
- agreeing actions to improve levels of performance by health boards.

In order to demonstrate progress and success, it will be necessary for each health board to adopt a standard measure of patient experience.

The Patient Reported Experience Measure (PREM) for Urology will be developed in collaboration with Community Health Councils against a high volume pathway (with discrete pathway points) determined by the Welsh Urology Board.

### **3.2 Achieving a sustainable service**

The purpose of the plan is also to achieve a sustainable service by matching demand and capacity for each of the following patient streams:

- Raised PSA
- Haematuria
- All other

Each stream will have a prioritisation on the degree of urgency: Suspected cancer, urgent and routine.

Health boards will adopt systems to measure demand, capacity and activity in each of the above patient streams at the high-level pathway points:

- New outpatient
- Diagnostics
- Follow up outpatient
- Treatment

**Action 1 Health boards will put in place systems to “collect” patient reported experience measures (PREM) and report service changes.**

**Action 2 Health boards will put in place systems to measure and report “capacity and demand” according to an agreed set of national (all Wales) parameters for each of the pathways above.**

### **3.3 Clinical Value Prioritisation**

#### **3.3.1 Do not do**

Prudent healthcare principles encourage clinicians to “*do no harm*”. The list of procedures that clinicians should avoid includes NICE “do not dos”, “interventions not normally undertaken” (INNU) and health board decisions on procedures that should not be undertaken. In Urology this list will include;

- Circumcision unless there is clear evidence of balanitis, phimosis / paraphimosis or suspected cancer of the prepuce
- Investigation of asymptomatic non visible haematuria based on recent NICE Guidance<sup>12</sup>

There may also be patients on waiting lists that, for administrative or good clinical reasons, do not need to be seen. A process of validation can remove such waiting list entries by either administrative or clinical staff.

**Action 3 Welsh Urology Board to review and where necessary amend the list of “do not do’s” and review responses from each health board medical director**

**Action 4 Health boards will undertake a waiting list “validation” to remove patients who don’t require a new or follow-up outpatient appointment.**

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<sup>12</sup> Suspected cancer: recognition and referral”; NICE guidelines NG12, June 2105, number 164

### 3.3.2 Thresholds

The prudent health care principle of caring for those with the greatest needs first, involves carrying out the minimum appropriate interventions while focusing upon a smaller number of areas with greater impact and outcomes.

Health boards should establish processes to prevent referral into secondary care of patients who will gain little benefit from the referral. For example: patients should have two sequential and abnormal PSA results before referral, urinary tract infection should be excluded in patients referred to the haematuria service and referrals with erectile dysfunction should be restricted to patients who have failed treatment with sildenafil.

In order to make most appropriate use of secondary care capacity (and at the same time optimise patient experience) health boards should maximise the use of community continence services to include the effective management of continence resources including staff and products, routinely adopt one-stop pathways for patients with haematuria and provide virtual follow up services for a defined group of patients with prostate cancer.

Health boards should adhere to NICE guidance<sup>13</sup> relating to repeat cystoscopy in selected patients with bladder cancer, which specifies *“Discharge to primary care people who have had low-risk non-muscle-invasive bladder cancer and who have no recurrence of the bladder cancer within 12 months”*.

**Action 5** Health boards will report on new Urology referrals / 100,000 populations and have an action plan to correct “outlier status”

**Action 6** As well as reporting the number of patients referred with haematuria health boards will report the proportion of patients with haematuria treated on a one stop basis.

**Action 7** Health boards will report the number and proportion of prostate cancer patients who are reviewed (followed up) in “virtual” clinic

**Action 8** Health boards will change their practice in patients with low and medium risk bladder cancer who are undergoing cystoscopy surveillance (in line with NICE Guidance) and report the impact on numbers of patients discharged and appointment delays.

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<sup>13</sup> (Bladder cancer: diagnosis and management; NICE guidelines NG2 Published date: February 2015 Number 1.4.5)

### 3.3.3 Urgent and priority groups

Many referrals to Urology services are suspected cancer. Health boards are already committed to national cancer standards and will continue to report compliance with targets for urgent suspected cancer new outpatient appointment (2 weeks) and referral to treatment (62 days)

**Action 9 Health boards will continue to report cancer standards for urology**

### 3.3.4 Holistic care

Smoking is the most important known risk factor for bladder cancer. Evidence from the National Institute for Health has found a stronger association between smoking and bladder cancer. As with many other smoking-related cancers, smoking cessation is associated with reduced bladder cancer risk<sup>14</sup>

Obesity is a risk factor for benign urological disorders<sup>15</sup> such as incontinence but the association between obesity and urological cancer is more difficult to define. However, there is also a body of evidence that lifestyle factors may also be associated with higher rates of postoperative complications and length of stay<sup>16</sup>.

Smokers and those patients with a BMI>35 will be referred to the appropriate local service for antismoking and weight reduction management respectively as part of their active treatment.

In order to enable this health boards should:

- ensure that there are a suitable range of antismoking and weight reduction support services available to local communities
- appropriate referral mechanisms exist.

**Action 10 Health boards will report on the number of bladder cancer patients who smoke and patients with a BMI > 35 who have undergone major surgery and who have taken part in either an antismoking or weight reduction programme.**

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<sup>14</sup> <http://www.nih.gov/news-events/nih-research-matters/smoking-bladder-cancer>

<sup>15</sup> Parsons JK, Sarma AV, McVary K, Wei JT. *J Urol.* 2013 Jan; 189(1 Suppl):S102-6

<sup>16</sup> Ash.org.uk

### **3.4 Integrated care**

#### **3.4.1 Interface collaboratives**

New structures “collaborative care groups” will be established in each health board to manage the flow of patients between primary and secondary care. Some similar structures already exist; most health boards have eye care groups and many have established musculoskeletal referral services (MSK).

It will be the responsibility of each health board to establish their own care collaborative groups based on national terms of reference (ToR). The collaboratives will have the following principles:

- Include local professionals, patients and service managers
- Oversee appropriate patient streams and referral thresholds and where necessary to triage referrals before submission to secondary care.
- Provide life style services for all patients identified with a BMI over 35 and patients who smoke.
- Establish services to improve patient activation and decision making
- Monitor progress against the Urology Implementation Plan

**Action 11 Each health board will establish a urology collaborative care group with a view to monitoring patient flow and to facilitate delivery of the Urology Implementation Plan.**

### **3.4.2 Patient empowerment**

Co-production Wales is clear about enabling citizens and professionals to share power and work together in equal partnerships.

There is sufficient evidence which apprise patient activation improves patient outcomes and decision support tools enhances patient experience. Evidence suggests that patients will benefit from a “supportive environment” to make important decisions about their health and well-being.

Health boards will establish “structures” in community settings to activate patients and provide decision support mechanisms as part of the interface collaboratives.

**Action 12 Health boards will establish and report on measures of patient activation (PAM) and decision support scores (DQM)**

### **3.5 Best in class**

It is self evident that in order to demonstrate that they are making most effective use of resources, individual services should be able to measure ‘value for money’ in a way that allows comparison with recognised high performing services or ‘Best In Class’.

There will be a nationally adopted methodology for costing. Prostate cancer treatment will be the indicative pathway in urology. The methodology will be recommended by national reference group (Best in Class) and ratified by the Directors of Finance Wales.

The quality of the prostate cancer pathway will be defined by components of the International Consortium for Health Outcomes Measurement (ICHOM) standard set, which includes acute complications, patient reported outcomes and survival (disease control). Outcome and cost data will be collected for both surgical and radiotherapy treatments of prostate cancer.

Each health board will have responsibility for managing individual outliers. The Welsh Urology Board will support actions to improve collective outcomes in individual health boards.

**Action 13 Health boards will put in place systems to record, report and manage costs and quality of the prostate cancer treatment pathway according to a standard methodology.**



#### **4. Reporting and collaboration**

Health board's performance against the Urology Implementation Plan will be reported to the Welsh Urology Board scheduled to meet bimonthly.

The chairman of the Welsh Urology Board will report to the Planned Care Programme Board, which in turn will report to the Wales Executive Board (programme sponsors).

The planned care programme team will work with a health board to model the impact of the high-level service changes, and determine the indicative cost for a new "sustainable" Urology service. The health board will also assist in the communications and outcome of the Welsh Urology Board meetings.

## **Appendix A: List of Actions**

**Action 1** - Health boards will put in place systems to “collect” patient reported experience measures (PREM) and report service changes.

**Action 2** - Health boards will put in place systems to measure and report “capacity and demand” according to an agreed set of national (all Wales) parameters for each of the pathways.

### **Clinical Value Prioritisation**

**Action 3** - Welsh Urology Board to review and where necessary amend the list of “do not do’s” and review responses from each health board medical director

**Action 4** - Health boards will undertake a waiting list “validation” to remove patients who don’t require a new or follow-up outpatient appointment.

**Action 5** - Health boards will report on new Urology referrals / 100,000 populations and have an action plan to correct “outlier status”

**Action 6** – Health boards will report the proportion of patients with haematuria treated on a one-stop basis.

**Action 7** - Health boards will report the number and proportion of prostate cancer patients who are reviewed (followed up) in “virtual” clinic

**Action 8** – Health boards will change their practice in patients with low and medium risk bladder cancer who are undergoing cystoscopy surveillance (in line with NICE Guidance) and report the impact on numbers of patients discharged and appointment delays.

**Action 9** – Health Boards will continue to report cancer standards for urology

**Action 10** – Health boards will report on the number of bladder cancer patients who smoke and patients with a BMI > 35 who have undergone major surgery and who have taken part in either an antismoking or weight reduction programme.

## **Integrated Care**

**Action 11** - Each health board will establish a urology collaborative care group with a view to monitoring patient flow and to facilitate delivery of the Urology Implementation Plan

**Action 12-** Health boards will establish and report on measures of patient activation (PAM) and decision support scores (DQM)

## **Best In Class**

**Action 13-** Health boards will put in place systems to record, report and manage costs and quality of the prostate cancer treatment pathway according to a standard methodology.