Action On Urology

Good Practice Guide

Outcomes from 32 Action On Urology Sites

March 2005
In this guide, Action On Urology reports on service improvements which have been achieved in urology departments across the country.

Each section tackles a different aspect of urology service improvement. The accompanying CD provides much more detail on how results have been achieved.

The report is in three parts

- **Using this report**
  Part 1 describes how you can get the best out of the report and its CD

- **Issues**
  Part 2 sets out the issues facing urology over the coming years and the challenges people face in redesigning services.

- **Solutions**
  Part 3 describes the impressive results from 32 Action On Urology sites. Together they provide a range of solutions and new ways of delivering services. They cover five disease and generic pathways covering every stage and almost every aspect of urological care.

We do hope that this impressive portfolio of tried and tested results will help you solve the service delivery problems you face.

The National Action On Urology Steering Group
March 2005
Dear Colleagues

We are very pleased to give this report our endorsement.

This good practice guide captures a huge amount of work by professionals, managers and patients involved in urology services in all parts of the country. The results are impressive and reflect well upon Jennifer Fenelon, the Action On Team and the 32 project teams involved.

We share a common goal of creating modern urology services that are responsive to the changing world we live in.

There are many challenges to be met and the process of redesigning and improving services is not easy. We have, therefore, been extremely heartened by so many innovative, but practical, approaches to making urology services patient focussed, accessible and effective.

We hope you will find it helpful in meeting the service delivery challenges of today and tomorrow.

Roy Williams
Patient Member, Action On Urology

Mike Lockett
Patient Member, Action On Urology

Jerome Marley
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Paddy O’Reilly
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CD – Containing this report and full case studies from each pilot site

The CD inserted in this report contains examples of hundreds of service improvement approaches drawn from over 30 pilot sites.

Other reports issued with this good practice guide

‘Improving Diagnostic Services Together’

‘The new Urology Workforce – an overview of emerging trends’

‘Implementing Patient Decision Aids in Urology’
Interim report from the National Steering Group for Decision Support Aids in Urology + CD with references and useful web links. Supporting patient choice.
Executive summary

The need for change is affecting all specialties, but urology has specific issues that need responses now. This report offers PCTs, clinicians and managers a wide range of new approaches to meet new demands.

Issues

There are two sets of drivers forcing new ways of thinking which need to be addressed urgently.

1. Demand for urology services is rising rapidly & the pattern of disease is changing
   - There is an overall rise in demand from an ageing population especially the over 50s who make the heaviest demands upon urology care.
   - Prostate disease incidence is rising rapidly and PSA requests are generating further demand.
   - Haematuria/bladder disease demand is also rising, stimulated by the combined availability of dipsticks & flexible cystoscopes.
   - There is evidence of large undeclared demand for continence services which is currently held in check by the embarrassment factor but likely to manifest itself as services get redesigned.
   - Work is shifting away from surgery towards diagnostics & medical treatments

2. National policy requirements are driving PCTs to look for different approaches & new models of care
   - The convergence of a number of national policies – patient choice / access targets/ GP commissioning/ payment by results and plurality of provision is leading PCTs to look for faster and more patient-focussed models of care.

Solutions from action on urology

32 Action On Urology projects have generated approaching 100 new ways of delivering care with impressive outcomes. They address whole delivery systems and complete pathways of care. If applied across the country they could enable urology services to:-

1. Achieve faster & more effective access
   - We describe new referral systems which are helping GPs ensure patient referrals are more appropriate and which have dramatically reduced the time from referral to diagnosis.

2. Unlock the diagnostic bottleneck
   - Many of our projects have resolved diagnostic bottlenecks and have reduced waiting times by up to 20 weeks, whilst also freeing capacity in the system. At the same time the process has become more acceptable to patients. They have done this by redesigning services to cut out wasted visits and by creating new roles to increase the diagnostic capacity for ultrasound, cystoscopy and TRUS & biopsy. Novel use of CT is also reducing admissions.

3. Cope with the rising tide of referrals and provide new out patient models which patient prefer and which deliver diagnoses faster
   - Action On sites are providing integrated out patient services that are: faster to access; provide all diagnostic services together from a team and/or based in the community. Long waits are being demolished.

4. Provide treatment which reduces inpatient stays and supports patients in their own homes
   - We describe projects which minimise the days spent, if any, in hospital and utilise community resources to enable patients to return home sooner. These include greatly reduced inpatient stays for bladder tumours, TURP and acute urinary retention. Most are achieved by working collaboratively across primary and secondary care

5. Provide effective management of the rising numbers of follow up patients.
   - A number of our projects have found effective ways of helping patients avoid having to come to hospital for follow up. They are managing the rising workload through telephone follow up, computer monitoring systems and training community staff. Patients like these new approaches very much indeed.
Using this report

What it contains
This report comes with the endorsement not only of the Presidents of the two major professional bodies, BAUS and BAUN, but also that of patients who have taken very active roles in the work of Action On Urology. Their combined vision of a urology service for the 21st century is very clear indeed – modern urology services should be designed to achieve accessible, high quality, effective and sensitive services that place the patient at the centre and respond to his or her values and preferences.

Turning that vision into reality is not so easy. For urology, the challenge is two-fold – not only making existing services better but planning to respond to a whole set of new challenges just over the horizon.

We believe our 32 trusts have, collectively, found answers to major service delivery problems facing urology.

Much of what we describe in this report is not rocket science – but it does work. We know that a number of the individual initiatives have been tried before. What we offer that is new is a very wide collection of approaches that covers whole pathways of care. We offer a menu of approaches and leave it to you to pick and mix the solutions that appear to suit your own service best.

We have written each section not only to help with local service improvement, but we have also described how these outcomes can be applied to achieve the ‘10 High Impact Changes’ identified by the Modernisation Agency and in meeting cancer targets.

The matrix
We have produced a great deal of useful material. To present it in a manageable way, we have grouped the work into a matrix. The matrix follows the patient through his journey along five different pathways each with four steps:

- **Five pathways**
  - Generic Systems
  - Continence & Catheter Care
  - Prostate
  - Haematuria & Bladder
  - Renal

- **Four steps in the pathway**
  - Primary Care/Referral
  - Diagnostics
  - Treatment
  - Discharge & Follow up

More information about each project
Each project has produced an evaluation of its work which is written up as a case study together with supporting documents. Our 15 first wave sites (details Appendix B) have also been subject to both external evaluation by Birmingham University and peer review by a team representing the British Association of Urological Surgeons (BAUS) and the British Association of Urological Nurses (BAUN). Access this through the CD.

Using the CD
We have included this report and all of the documentation in the accompanying CD. It is organised in the same format as the matrix described below. It is intended to help you either find details speedily or just browse each section for new ideas. Please use it. It is set out in an easy to use format to help you find solutions easily. From the CD you can also access the web based good practice database which will keep project outcomes up to date. Alternatively access the whole report and CD via the web on www.portal.modern.nhs.uk/sites/clinicalimprovcollab/urology/default.aspx

The good practice database
We are working with the Cancer Team to keep all this information and cancer good practice on a web based database. It can be accessed by clicking www.modern.nhs.uk/innovationinurology
Current issues facing urology

People want to tackle problems
Action On Urology was launched in 2002 by inviting trusts across England to bid for funds to address practical problems which were stopping them from delivering fast and effective care to their patients. The strong backing given by BAUS and BAUN led to the speciality submitting more bids than any other. This response reflected urology’s obvious enthusiasm for providing a good service to patients.

Many rejected bids were very impressive so we funded more as associate sites. As a result, 32 trusts in total have become Action On Urology sites – the highest from any speciality. They have tackled problems as diverse as ultrasound by urologists, hospital at home for TURP patients and PSA follow up managed by computer and have come up with solutions that work.

Problems affecting all urology services
Patients and professionals conveyed a picture of a specialty where patients, many of whom are elderly, have often to negotiate a very disjointed route to treatment. Many do this with the possibility of cancer at the back of their minds. What patients want most, after high quality medicine, is be seen quickly and treated with dignity as individuals with a say in their own care. Professionals described how they tried to deliver that type of care but increasingly felt submerged under a rising tide of demand.

The main theme running through all the bids we received was the desire to knit together new approaches – to redesign the whole or at least a part of the journey which the patient would take so that it felt as though it was there for the well being of the patient rather than for the system.

The following issues were felt to be the most pressing: -

Rising numbers of elderly patients
When numbers of the elderly rise, so do demands upon urology. Even now, we can see the impact of rising numbers of elderly coming through the system. GP referrals to Urology are rising by an average of 8 % per annum. Over the next 20 years the proportion of over 50 year olds will continue to rise.

36% increase in men over 50 years and 8% increase in all male population – England 1998 2018 (source ONS)

Around 40% of urology work is cancer related and the rise in prostate and haematuria related referrals will add to these demands upon services. Services are struggling to stand still let alone meet access targets as a result of rising demand.

Diagnostic bottleneck
One of the biggest problems facing patients is multiple queuing – patients queue for outpatients and then for diagnostic tests. In 2002, the Audit Commission described the situation as unacceptable. The issues are complex and ultrasound is the largest bottleneck. We have worked for the past year with the Royal College of Radiologists, the British Medical Ultrasound Society (BMUS) and the Society & College of Radiographers and have produced a separate report on how to get the best out of your diagnostic services. A copy is included in this pack.

Primary/secondary location of work
Some of our most interesting work has been at the interface between primary and secondary care. Many PCTs, primary care professionals and managers are considering new models of demand management as a consequence of new policies. These include practice based commissioning, payment by results, Choice, GP commissioning and plurality of provision.

We examined the possible roles of general practitioners with an interest in urology (GpwSIs). It is clear that there need to be effective and collaborative ways of managing increasing demand across the primary and secondary interface. We learned of GpwSIs successfully undertaking this role but there are also other options.
A shrinking workforce pool
Demographic change will not only produce a greater proportion of elderly but will also lead to a decreasing proportion of workforce age. This will require imaginative approaches to new models of service delivery. Our workforce survey showed that there was no dearth of ideas in urology but they are developing in an unsystematic manner and help is needed to implement them in a systematic way.

Communication
The term ‘good communication’ can often be overworked, but it came up everywhere. It was top of every patient’s wish list. We were delighted to be invited to evaluate the introduction of decision aids in this country. Our patient representatives feel it makes the term ‘patient choice’ meaningful because it is about choice of treatment. We also describe a number of communication projects being undertaken by our associate sites. We could understand a consultant who plaintively said “No one knows what is going on”.

The effects of changing national policy
There is no doubt that new government policies not only around access targets but also new drivers such as choice and payment by results will drive different demands for alternative patterns of care. Access policies must be implemented.

- Cancer
  - maximum 2 month wait from urgent GP referral to treatment for all cancers by December 2005
  - maximum 1 month wait from diagnosis to treatment for all cancers by December 2005

- Choice
  - patients will be able to choose from at least 4 to 5 different healthcare providers for planned hospital care, paid for by the NHS, by December 2005

- Access
  - 18 week wait from GP referral to hospital treatment by 2008

Changing patterns of treatment
Urological work is changing. The proportion of surgical interventions is declining while the volume of diagnostic and medical work is rising. At the same time national guidance such as the NICE ‘Improving Outcomes Guidance’ for urological cancer is leading to a polarisation of surgery into highly specialised surgery in designated centres at one end of the spectrum and a range of minor surgical procedures suitable for treatment centres at the other.

A new pattern of service will need new roles and these need to emerge in a systematic way that reflects service needs rather than as uncontrolled development. Our workforce report [see separate document] carries a proposal that urology would benefit from a unified set of competences applicable to everyone working within urology. Such a framework could be backed by an educational framework. The indications are that these two frameworks would be valued.

One of the major issues for medical staff is developing the role of the ‘New Consultant Urologist’. This new, largely diagnostic, role planned for the new consultant urologist reflects the changing pattern of illness and treatment.

Urological medical staff are in the vanguard of thinking through these changes and redesigning a workforce which reflects service needs. We are indebted to Professor Mundy, President Elect of BAUS, for describing the changes in the following diagram. He has plotted the growth trend in consultant numbers. This has just about kept pace with growth in the medical side of urology while the surgical side is not increasing at the same rate.

Development of the ‘New Consultant Urologist’ or diagnostic focussed consultant urologist therefore appears timely.
Changing organisations successfully

Making change happen is hard work
The theme running through this report is that redesign of whole, or at least part, systems of urology care delivery is possible and can lead to dramatic improvements.

It was because of the need to support new ideas that we set up three additional subgroups which looked at different aspects of change that people said were difficult. The three groups looked at workforce issues, the relationship between urology and radiology and, the key issue for the choice agenda, of supporting and helping patients make informed choice about their treatment.

Each of these groups has published a separate report in which they offer very helpful advice to those contemplating organisational change. We summarise the recommendations of the workforce and radiology groups below. (The informed decision project has yet to report formally and its current report is an interim one)

Changing the workforce

New Role Development
We took a snapshot of the current urology workforce and BAUN also surveyed nursing staff in a complementary survey. We found a very confused picture. New roles are developing in an enthusiastic but haphazard way, educational support is lagging behind and those involved in implementing change need very practical help. In our workforce report we make recommendations to remedy the situation and we have inserted below a summary of our recommendations.

New Role Development

- That the British Association of Urological Surgeons (BAUS) and the British Association of Urological Nurses (BAUN) be invited to work together with other appropriate groups to develop a national competency framework for urology.
- That this competency framework should be compatible with the emerging national career framework and national competency framework. Development work should involve Skills for Health as the national body approved to develop NHS competency frameworks.

Education & Training

Access to appropriate training and education was the most pressing issue reported to both our group and to BAUN.

We found around 80 new educational and training initiatives under development and have described them. They range over: new professional roles; the need for new procedure based competencies and disease pathway based roles. There are many exciting new approaches.

We found that access to adequate training and education was the biggest factor hindering staff from making changes. Educational providers appear to be holding back for want of a clear national picture of the competencies required for the future. There is a current shortage of training and we recommend that Trusts, SHAs and PCTs act soon.

The workforce group therefore recommends:

Education & Training

- BAUS and BAUN be invited to work with appropriate educational and policy groups to develop a urology educational and training framework which maps on to and supports the competency framework described above. This will also help professional bodies consider how professional development should move forward. It should be compatible with the emerging national education framework.
- The Department of Health should consider a national approach to the assessment of competence to ensure that care is delivered to a consistent standard.
- In the short run, and while the educational framework is in development, SHAs, PCTs and trusts work to address the current short supply of procedure based skills training. We believe that trusts may have to develop in-house training in the short term to meet this urgent need.
We found enthusiastic professionals and managers seeking help with the complex task of change management. 70 Trusts reported over 300 implementation problems. We welcome the national career framework, HR strategies and NHS Knowledge and Skills Framework and we describe them. Front line staff told us how they also wanted help with many aspects of change management and we would welcome support from SHAs & PCTs and trusts.

The workforce group therefore recommends:

**Implementing new roles**
- SHAs PCTs and trusts work together to develop organisational development strategies.
- Front line staff would be able to find their way around better if they understood bidding arrangements for trust training strategies, business planning and other local planning arrangements.
- There is a powerful need for communication and change management training to equip those making change happen.
- Better dialogue between commissioners and providers in understanding the purpose of new services and roles.

**Improving diagnostic services together**
- **There are substantial challenges still to be addressed**
  This section describes the substantial challenges facing radiology departments (Section 2).

- **Working together pays dividends**
  Joint action can result in existing resources being used better – we describe trusts where long ultrasound and other waiting times have been cut by organising their diagnostic pathways in an integrated way. We also describe new ways of expanding the workforce by adopting new ways of working (Section 3 & 4).

- **Existing resources can be used more effectively**
  Much can be done by using existing resources better where bottlenecks exist. We list many practical examples of how professionals and managers have achieved dramatic improvements without extra resources by redesigning their services. Matching capacity with demand can, for example, generate reductions in waiting time of over 300 days as Derriford Hospital in Plymouth has done. (Section 3)

- **Things can be done in different ways**
  Many departments have looked at completely new ways of doing things - especially approaches which relieve the pressure on diagnostic departments and free radiology and sonography experts for more challenging tasks. We give examples of how new ways of delivering services can relieve pressure upon radiology and urology departments. Urologists at Ashford & St Peter’s, for example, describe what has been achieved by limited ultrasound scanning being undertaken by urologists. (Section 4)

- **Appropriate training is key to implementing successful new approaches**
  We address governance issues ensuring that professionals adopting new approaches have the necessary competencies. This requires standards and training & regular assessment of fitness to practice. This chapter features the new national ultrasound training syllabus for medical staff other than radiologists from the RCR together with recommendations for keeping skills up to date. (Section 5)

- **Equipment must be fit for purpose**
  Only when resources have been used effectively, can it be clear if more capacity is needed to meet demand. This chapter describes how to get the best out of your equipment. This includes newly published guidance from the Royal College of Radiologists. (Section 6)

- **Clinical Governance must be assured when making changes**
  We have developed a governance checklist to help managers and clinicians manage change. It gives a list of key requirements to ensure that high quality is achieved (Section 7)

**Improving diagnostics**
At the start of Action On Urology, professionals and patients told us that there are very substantial diagnostic bottlenecks within ultrasound in particular. ‘Improving Diagnostic Services Together’ is a guide to diagnostic good practice produced by Action On Urology in collaboration with major colleges, the Department of Health and the Modernisation Agency. Its main recommendations are set out below.
Applying the 10 high impact changes to urology

‘10 High Impact Changes’ from the Modernisation Agency is a key document which describes the transformation which could be achieved if good practice were extended nationally. In the next section we describe how this advice has been turned into practical examples by Action On Urology sites and could be extended to urology services everywhere.

An example of the potential national impact of applying change Number 2 to improve diagnostic testing is set out below.

Change 2 - The Ashford Project – Ultrasound by Urologists

Training in ultrasound will be part of the syllabus for specialist registrars preparing to be ‘New Consultant Urologists’. Ashford examined the training and equipment needs as well as potential benefits.

After allowing for proper funding of equipment and training the potential benefits in England over 10 years are estimated as follows:

- **Quality**
  
  The quality of patient care will be improved both by shortening the patient journey and by ensuring urologists are appropriately trained for this important diagnostic technique.

- **Patient access times**
  
  Waiting time from referral to diagnosis would be reduced by taking 1.5 out of three diagnostic steps out of the system.
  
  Time in clinic for the patient would be reduced from 40 to 25 minutes.

- **Attendances saved**
  
  131,351 patient visits saved per annum could be saved (ratio 2 radiology : 1 urology)
  
  It is estimated that around 21,892 hours of radiology/sonographer & urology clinic time could be saved each year.

- **Cash equivalent generated**
  
  If the savings are expressed in cash rather than attendances saved, the savings are estimated at £33 million over 10 years (discount rate 3.5%)
Improving Cancer Access Times
The Cancer Services Collaborative has prepared a checklist for urology cancer which is set out below:

<table>
<thead>
<tr>
<th>One referral route into the system (streamline referral)</th>
<th>Nothing planned</th>
<th>In progress</th>
<th>Implemented</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop appropriate referral criteria with primary care within the NICE guidance on referral for suspected cancer</td>
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<tr>
<td>Agreed patient pathway across the Trust for 5 main urology cancers. Audit and identify referral patterns for patients referred for all main urology cancer</td>
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<tr>
<td>PSA guidance to GPs following testing</td>
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<tr>
<td>Implemented electronic or faxed referral for urgent suspected cancer referrals</td>
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<tr>
<td>Single point of contact for referral</td>
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<tr>
<td>Pooling of all referrals with appropriate triage to sub specialists</td>
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</table>

Reducing the steps to diagnostics: straight to test

<table>
<thead>
<tr>
<th>One referral route into the system (streamline referral)</th>
<th>Nothing planned</th>
<th>In progress</th>
<th>Implemented</th>
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<tbody>
<tr>
<td>Rapid access haematuria clinics</td>
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<tr>
<td>Rapid access prostate assessment clinics</td>
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<tr>
<td>Pre-booked diagnostic test prior to first appointment</td>
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<tr>
<td>Single visit clinics with combined tests/single preparation</td>
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<tr>
<td>Pooled referrals and single queues</td>
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<tr>
<td>Segmentation where appropriate, avoid carve-out</td>
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<tr>
<td>Standardisation referral protocols and reporting</td>
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<tr>
<td>Booking and scheduling systems including waiting list validation, and DNS and A/Leave policy</td>
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<tr>
<td>Extended roles: Nurse-led clinics, Nurse surveillance cystoscopy service</td>
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<tr>
<td>Ultrasound guided prostate assessment clinics including Trus and biopsy</td>
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<tr>
<td>Timely reporting and access to results – maximise use of technology</td>
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<td></td>
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<tr>
<td>Diagnosis followed by immediate staging and intervention where appropriate</td>
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</table>

Spreading good practice
At the start of Action On Urology our national sites agreed to share their work as they went along. We established the National Urology Learning Network and our sites reported back to the rest of Urology as their work progressed. Between 250 and 450 clinicians and managers came to these events which have addressed such topics as:

- ‘Improving Patients’ Experience of Urological Care’ a review of modernisation tools and techniques for urology. Queen Elizabeth Conference Centre, Westminster – September 2003. Keynote speakers included Professor Aidan Halligan, Deputy Chief Medical Officer.


- ‘Haematuria referral issues’ and ‘Developing new roles- New Consultant/ GPwSI /Specialist Nurses’ Lords Cricket Ground – March 2004. Keynote speakers included Mr Mark Fordham – Haematuria and Mr Ralph Beard & Dr John Connolly on new roles and how they fit together.


The most rewarding part of this network has been, without doubt, the sharing of experience from innovators quietly changing things at the front line. We all learned a great deal from them. There is no doubt that there is an appetite among urology staff to improve care delivery which Strategic Health Authorities will now take forward. Each SHA has had a Service Improvement Lead in post funded by Action On Programmes and these leads have been enthusiastic in their support of new initiatives.

(From the ‘How to Guide – achieving cancer waiting times’)
Good practice from Action On Urology

32 Action On Urology Sites contributed to this guidance (* Denotes 1st Wave)

The outcomes from these 32 sites provide new ways of delivering services across all stages of the five major clinical pathways in urology. They are impressive.

To help guide the reader through such a large number of projects we have grouped their work together into a matrix. The matrix follows the patient through his journey along five pathways each with four steps:

Each of the following sections outlines all the work done in that step of a pathway.

To find out more about any of the projects listed and contact names/telephone numbers go to the accompanying CD or log on to www.portal.modern.nhs.uk/sites/clinicalimprovcollab/urology/default.aspx

Five pathways
- Generic Systems
- Continence & Catheter Care
- Prostate;
- Haematuria & Bladder;
- Renal

Four steps in the Pathway
- Primary Care/Referral
- Diagnostics
- Treatment
- Discharge & Follow up
3.1 Generic systems

This section looks at ‘generic’ systems – those systems which cross all disease specific pathways.

We examine how whole systems can be improved at different stages in the patient pathway. A large number of projects are described which, if applied individually or collectively, could improve the patient’s pathway.

We have grouped these projects along steps of the patient pathway and give examples of what can be achieved. Each project has a full case study which can be found on the accompanying CD.

1. Referral systems
2. Diagnostic systems
3. Out patient systems
4. Treatment systems
5. Follow up systems

Using these examples can help you put national policies in place as well as improve services for patients. This section gives many examples of how to achieve the 10 high impact and other changes listed below.

‘10 High Impact Changes’ that can be addressed using the examples in this section

✔ Number 2 – Improve flow across the whole NHS system by improving key diagnostic tests

✔ Number 4 – manage variation in the patient admission process

✔ Number 8 – Improve patient access by reducing the number of queues

✔ Number 9 – Optimise patient flows through process templates

✔ Number 10 – redesign and extend roles in line with efficient patient pathways

CSC ‘How to Guide – Achieving Cancer Targets’ Urology self assessment questions that can be addressed using these examples from this guide

✔ Identify referral patterns

✔ Electronic or faxed referral with booking and scheduling systems

✔ Single point of contact for referral & standardised referral protocols

✔ Pooling of all referrals and single queue

✔ Rapid access diagnostic clinics

✔ Single visit clinics with combined tests/single preparation

✔ Segmentation but avoid carve out

✔ Extended roles

✔ Timely reporting and access to results
3.1(i) Generic systems change – referral

Problems to be tackled
At September 2004, 15,453 urology patients had waited more than 13 weeks before being seen in out patients across England. The rate of GP referrals to urology departments is rising rapidly with an average increase of approximately 8% each year since 1999. Such demand has to be managed.

In primary care, a proportion of patients could be better managed at home if primary care professionals had access to better clinical information and investigative resources. A number of projects look at how primary care can be supported in managing demand. Where patients do get referred to secondary care, that step must be effectively organised.

A range of solutions
Several Action On Urology sites looked at the referral interface between primary and secondary care. West London (Whole health economy urology referral system) has established a co-ordinated system which incorporates a duty consultant ready at any time to support GPs maintain their patients at home. Stockport, Tameside & Glossop (Referral management system) have developed a referral management system for the health economy. NE Wales (Outpatient and treatment whole system review – referral management) has taken a whole systems approach. Bath (Promoting direct electronic referral) have reached 100% coverage. Colchester (Assessment & diagnosis closer to the patient’s home) has taken the whole assessment process out into community hospitals in Clacton and Harwich and their experiences are described later. The following have all looked at the referral process within a specific clinical pathway: Addenbrooke’s (Integrated female incontinence pathway incorporating MDT) Ipswich (Rapid access ultrasound from primary care; Direct referral to nurse/ physio for UTI/ incontinence), East Berkshire (Avoidance of emergency admission for blocked catheters), S Derbyshire (Integrated continence project) and Wirral (Integrated continence pathway redesign). Their experiences of trying to retain and manage referrals in the community are described. Their experiences have been similar to those of West London. (For more information about these projects use the CD version of this report)

Whole health economy urology referral system – An example from West London

W. London – 3 Acute trusts on 6 sites and 3 PCTs
Project Manager – Jack Short
Clinical Lead – Mr Simon Carter

Problems to be tackled
West London had the highest urology out patient DNA (did not attend) rates in England, rising as high as 26%. GPs were making multiple referrals in the hope that they would secure an early appointment.

Solutions
Three acute trusts (Hammersmith, Ealing & W.Middlesex) and three PCTs (Ealing, Hammersmith, Fulham & Hounslow) designed a complete new urology referral system. The aim was to actively manage the referral process across the whole health economy of West London (south). They planned to reduce patient waits and maximise capacity. Referrals are pooled and, with electronic help, managed by a urology referrals manager who is backed by the whole consultant and nursing team. A duty consultant is always available to advise GPs and suggest other approaches

Key features
- By actively managing referrals from the day they arrive in the trust through
  - New centralised referral administration for the network
  - Dedicated communication pathways for GPs to receive advice
  - Duty consultant available at any time during the working day
- How it works – Patients are offered choice of where and when they would like to be seen.
  - Referrals are actively, centrally & electronically managed from the day they arrive in a trust through a system designed to maximise communication between primary & secondary care
  - Patients are given a choice of three trusts
  - The referral is actively managed to ensure that they are seen in the most appropriate place.

- A new Urology Referrals Manager, the team of urology consultants (including a duty consultant for advice) oversees these new processes with the assistance of the urology nurses.

Outcomes
- Since January 2005 results are being seen and the impact of the new system felt. The main benefit has been much more effective planning and management of out patient resources. DNAs and cancellation rates are down by 2% and 3.5% as is time from referral to first appointment (by 4 days). There has been an increase in ‘Dear Doctor’ referrals (30% to 70%)
  - GPs like consultant support & advice by duty consultant and it uses consultant time better
  - Electronic transfer of referrals allows you to speed up administration process and eliminate unnecessary steps in the process.
3.1(ii) Generic systems change – diagnostics

Problems to be tackled
Urologists, radiologists and sonographers agree that there is a national problem in ensuring ultrasound examinations do not create bottlenecks in the urology patients diagnostic pathway.

The rising rate of patients referred with prostate problems in particular could add significantly to this burden of demand. In 2002 the Audit Commission reported considerable room for improvement.

A range of solutions
During 2004, Action On Urology hosted the production of “Improving Diagnostic Services Together” – a joint publication from national radiological, ultrasound and urology groups in partnership with the Modernisation Agency. It is being issued with this good practice guide and describes how major improvements can be achieved by urology and radiology departments redesigning services together.

This report includes many examples from trusts across the country and include examples from six Action On Urology sites at Ashford (Ultrasound by Urologists), York (Streamlined pathway from referral to diagnosis), Colchester (Assessment & diagnosis closer to the patient’s home – sonographer – led ultrasound in primary care), Ipswich (Nurse & sonographer led TRUS & biopsy), Addenbrooke’s (GP direct access to radiology for renal colic) and Birmingham Heartlands (CT for renal colic in A&E).

Royal West Sussex (GPwSI prostate assessment service), Bath (GPwSI-led prostatic biopsy) and East Berkshire (GPwSI service for LUTS, andrology and vasectomies) have involved GpwSIs in diagnostic processes. (For full details of these projects go the CD)

Ultrasound by Urologists – An example from Ashford and St Peter’s & East and North Herts

Project Managers – Lucy Turner & Sarah Johnston
Clinical Lead – Mr Brian Ellis

Problem
Many urologists already undertake ultrasound scanning but few are formally trained. The Ashford & St Peter’s project examined the cost benefit of training existing consultants and specialist urology registrars to undertake limited ultrasound scanning (to international Level 1)

Solution
Ashford & St Peters and E & N Herts. Trusts examined the feasibility of training specialist registrars in simple ultrasound examination to relieve radiologists and sonographers of a rising routine burden. The project included:

- Piloting a training course for existing consultants
- Working with the three key professional groups (radiologists, sonographers & urologists) through questionnaires and conferences
- Seeking international comparisons and advice
- Piloting training of a specialist registrar to identify training and other issues to be addressed
- Contributing to the production of “Improving Diagnostic Services Together” - a compendium of current good practice on the interface between urology and radiology

Outcomes
- The Royal College of Radiologists has agreed a new curriculum which will be incorporated within urology specialist registrar training towards the “New Consultant Urologist.” which has also now been agreed
- If rolled out across England, national costs and benefits are projected as:
  - Quality – patient journey shortened & urologists appropriately trained
  - Patient access times - 131,351 patient visits could be saved per annum
  - Attendances saved – 121,892 hours of clinic time could be saved each year
  - Cash equivalent generated £33 millions equivalent savings over 10 years
- This report will be formally presented to professional bodies and is commended to clinicians and managers as a contribution to streamlining the urology patient’s diagnostic journey.
**Problems to be tackled**

There is much debate about how outpatient services should be designed. Should they be consolidated so that they can offer a ‘one stop’ service? Are new treatment centres a good location with their diagnostic back up? Can all this be achieved as locally as possible?

**A range of solutions**

Several Action On Urology projects tried to examine how best to organise and locate out patient services along the interface between primary and secondary care.

SW London (Integrated rapid diagnostic outpatients in a primary care setting) and Colchester (Assessment & diagnosis closer to the patient’s home – nurse-led prostate assessment in primary care) have established out patient and nurse led assessment services in community settings. Queen Elizabeth, Woolwich (Hospital/community outpatient liaison) employs a nurse co-ordinator who ensures everything is organised. NE Wales (Outpatient and treatment whole system review – ultrasound) and York (Streamlined pathway from referral to diagnosis) have reduced the patients’ visits by synchronising services either as ‘one stop’ or as in Wales where ultrasound is offered in advance. (For full details of these projects go the CD)

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**Project Manager – Dr Janice Roper**  
**Clinical Lead – Mr Ken Anson**

**Problem**

In South West London service pressures on two acute hospital sites (St George’s & Kingston) required redesign of outpatient and diagnostic services, in particular, to address the high new to follow up ratio for outpatient appointments caused by lack of rapid access diagnostic services. A further aim was to increase the roles of specialist nurses. The project’s plan was to transfer provision of general urology outpatient services to a primary care setting at Queen Mary’s, Roehampton, where patients now have rapid access to diagnostic tests.

**Solution**

Traditional general urology clinics previously held at these three hospitals have been replaced by a clinic on two full days per week at Queen Mary’s Hospital, Roehampton and will transfer to the new treatment centre under construction on the same site.

Concentration of personnel and services allows same day consultation and diagnostic tests to be done. Referral protocols have been agreed and distributed to GPs in the 6 local PCTs. The Booking & Choose and Book project teams have also been involved. The service is available to all general urology referrals from GPs plus some 2 week rule referrals.

The unit is staffed by the existing doctors and nurse specialists from all three trusts plus two new specialist nurses, and includes same day access to radiological investigations, cystoscopy and urodynamics. Patients may be allocated to one of seven pathways with pre-defined referral criteria, nurse led assessments and/or investigations, and be given the results of these investigations on the same day. A ‘general’ appointment is given to those who do not fit any of the pathways. Any patient may have additional investigations booked and performed on the day of their first appointment and then be reviewed with the results.

**Outcomes**

**Patient satisfaction** The service is perceived by patients to be a great improvement. It is also seen as a possible base for the development of urology services and is regarded as a model for services such as gastroenterology. 96% of respondents thought it was a ‘good idea’ or ‘very good idea’ to do tests on the same day as the first appointment. Over 90 percent of respondents stated that they ‘definitely’ or ‘probably’ preferred coming to this type of clinic instead of having to make repeat visits.

**Cost** In the first year the new service was cost neutral to PCTs. In subsequent years it is estimated the service will cost commissioners 40% less than it did before the change.
Outpatient and treatment whole systems review – N E Wales

**Project Manager – Jude Leslie**
**Clinical Lead – Mr P. S. Anandaram**

We are extremely grateful to the NE Wales Health Economy & Welsh Assembly for funding an Action On Urology project in Wales. This has enabled us to share learning and we include details of the Welsh project in this guide. This project is an ambitious one which looks at whole system redesign. It is focussed upon the construction of a new outpatient and diagnostic centre which opened in January 2005. It covers a total of five separate redesign projects:

- **Outpatient and diagnostic centre**
- **Integrated outpatient booking**
- **Urological physiotherapy service**
- **Redesign of ultrasound service**
- **Improved theatre and bed scheduling through pre-operative assessment**

**Redesign booking system**
- Merge all urology outpatient waiting lists to reduce the overall waiting time. Introduce direct booking by appointment clerks, for all urgent suspected cancer referrals.

**Outpatient redesign**
- Synchronise urology out patient appointments with diagnostic tests to reduce hospital visits. This has already been achieved for patients with haematuria by developing a “one stop” service, including ultrasound scan, blood tests, cystoscopy and a consultation appointment. The department wanted to develop a diagnostics and urology out patients unit that could respond quickly to patients needs. In order to achieve this additional endoscopy and ultrasound facilities were required.

**Redesign theatre & bed scheduling model**
- Introduce a combined theatre, equipment and bed-scheduling module.
- Introduce a health-screening questionnaire as part of the T.C.I booking form. This will include a section giving the expected length of hospital stay.
- This will improve discharge planning.

**Develop continence physiotherapy**
- Development of the continence physiotherapy service to include a service for male patients.

**Increase ultrasound capacity**
- Introduce additional U/S resources to reduce waiting times for this procedure.
3.1(iv) Generic systems change – redesigning treatment services

Problems to be tackled
Redesigning treatment delivery can often lead to services that are more acceptable and a better use of resources. For example the men of Stockport are very happy with the new vasectomy service described below but it has also reduced the Stockport urology day case waiting list by 45%. We describe a number of such changes from Action On Urology many of which focus on shifting treatment from a secondary to primary setting.

A range of solutions
Stockport and Tameside & Glossop PCPs (Vasectomies in primary care) established vasectomy services in primary care undertaken by GPs with a special interest in urology (GPwSIs). Dartford (Redesign of TURP pathway) and Bath (Reducing length of stay for TURP) both tried to achieve day case TURPs; New Cross, Wolverhampton (Hospital at Home for TURP & telephone follow up) set up a successful Hospital at Home for TURP patients; S Derbyshire (Integrated continence project), Bolton (A structured approach to catheter care), Rotherham (Redesign of pathway for acute retention of urine) E Berks (Avoidance of emergency admission for blocked catheters) and York (Improve management of urology patients in the community) have been concentrating upon keeping patients out of hospital for acute urinary retention by supporting better catheter care in the community. Ipswich transferred treatment of superficial bladder tumours to a day case basis. NE Wales (Outpatient and treatment whole system review – theatre scheduling) focussed on the internal scheduling of theatres and produced a new scheduling system. York (Booked admissions & use of short stay facility) also focussed on the optimum organisation of a short stay treatment unit. (For full details of these projects go the CD)

Vasectomies in primary care – An example from Stockport & Tameside

(Project Manager – Suzanne Denley Clinical Lead – Mr Rick Brough)

Problem
Waiting times for this procedure were lengthening in both Urology & General Surgery at Stockport. Patients were waiting up to 11 months from GP referral to local anaesthetic vasectomy. The DNA rate for this procedure was high and multiple dates offered to patient seemed not to be suitable. There was also insufficient day case capacity to allow suitable procedures to move from main theatres to day case.

Stockport PCT was at the same time developing its Tier 2 services, and this procedure (bilateral vasectomy using a non-scalpel technique and local anaesthetic) was agreed by both parties to be suitable to be undertaken in primary care.

Solution
Suitable general practitioners were identified. A lead consultant met with PCT and GP providers to agree a service specification, and to confirm that the General Practitioners (GPwSIs) were initially clinically competent in this procedure. This consultant continues to re-accredit and work with the providers as part of continued professional development. The service is commissioned from its GP providers via a service level agreement.

Referrals are directed to the referral information centre, where patients are able to choose their appointment date and time. All are offered a procedure date within 6 weeks of their referral, although patient choice can extend this period. The referral information centre will also deflect any vasectomy referrals that do not specify anaesthesia type and LA Vasectomy referrals from the local hospital directly to the GPwSI.

Stockport service is provided by two GPwSIs, a third is being trained. 2 GPwSIs for Tameside and Glossop PCT have been trained and are deemed clinically competent. This service will start in 2005

Outcomes
Waiting Times In the first 9 months 288 procedures were undertaken, with only 3 onward referrals, all within 6 weeks. Infection and complication rates are monitored.

This service has also reduced the total day case waiting list for Urology by 45%.

Patient views have been positive with comments such as “excellent service, fast and trouble free”.

This change has increased satisfaction for patients and primary & secondary care professionals.

Cost has reduced from £463 to £150 per case
Good practice guide

We asked urology patient groups what they wanted from a good urology service. They all wanted better two way communication, to be treated as individuals and to be involved in decisions about their care. The combined effect of the Choice policy coupled with payment by results and GP commissioning is likely to be a powerful force for change. Several of our projects looked at different aspects of communication.

**Problems**

All services are faced with the challenge of ensuring adequate information and support are given to patients for decision making and that their views are included in the planning of services.

**Proposed Solutions**

- **Informed decision making.** Four Action On Urology pilot sites are taking part in an evaluation of the implementation of North American decision aids and nurse training for prostate cancer & BPH treatment. They are at Stockport, Ipswich, Colchester & East Berkshire. Two other AOU sites – Bradford and York are working with the National Library of Health on Haematuria. See separate Interim Decision Support Report for more detail. Patient Information Five Associate Action On Urology Pilots are investigating systems for making communication better:
- **UCLH NHS Trust – Rapid information transfer from MDT** (Project lead Mr Mark Feneley) is auditing the effectiveness of a new computer system designed to communicate MDT decisions rapidly between primary and secondary care for patients with urological malignancy.
- **Queen Elizabeth NHS Trust, Woolwich – Hospital/community outpatient liaison** (Project Lead – Louisa Ashford) is testing the effectiveness of out patient coordination through the appointment of an OP clinical liaison nurse. Her role is be available to patients and to ensure notes, results patients and staff all arrive together at the same place and time.
- **Winchester & Eastleigh Healthcare – Patient perspective on services** (Project Manager – Ailsa Gibb Clinical Lead – Andrew Adamson) is tackling the hard subject of how to get a real feel of consumer opinion about services without having to rely upon a few individuals with specific axes to grind.

In the meantime five Action On Urology pilot sites have been looking at ways in which information for and about patient decision making can be improved. As Associate pilot sites came later, these sites are not yet able to describe outcomes but the following section describes the areas they are examining.

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### Communication support for patients – Examples from Action On Urology Associate Sites

We asked urology patient groups what they wanted from a good urology service. They all wanted better two way communication, to be treated as individuals and to be involved in decisions about their care.

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**United Bristol Teaching Hospitals – Improved visual information for patients** (Project Manager – Kate Conlon Clinical Lead – Mr Raj Persad) are exploring converting an undergraduate electronic anatomy teaching aid into a discussion aid when discussing diagnosis and treatment with patients. It is hoped that the aid will be able to simulate the effect of operations.

**Bradford Teaching Hospitals – Improved visual information for patients** (Project Lead Mr Rajiv Puri) are exploring the use of videos in explaining treatment options.

**Outcomes**

Still to be reported.
3.2 Continence & catheter care pathways

Our approach

Health & Social Care Continence strategies
The first clinical pathway we consider is continence with which we have grouped catheter care. The need for joined up strategically planned continence services has been recognised nationally by the Older Peoples NSF and is a specific national recommendation. There are still very many places where the continence care system is uncoordinated leading to poor use of scarce resources and, above all, a very poor experience for many patients.

Unmet demand
Should continence services manage to develop as whole systems which patients can move through with ease, there is a second set of challenges. Many potential patients are too embarrassed to declare their needs to health and social services. As services improve, these hidden patients could decide to access the system and could appear in substantial numbers.

Catheter care
Lastly we looked at acute urinary retention and the growing burden of catheter care which is falling either upon district nursing staff or, often inappropriately, in hospital beds. Several of our pilot sites have tried to devise new systems to help manage this growing demand.

A national overview
It is estimated that best practice for long term conditions could:-
- Extend quality of life for millions
- Reduce emergency admissions by 25%
- Reduce bed days needed by 1.2m

There is strong evidence that, if properly managed, the benefits to patients and the NHS by adopting best practice for continence services could be even more dramatic. The numbers are large. The Royal College of Physicians in 1995 estimated the number of patients involved at 2.5 – 4m (compared with 1.4m for Diabetes and 3.4m for Asthma)

DOH guidance in 2000, based on an expert group chaired by Professor Abrams of Bristol, said “Incontinence is a treatable condition”. But the Audit Commission reported in 1999 that “In practice district nurses implement a conservative care plan focused on managing the problem rather than treating the underlying causes”. Apart from what for many is a sentence to many years of embarrassment and poor quality of life, the sheer cost benefits of good care are large. The Continence Foundation in 1998 estimated the total bill for England to be over £353m annually and demonstrated substantial cost benefit from good practice:-
- Avoiding residential care because of incontinence (source Royal Commission on Long Term Conditions1999) – up to 90% lower cost
- Conservative treatment and cure v pads – £100 to £600 per annum for life with pads against treatment by nurse or physiotherapist at a one off total of £150.
- Treatment by nurses as nurse continence advisors as against uro-gynaecologists – 30% lower cost
- Delaying the onset of urinary incontinence – the Royal College of Physicians in 1995 showed scope for 70%-80% cure or improvement rates of suitable cases in primary care. The Audit Commission took a sample of 7 trusts and compared actual assessments with a list of key items from guidelines on best practice. The best trust used only 70% of them and the worst 31%.

The NSF for the Elderly recommended SHAs, PCTs and local authorities to develop a strategy for integrated continence services by April 2004. DOH ‘Good practice in continence services’ in 2000 recommended:
- Identification at practice level of all patients with incontinence
- Full assessment leading to treatment plans and first line treatment in primary care setting
- Integrated continence services run by a Director of Continence Services
- Continence service to be comprehensive
- NICE guidance on incontinence and the Long Term Conditions NSF are in preparation
Continence – Developing a strategy
The Department of Health produced ‘Good Practice in Continence Services’ in 2002; this is also supported by ‘Essence of Care’ which contained patient focused benchmarking for healthcare practitioners. The National Service Framework for Older People (Standard 2) set a goal of having an integrated continence service by April 2004. Both these documents laid a firm foundation for the direction and content of an integrated continence service. There are a number of exemplary strategies in existence including Dorset, Cornwall, Norfolk and Nottingham.

The task of promoting consensus among so many diverse professional groups is very complex. Despite successes therefore there remain many areas of the country where continence services remain a patchwork of ill-connecting services.

The Association of Continence Nurses (ACA), has produced new guidance on how to develop a strategy bringing together PCT commissioning and the challenge of organising services in a way that will ensure the patient finds them seamless. ‘Steps 2 Success’ has been specifically developed to promote integrated continence services and improve the identification, assessment, treatment and long-term management of people affected by incontinence.

One of the specific aims of the toolkit described above is to assist continence advisors to develop their services in line with the requirements of the National Service Framework (NSF) for older people and the Department of Health’s ‘Good Practice in Continence Services’ and thus provide the framework for optimal care of those suffering with incontinence.

Applying good practice
In this section we follow the patient through primary care & referral; diagnosis; treatment and follow up and describe good practice at each stage. We identify ways of implementing the 10 High Impact changes for continence success and these are highlighted below:

Implementing the good practice in this section can help address the following ‘10 High Impact Changes’

✔ Number 2 – Improve flow across the whole NHS system by improving key diagnostic tests
✔ Number 4 – manage variation in the patient admission process
✔ Number 8 – Improve patient access by reducing the number of queues
✔ Number 9 – Optimise patient flows through process templates
✔ Number 10 – redesign and extend roles in line with efficient patient pathways
3.2(i) Continence – designing an integrated service

Problems to be tackled
Continence care is a Cinderella service and has not had the resources it needs. It affects over 15% of all women, and 40% of the over 60s. It is estimated that 40% of people with continence problems keep them hidden for fear of embarrassment. The challenge for many patients is to come forward for help. The task for professionals is to cope not only with the limited resources at present but also with the huge increase in demand which patient confidence could generate.

A range of solutions
We found huge enthusiasm especially from our associate sites to try to improve service integration. Sites worked together sharing good ideas and appreciated the support of the Elderly NSF Continence Lead. There is evidence, however, that despite limited resources there is duplication of services. We heard many reports of several different assessment systems operating in the same area and of patients failing to get optimum care as a result of disjointed systems. Many pilot sites wanted to try to achieve an integrated service. Getting many diverse services together is difficult but we can report on a number of our associates who are making good progress even if they are not yet there.

Stockport, Tameside & Glossop (integrated continence service), Ipswich (Direct referral to nurse/physio for UTI/incontinence), Norfolk & Norwich (A coordinated treatment pathway for continence), Wirral (Integrated continence pathway redesign) and South Derbyshire (Integrated continence project) are all at various stages of mapping and developing integrated services. Addenbrooke’s (Integrated female incontinence pathway incorporating MDT) is developing an integrated female pathway incorporating an MDT for gynaecology and urology joint assessment. In Cambridge a Continence Steering Group has been established to build on the work started by Action On Urology (For full details of these projects go the CD).

Developing an integrated continence service – An Example from Stockport, Tameside & Glossop

**Project Manager – Suzanne Denley**  
**Clinical Lead – Mr Stephen Brown**

**Problem**
Lack of clarity about each professional’s role in preventing, assessing and managing continence issues. Patients had long waits (up to 15 weeks) and were referred to inappropriate professionals. Social care teams are also identifying more continence issues among their clients. Continence leads were already striving to make changes before Action On Urology.

**Solutions**
Over 100 patient, health and social care colleagues came together to map current services for adults, and highlight areas for improvement and possible solutions. Many solutions were found to exist but had not been communicated to all professionals. It was at this point that improvement projects were established.

- Services provided in urology and gynaecology utilise the same protocols and care pathways.
- Continence leads have also developed referral protocols for each service.
- The Incontinence Following Childbirth Risk Assessment Tool (SIFCRAT) has been implemented and assessed. The aim is to prevent future incontinence problems.
- Social services has led the development of a single assessment process for older people.

**Outcome**
Implementation of a continence assessment service has been agreed by all parties. This will ensure that patients needing specialist assessment (including community continence services and secondary care assessment) will be forwarded to the continence assessment service (CAS) for triage and direction to the most appropriate professional, which may include advice for the referring source to implement. The CAS will be piloted in early 2005.
3.2(ii) Continence – primary care, assessment & referral

Problems to be tackled
One of the key organisational problems in treating continence lies in the haphazard way in which patients access (or do not access) care. In many places there are several referral and assessment processes in place led by different organisations resulting in wide variation in outcome and patient experience.

A range of solutions
● Addenbrooke’s (Integrated female incontinence pathway incorporating MDT) have looked both at the route to specialist services and at synchronising urology and gynaecology through an MDT approach to assessment (Gynaecology & Urology) and treatment through a nurse/physio led clinic for incontinence
● Norfolk & Norwich (A coordinated treatment pathway for continence) – Use of non-medical staff to assess, treat and follow-up patients developing a single assessment process supported by direct access to treatment
● Stockport, Tameside & Glossop (Integrated continence service) have developed: - a single assessment process for older people; direct access to urodynamics from community continence and a joint urodynamics protocol
● Ipswich (Direct referral to nurse/physio (for UTI/ incontinence)) The initial assessment, investigation and early management of patients with incontinence and recurrent urinary tract infections within the Urology Department, has been transferred from general Consultant outpatient clinics to an outpatient service lead by a Specialist Nurse
● Colchester (Assessment & diagnosis closer to the patient’s home – nurse-led urodynamics) and
● South Derbyshire (Integrated continence project) have redesigned community based urodynamics services. (For full details of these projects go the CD)

Integrated female incontinence pathway incorporating MDT – An example from Addenbrooke’s

Project Manager- Linda Clarke
Clinical Lead – Mr William Turner

Problem
In Cambridge, female continence services have been provided separately within the specialities of Urology and Gynaecology. Despite the availability of community continence advisors providing services to the surrounding PCTs, the consultants have often remained the first point of referral.

Solution
● New GP Referral proforma for patients with stress and urge incontinence
● Nurse and physiotherapy led clinic for assessment and treatment of stress/urge incontinence
● Establishment of a multidisciplinary clinic for female continence (urology & gynaecology) for complex cases.
● Formation of a continence steering group for the local health economy

Outcomes
Access Despite a slow start, GP referrals are rising and the service is now established and on course to achieve out patient and in patient targets. Waiting times are now 3-6 weeks at both new clinics

Patient satisfaction “So far it has been a satisfying experience in that we can assess the patient in a multi disciplinary approach at one appointment to start with. The patients appear to be pleased at the immediate action and treatment programme which is implemented at the initial appointment.”
Urology Nurse practitioner

Cost additional G Grade Nurse for half day per week & Senior Physiotherapist for half day per week

Clinician conclusions “Having started to run the clinic, it is apparent that to achieve the full potential of such a multidisciplinary team, we will need to follow an oncology multidisciplinary model, and look for formal involvement of colleagues from GU Medicine, Pain Management, Colorectal Surgery, Care of the Elderly, Neurology, Neurosurgery, Psychology, and probably others”. They conclude that plans along these lines “cannot start too early for anyone considering setting up such a service.”

Referrals and attendances at new clinics

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<td>Nurse and physio clinic – inappropriate referral</td>
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<td>Multidisciplinary clinic attendances</td>
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GOOD PRACTICE GUIDE
3.2(iii) continence care – treatment, discharge & follow up

**Problems to be tackled**
There is much evidence of discontinuity of treatment for patients both for incontinence and catheter care.

**A range of solutions**
Several projects looked at how treatment could be integrated as part of the care pathway. Ipswich (Detrusor instability treatment protocol) developed a more effective protocol with primary care for detrusor instability, Norfolk & Norwich developed (A co-ordinated treatment pathway for incontinence) and NE Wales (Continence service for male patients) developed a continence service for male patients. (For full details of these projects go the CD)

**Detrusor Instability Treatment Protocol – An Example from Ipswich**

**Project Manager**- Paul Bloomfield  
**Clinical Lead**- Mr John Parry

**Problem**
Multiple drugs are used for detrusor instability and bladder outflow obstruction. As these drugs are tried on a sequential basis the process showed little uniformity and could take many months. This caused inconvenience to GPs undertaking the collaborative management of these patients and a negative impact on waiting time targets due to the number of outpatient appointments required.

**Solution**
To speed up the patient pathway, reduce ineffective medication and unnecessary consultant appointments, through the introduction of drug protocols coordinated by a Urology Nurse Specialist.

**Outcome**
- Improved pathway, with the next step in treatment being introduced more quickly. Due to length of treatment cycles, data is pending on this outcome. However, as the data below shows, 34 patients have been initiated on appropriate treatment within three months. Previously, this would have taken on average 9-12 months minimum.11 patients have been discharged
- Standardised approach, culminating in a consistent service with patients followed up at the optimal time.

**Patients followed up by telephone**

- Further protocol was developed for telephone follow up by Urology Nurse Specialist, so patients do not have to attend the hospital for follow up, unless clinically indicated. As the data below shows, the number of patients being followed up by telephone steadily increased in the first four months of the new service, before the Christmas break.
- GPs also have the option of having drugs dispensed without the need for an appointment.
- Increased consultant and GP consultation capacity due to reduction in number of outpatient appointments required and service being operated by Urology Nurse Specialist.
- The most recent outcome is that Urology Nurse Specialist can now discharge appropriate patients.
- Early days but tentative data suggests reduced drug costs will result.
3.2(iv) Catheter care

Lastly, in this continence section, we looked at acute urinary retention and the growing burden of catheter care which is falling either upon district nursing staff or, often inappropriately, in hospital beds. Several of our pilot sites have tried to devise new systems to help manage this growing demand.

Problems to be tackled
Sharon Eustace, Nurse Consultant, Royal Cornwall Hospital expressed the view that

“Although the urinary catheter is a fundamental part of modern healthcare, it is an appliance that should be treated with great respect in terms of its impact on morbidity and mortality. The National Institute for Clinical Excellence (NICE) launched guidelines for the care of long-term catheters in June 2003, which focus on preventing healthcare-associated infections in primary and community care.

The EPIC guidelines for preventing hospital-acquired infections associated with short-term indwelling catheters were published in 1998 and set out practice principles. Nosocomial urinary tract infections are costly, mainly associated with the urinary catheter and can delay discharge from hospital.

Therefore when catheters are used inappropriately or left in place too long, it can become a hazard to the patient. Current practice in managing trial without catheters and managing acute urinary retention puts extra strain on secondary care. Refocusing these services in the community can facilitate freeing up of secondary care time and ultimately is better for the patient to be cared for in their own environment.”

A range of solutions
This view is shared by a number of Action On Urology sites who have looked at a variety of ways of managing catheter care in a more effective way

- Dartford & Gravesham (Redesign of TURP pathway) are planning a clearer pathway focussed upon keeping patients out of hospital.
- Stockport, Tameside & Glossop (Catheter care in the community) are using a district nurse/rapid response team to support patients from A & E. They are now looking at the whole pathway
- South Derbyshire (Integrated continence project) is improving the management of primary care patients who require ad hoc catheter intervention within an acute setting.
- Norfolk & Norwich (A coordinated treatment pathway for continence) are developing a co-ordinated treatment pathway.
- East Berks (Avoidance of emergency admission for blocked catheters) are reducing A&E admissions for blocked catheters
- South Tees Hospitals (Outreach nurse service for catheters) are increasing bed capacity through outreach nurse service for catheters
- Bolton Hospital (A structured approach to catheter care) is planning a co-ordinated system of catheter care
- Rotherham General Hospital (Redesign of pathway for acute retention of urine) is redesigning the patient pathway for acute retention of urine.
- York (Provide extended community-based services) is supporting catheter care in the community

(For full details of these projects go the CD)

Redesign of TURP pathway – Example from Dartford & Gravesham

Project Lead – Diane Pearce
General Manager – Alex Tan

Problem
There was a lack of a clear pathway for AUR, which often resulted in patients, who were otherwise well, being admitted to acute surgical beds for protracted lengths of time waiting for urology opinions. This impacted negatively on bed availability for elective surgery, Accident Centre waiting time targets and patient satisfaction.

Solution
Development of a nurse led protocol for management of patients with acute urinary retention attending the accident centre to prevent unnecessary admissions, improve patient pathway and facilitate day case TURP.

Outcomes
- Patient and staff satisfaction surveys – not yet complete but anecdotally patients have increased community care support, better information and reduced hospital visits without emergency admissions
- Number of emergency admissions with acute urinary retention reduced – 98 to 72 in first year
- Reduction in number of steps on pathway – reduced from 6/7 to 5/6
- Elective and emergency target attainment – all targets met including A & E targets.
**Trial removal of catheter at home – Example South Tees**

**Project manager – Sarah Danieli**  
**Urology Clinical Manager – Dawn Watson**

**Problem**  
Patients were being admitted for an average of 2 days for trial removal of catheter (TROC), thus occupying urology beds which could be better used for other patients. It was also felt that providing such a service in the home would provide improved quality of care to patients undergoing TROC.

**Solution**  
An experienced nurse, who was competent in this field, was recruited following consultation with Middlesbrough PCT and other relevant stakeholders. A nursing care plan, male catheterisation competency, and lone worker policy (for those who travel to patients’ homes alone) were developed. The service commenced on 1st September 2004. Once the patient has been seen in A+E, catheterised and given any necessary prescriptions, an appointment is made with the outreach nurse and he is discharged. The nurse visits, removes the catheter, then returns 3 hours later and scans the bladder with a portable scanner. Depending upon the residual volume and ease of passing urine, the patient may then be re-catheterised and given an outpatient appointment or have 1-2 repeat scans at intervals until either he is passing urine well and can then be discharged, or until the trial is deemed to have failed and re-catheterisation is performed.

**Outcome**  
In the first 4 months of the service, 40 patients have been seen, saving 80 bed days. None required emergency admission. It has also been possible to perform pre-assessment at home for some patients who require a TURP. As a result a revised care pathway for TURP is being developed. Patients have been taught intermittent self catheterisation and sheath management where appropriate.

**Avoidance of emergency admission for blocked catheters – Example East Berks**

**Project Lead – Jenny Jones/**  
**Natasha Kennedy**  
**Clinical Lead – Mr Omer Karim**

**Problem**  
Patients with a blocked catheter were unnecessarily attending A & E due to a breakdown in communication between the patients, the ward and the community nursing service. This culminated in a negative impact on A & E waiting times, onward referrals to urology, when patients could be better seen elsewhere and ambulance services being utilised unnecessarily by patients with this condition.

**Solution**  
Implementation of well-publicised out-of-hours District Nurse support for patients with a blocked catheter. Along with provision being made on the ward to provide detailed referral information for district nurses regarding catheter patients.

**Outcomes**  
- Alternative routes to A&E already in place but not being utilised are now part of the revised patient flow
- Data analysis of A&E notes and patient administration system (PAS) identified referral trends, which are being or have been addressed
- The newly revised patient flow is publicised through use of patient information on a handy card, making more information available to the patient on discharge
- Data on outcomes pending. Audit of patient information currently being undertaken
3.3 The prostate pathway

The problems to be tackled
In this section we consider arrangements for the delivery of services for benign prostatic hyperplasia and suspected prostate cancer sufferers.

Prostate cancer
Demand for prostate care continues to grow at a rapid rate (+35% in the last five years) and is set to rise further. The Cancer Programme’s report “Making Progress on Prostate Cancer” November 2004 reports a continuing rise in demand.

- Prostate cancer is now the most common cancer in men in England, with 26,027 new cases diagnosed in England in 2001
- Five-year survival rates improved from around 42% in the late 1980s to 68% in the late 1990s, due in part to the effects of increased PSA testing and earlier detection
- There was a large increase in Prostate Specific Antigen (PSA) testing from prostate cancer in the 1990s
- The main risk for prostate cancer is age

Much has been done in the field of prostate care, particularly through the National Prostate Programme, which was established in 2000, and aims:
- to improve the early detection of prostate cancer
- to improve treatment and care for patients with prostate cancer in the UK
- Organising the delivery of prostate care is a challenge for most departments and many struggle to cope with rapidly increasing demand. Urology professionals told us that managing the numbers, which are cumulative, is a major problem. We have therefore worked closely with the Cancer Programme to produce a joint database of good practice drawn from the Action On Urology Programme and the Cancer Services Collaborative Improvement Partnership.

A good number of Action On Urology sites have undertaken studies into how best to cope with this cumulative caseload.

Trends in prostate cancer incidence and mortality

Source: ONS figures include Wales
Benign prostatic hyperplasia (BPH)

Organisationally the challenges faced in providing good quality and sufficient services for patients with suspected prostate cancer are mirrored in providing services to meet the demands of BPH. An ageing population is bringing the same increasing demands. BAUS abstracts 2004 report that autopsy data indicates that anatomic (microscopic) evidence of BPH is seen in about:
- 25 percent of men age 40 to 50
- 50 percent of men age 50 to 60,
- 65 percent of men age 60 to 70,
- 80 percent of men age 70 to 80
- 90 percent of men age 80 to 90.
S.J Jacobsen et al. ‘Natural history of benign prostatic hyperplasia’ report that the 10 year cumulative incidence of acute retention is very variable, but in large studies it is about 7 per 1000 person years, or about 1% a year. A 60 year old man with moderate to severe symptoms would have a 1 in 7 chance of developing acute retention in the following 10 years. Older age, more severe symptoms and low flow rate all make acute retention more likely. Many colleagues described initiatives to address services for AUR. The associated catheter care issues are described in the previous continence section.

In this series we are also publishing an interim report on the pilot work being done in Action On Urology sites to evaluate the implementation of decision aids for patients deciding upon treatment options for BPH.

What national targets can be addressed by applying these examples?

We describe many examples of service redesign that Action On pilot sites have used to address the growing demands from an ageing population. Applying good practice described in this guide can help you address the following national guidance and targets.

The prostate pathway

The following ‘10 High Impact Changes’ can be addressed by applying some or all of the examples that follow

✔ Number 1 – Day surgery
✔ Number 2 – Access to diagnostic tests
✔ Number 4 – Manage variation in the admission process
✔ Number 5 – Avoid unnecessary follow ups & create the right setting
✔ Number 8 – Improve access by reducing queues
✔ Number 9 – Optimise patient flow through templates
✔ Number10 – Redesign and extend roles in line with pathways

CSC ‘How to Guide – Achieving Cancer Targets’ Urology self assessment questions that can be addressed using these examples from this guide.

✔ Agreed urology pathways.
✔ Electronic or faxed referral with booking and scheduling systems
✔ Single point of contact for referral & standardised referral protocols
✔ Pooling of all referrals and single queue
✔ Rapid access prostate assessment clinics
✔ Single visit clinics with combined tests/ prebooked diagnostic tests
✔ Segmentation but avoid carve out
✔ Extended roles/ Nurse led clinics/Ultrasound led TRUS & Biopsy
Problems to be addressed

Colleagues across the country emphasised the size of the challenge of speeding access to diagnosis for prostate patients. In addition to the sheer weight of numbers being referred there are substantial diagnostic bottlenecks at the stage of ultrasound investigation. Our radiology report describes current best practice. Our workforce report describes how many hospitals have developed extended roles for sonographers or nurses to undertake TRUS and biopsy. In order to create a national set of competencies ‘Skills for Health’ has been commissioned to develop a national competency framework for Cystoscopy and TRUS & biopsy. York, Wolverhampton & Frimley are national pilot sites for TRUS & biopsy.

A range of solutions

Bath (GPwSI-led prostate biopsy) looked at referral and assessment for BPH drawing on primary care support as far as possible including a GPwSI. York (Streamlined pathway from referral to diagnosis) employed a sonographer to undertake TRUS & biopsy and reduced waiting time from referral over 20 down to 4 weeks. Ipswich (Nurse & sonographer led TRUS & biopsy) set up a similar service to York with a specialist nurse undertaking TRUS & biopsy. Colchester (Assessment and diagnosis closer to the patient’s home – nurse led prostate assessment in primary care) established a nurse and sonographer led prostate assessment service in community hospitals in communities remote from the DGH. Royal West Sussex (GPwSI prostate assessment service) established a GPwSI who took direct referrals from GPs and offered much faster service yet take up by primary care was poor. (For full details of these projects go the CD)

Streamlined pathway from referral to diagnosis – An example from York

Project Managers
– Kathy Nicholson- Banks
/ Catherine Bamford
Clinical Lead – Mr Graeme Urwin

Problem

Waiting times for prostate assessment and diagnosis were exceptionally long.

Solution

The aim was to increase the speed of access for the patient by redesigning services. Patients were previously waiting over 20 weeks for a TRUS and Biopsy. The project aimed to maximise patient choice of appointment time, reduce the number of hospital visits by the patient and make better use of consultant time. It was felt that the patient’s first appointment could be better utilised.

Outcomes

Waiting Times

- TRUS and Biopsies – In April 2004 patients were waiting upwards of 20 weeks for a TRUS and Biopsy. With the introduction of the clinic this has been reduced to approximately 4 weeks. This reduction in waiting times has coincided with a quadrupling of demand for TRUS and Biopsies.
- First appointment to diagnosis Prior to the clinic opening patients were waiting approximately 5 weeks. Patients going through the clinic now receive their results 2 weeks after being seen.
- % of urology outpatients fully or partially booked. Between September 2003 and 2004 the percentage booked increased from 38% to 86%

Patients & staff

- One clinic visit was removed on pathway – this freed 500 out patient slots per annum
- Patients are now guaranteed a follow up appointment for results within 2 weeks
- No waiting for TRUS & Biopsy
- High level of satisfaction for patients and staff

Waiting times for TRUS and biopsies

- June 2003 to November 2004
- Number performed
- Median waiting time
3.3.(ii) Prostate – treatment

Problems to be addressed
The rising incidence of prostate disease has created the need to maximise treatment capacity. Several of our projects set about trying to find ways of treating patients’ prostate disease as far as possible in their own home or by discharging them home with support as soon as possible.

A range of solutions
Bath (Reducing length of stay for TURP) attempted to enlist the help of primary care staff and reduce the length of stay for TURP to a day case basis, as did Dartford (Redesign of TURP pathway). Both found the level of twilight and night district nurse support was a limiting factor.

Royal Wolverhampton (Hospital at home for TURP & telephone follow up) supported patients sent home after TURP by senior ward staff who had been formed into a ‘Hospital at Home’ team.

Several sites looked at the management of blocked catheters and acute retention. Their work is described in the previous section ‘Catheter Care’. (These trusts included Dartford & Gravesham, York, South Tees, Rotherham, Bolton, Stockport, Tameside & Glossop and East Berkshire) (For full details of these projects go the CD)

Reducing length of stay for TURP – An example from Bath

Project Manager – Dr Alison Fry
Clinical Lead – Mr Chris Gallegos

Problem
Patients undergoing TURP typically stay in hospital for about 3 days post-operatively, spending a significant part of that time waiting around for a trial without catheter. For younger, fitter patients, there is the potential to reduce length of stay, benefiting the patient and making cost savings on bed days.

Solution
The initial plan was to treat a proportion of TURP patients as day cases, provided they met strict inclusion criteria (i.e. no known cancer of the prostate, were mobile, had no urine retention and prostate ≤ 50mls). Given the difficulties in establishing community nursing support for this cohort on discharge, the project turned to reducing length of stay. This was achieved through a consultant-led initiative to flag-up fitter patients prior to surgery and to closely monitor their inpatient care to promote, wherever possible, discharge within 1 or 2 days.

Outcomes
Average length of stay of cohort group prior to the change was 3.2 days. Average length of stay for patients treated as short-stay cases during the project was 1.8 days. (N=21; average age 62.5 years; 5 bladder neck incisions; 16 TURPs; average resected weight = 10gms).

Quarterly average LOS (in days) for all patients undergoing TURP who were aged under 70 years and had no complications or co-morbidity:
Prostate – follow up, discharge

3.3(iii) prostate follow up

Problems to be tackled
Numbers of patients with raised PSA are estimated to have risen by 42% since 1999 but their need for continual surveillance means that this figure is cumulative. The sheer weight of numbers to be managed in prostate follow up clinics is proving to be a major challenge for most urology departments.

Many Action On Urology projects searched for new ways of managing this workload. Solutions include new nurse roles, telephone follow up and bespoke computer software.

A range of solutions
Bath (PSA tracker software + nurse led telephone follow up) has developed a PSA follow up clinic based on a specialist nurse backed by recall software they have developed; Airedale (Separation of diagnosis and surveillance (prostate cancer)) has separated the diagnostic from surveillance and a specialist nurse now leads on surveillance; Barnet (Nurse led follow up and hormone treatment for prostate cancer) and E Berks (Nurse led follow up for stable prostate cancer) have both established nurse led follow up systems. York (Provide extended community based services), Royal Lancashire (Nurse-led telephone follow up for prostate cancer) and Good Hope, Sutton Coldfield (PSA support including telephone follow up), are also developing follow up based upon telephone follow up and run by a specialist nurse. Royal Wolverhampton (Hospital at Home for TURP & telephone follow up) has established “Hospital at Home” system for TURP patients and now also follows them up by telephone. (To access details of any of these projects go to the CD).

PSA tracker software & nurse-led telephone follow up – Example from Bath

Project Manager – Alison Fry
Clinical Lead – Mr Jonathan McFarlane

Problem
The urology department at the Royal United Hospital saw a 100% increase in the rate of patients diagnosed with prostate cancer between 1999 and 2002. Once their disease has been stabilised, most of these patients will be followed up every 6 months in consultant outpatient clinics over many years, with little change in disease status and only occasional need for intervention.

The department (of 4 consultants) currently sees around 30 follow up prostate cancer patients every week. The new model of patient care that would relieve the burden on patients of attending a hospital appointment, and free up a significant number of consultant slots is described below.

Solution
Rather than seeing a consultant for every follow-up visit, routine follow-ups will be overseen by a specialist nurse, assisted by a new piece of software. Patients will receive a postal questionnaire asking about their general state of health, and have bloods taken for PSA testing in primary care (as they do currently). PSA levels and treatment history will be captured on a new computer system, “PSA Tracker”, which will automatically trigger routine postal follow-up or recall to an outpatient clinic, based on clinically established algorithms for PSA.

The new care pathway is suitable for the majority of patients with slow-growing tumours who are willing and able to complete the health questionnaire.

Exceptions:
(i) Patients with aggressive or late-stage disease.
(ii) Patients who find postal follow-up unacceptable.
(iii) Patients who are unable, for social reasons, to comply with postal follow-up (e.g. elderly people with mental health problems).

As fail safe, patients will be recalled at 2 years.

Outcomes
Estimated benefits
● 100 consultant slots saved per annum (Estimated around 80% of eligible patients will take up questionnaire service)
● Cost of patient pathway reduced from £88,200 pa to £30,063 pa
● Patient satisfaction will be surveyed after service running for 18 months
Problem
To address cancer targets, hospital consultant numbers increased from 3 to 4 with an increase in operating sessions but no increase in bed numbers. It was necessary to look at new ways of increasing capacity.

Solution
‘Hospital at Home’ was developed in April 2002 to try to decrease hospital stay for TURP to allow a greater throughput of patients from the same number of beds.

The service has been expanded to include other patients with a catheter in place who require management previously done within the hospital setting such as trial without catheter (TWOC) and intermittent self catheterisation/dilatation (ISC/D). Some changes of catheter where the primary care nurses are reluctant to be involved are also now performed by Hospital at Home.

Outcomes
● Length of Stay – In 2002, the average length of stay for elective Trans Urethral Resection of Prostate (TURP) patients was 5.8 days. In 2002 and 2003 this figure reduced to 4.6 and 4.8 respectively. Some patients are now being sent home 1st day post op and by December 2004 the length of stay had decreased again to 3.5
● Out patient appointments saved – Telephone follow up for TURP was introduced in 2004 and has reduced the need for follow up hospital appointments by 67 in the first 9 months A further 14 patients required a follow up appointment.
● TWOC at home – In 2003 120 patients had their TWOC carried out in their own homes.
● Family convenience – There is less stress for patients and their families as they do not have to find a parking space at New Cross Hospital
● Ambulance costs – Changing supra pubic catheters in patients’ own homes can reduce ambulance costs. Many of these patients have motor sensory problems which means they require ambulances to get to and from the hospital with long waits at both ends for transport
● Use of Nurse Practitioner Time – Teaching intermittent self catheterisation (ISC/ISD) by the Hospital at Home team frees out patient slots with Nurse Practitioners
● Patient satisfaction – There is a high level of patient satisfaction:
- patients go home from hospital sooner and, due to the age of patients, this is often very important as they worry about their partner being at home alone
- patients have a one to one relationship with the nurse who is looking after them
3.4 The haematuria & bladder pathway

The problems to be tackled
The rising volume of haematuria referrals is, with prostate referral, another major challenge facing both primary and secondary care urology services.

Although the incidence is not rising, the age distribution of bladder cancer is described below, demand for services follows an ageing population. With the availability of dipsticks in primary care & the flexible cystoscope which allows easier investigation, demand for investigation is rising very rapidly.

The national cancer referral guidelines issued in 2002 describe the ratio of benign to malignant disease. This means that for every patient diagnosed with bladder/kidney cancer six patients will have to be investigated and given the outcome. Delivering adequate diagnostic investigations either in primary or secondary care is, therefore, the urgent challenge.

Percentage age distribution – Bladder Cancer

Age standardisation (European) incidence and mortality per 100,000 population, bladder cancer, by sex, Great Britain, 1971-2002

<table>
<thead>
<tr>
<th>Year of diagnosis/death</th>
<th>Rate per 100,000 population</th>
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<tbody>
<tr>
<td>1971</td>
<td>1974</td>
</tr>
<tr>
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<td>1997</td>
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<td>2001</td>
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Rising demand
Two innovations have changed both the level of demand and the way it can be met.
1) Dip sticks have become available, and "ward based" urinalysis have become a standard routine for all patients (a screening test) in hospital outpatient attendances and new patients in general practice.
2) The introduction of the flexible cystoscope. This allows examination of the bladder without the need for a general anaesthetic. Greater numbers of patients can be processed including, potentially, a good proportion of 'worried well'.

How to respond to this rising demand
These innovations raise national issues such as the role of dip stick positive haematuria and who should undertake flexible cystoscopy. These issues were debated at the national learning network at the Lords Cricket Ground conference and the evidence examined. At that event two views were expressed:

Dip Stick Haematuria
It was felt that there should be a differentiation between macroscopic and microscopic haematuria. There is a case for patients with macroscopic haematuria to have a GA cystoscopy and biopsy, preceded by renal scan, to avoid hospital delays. There is an argument to support one stop clinics so that the flexible cystoscopy is done in the out-patient setting at the first visit, ideally with a renal ultrasound scan.

Who should perform flexible cystoscopies?
The evidence examined suggests that a properly trained specialist urology nurse can undertake diagnostic and surveillance flexible cystoscopies to the same degree of accuracy as a urology specialist registrar. Action On Urology therefore focused upon ways of responding to this rising demand both at the stage of diagnosis and later for surveillance cystoscopy.

What targets can be addressed by applying examples in this section?

The following ‘High Impact Changes’ can be addressed by adopting some or all of the following approaches
✔ Number 1 – Day surgery
✔ Number 2 – Access to diagnostic tests
✔ Number 4 – Manage variation in the admission process
✔ Number 5 – Avoid unnecessary follow ups & create the right setting
✔ Number 8 – Improve access by reducing queues
✔ No 9 – Optimise patient flow through templates
✔ Number 10 – Redesign and extend roles in line with pathways

CSC ‘How to Guide – Achieving Cancer Targets’ Urology self assessment questions that can be addressed using these examples from this guide
✔ Agreed urology pathways.
✔ Electronic or faxed referral with booking and scheduling systems
✔ Single point of contact for referral & standardised referral protocols
✔ Pooling of all referrals and single queue
✔ Rapid access prostate assessment clinics
✔ Single visit clinics with combined tests/ prebooked diagnostic tests
✔ Segmentation but avoid carve out
✔ Extended roles/ Nurse led clinics/Ultrasound led TRUS & Biopsy
3.4 (i) Haematuria & Bladder – Primary Care & Referral

Problems to be addressed
The most pressing problem lies in finding a satisfactory way of meeting rising demand. There has also been much debate around whether diagnostic work up is part of primary or secondary care. The model described below from Colchester takes the assessment process out into the community in the coastal areas of Clacton and Harwich.

A range of solutions
Colchester (Assessment & diagnosis closer to the patient’s home – nurse-led cystoscopy) has developed comprehensive nurse led services and introduced ultrasonographer led urosonography to complete the primary care diagnostic range in the coastal towns of Clacton and Harwich. Cystoscopy is part of the range of services provided. Addenbrooke’s (One stop haematuria clinic with CT) in another study replaced ultrasound and IVU with Spiral CT as the investigation of choice for High Risk Haematuria. Airedale (Step approach to creating one stop haematuria clinic) took a stepped approach to ‘one stop’ haematuria clinics. (For full details of these projects go the CD)

Assessment & diagnosis closer to the patient’s home – Nurse Led Cystoscopy – An example from Colchester

Project Manager – Susie Nichol/Margaret Sims
Clinical Lead – Prof Chris Booth

Problem
There has been much debate around whether diagnostic work up is part of primary or secondary care. This model from Colchester takes assessment entirely into primary care and compares implementation in two PCTs, one central (Colchester) and one isolated and rural-centred around Clacton & Harwich Community Hospitals (Tendring). For the retired elderly patients living along the Essex coast in Clacton, Harwich and other retirement towns many of whom do not own cars, a 40 or 50 mile round trip to Colchester can be difficult.

Solution
Community based clinics – andrology, cystoscopy, prostate assessment, and urodynamics, were established in two community facilities in Tendring (Clacton & Harwich). This is an isolated rural PCT. The project was strongly supported by the PCT & DGH CEOs. Capital funding of £160,000 was provided by 2 charities. Community based clinics were established. This evaluation covered translocation of 6 services:
- Prostatic Assessment
- Intravesical Chemotherapy
- Pressure/flow urodynamics
- Andrology
- Nurse Cystoscopy

Clacton – overall how satisfied are you with nurse-led Cystoscopy services

- Abdominal Ultrasonography
  - Clinics have nurse and sonographer led ultrasound. Apart from travel benefits to patients, there are service delivery benefits. The provision of portable urodynamic equipment will halve the number of patients travelling from the periphery to the DGH and free two day unit sessions per week for more appropriate use. Nurse training was important and time consuming. There is a need for national competencies, which Skills for Health are addressing.

Outcomes
In this isolated rural PCT all services were successfully implemented. In the central PCT surrounding the Colchester General Hospital only prostatic assessment and andrology were ultimately translocated. It was concluded that a DGH specialist urology suite remains the best service model for this geography with its urban setting close to the DGH.

Overall, prostatic assessment doubled to 1,100 new cases per annum. Nurse cystoscopy released 2 middle grade urologist sessions a week, urodynamics released 2 Colchester General Hospital day unit sessions a week, and PCT ultrasonography cut the wait from 8 to 2 weeks in both the Colchester General Hospital and the 2 PCTs.

Patient views from Clacton:
- 92% had confidence in nurses
- 92% were satisfied with waiting times
- 100% felt they had enough information
- 76% had important questions answered
- 97% felt privacy was respected

“Easy to get to. Easy to park, no queues or waiting. Very efficient and probably the least discomfort I have experienced from any cystoscopy” Patient.
3.4 (ii) Haematuria & Bladder – Diagnostic investigation

Problems to be addressed
With the increasing demand for cystoscopies, urology has looked to develop the roles of non medical staff to undertake this task. With this report we are also issuing “The New Urology Workforce: Overview of emerging trends”. This report contains a summary of new roles and educational initiatives being developed in urology. It is clear that many new roles are being created, mainly among specialist nurses, to undertake cystoscopy. Many trusts also report developing local competency frameworks and training courses.

It was to halt the proliferation of different competency frameworks, that Skills for Health were commissioned jointly by the Changing Workforce Team; the National Screening Programme; Action On Urology and the National Cancer Programme to develop a national set of competencies with TRUS and biopsy pilot sites at York, Frimley Park and Wolverhampton. (Pilots for Cystoscopy are at Airedale and Milton Keynes).

A range of solutions
Addenbrookes (One stop haematuria clinic with CT) has used CT as part of a one stop haematuria clinic. Stockport, Tameside & Glossop (Holistic bladder cancer pathway) have taken a radical look at the whole bladder cancer pathway. Airedale (Separation of diagnosis and surveillance (bladder cancer – including nurse cystoscopist) has developed a specialist nurse role for the surveillance of cancer patients. Addenbrooke’s (One stop haematuria clinic with CT) has tried the use of CT for high risk haematuria. Colchester (Assessment & diagnosis closer to the patient’s home – nurse-led cystoscopy) undertake cystoscopy in a community setting. (For full details of these projects go the CD)

One stop haematuria clinic with CT – Example from Addenbrooke’s – A possible solution awaiting further clinical evaluation

**Problem**
Overwhelming demand from haematuria referrals.

**Solution**
To extend the benefits of a one-stop clinic to patients presenting with high risk haematuria by taking advantage of novel diagnostic processes within radiology.

- Replace USS and IVU with Spiral CT as the investigation of choice for high risk haematuria.
- Complete radiological and other diagnostic investigations in one attendance.

**Outcomes**
- Under National Tariff there is currently no additional cost to commissioners as a result of the change in imaging modality.
- This study directly contributed to a reduction in waiting time for one stop haematuria clinics from 13 weeks to 3 weeks between September 2003 and September 2004.
- It was considered that the volume of patients in the study would be insufficient to draw any conclusions on the clinical effectiveness of CT as the most appropriate imaging modality for high risk haematuria.

- The project will be considered along with a systematic review by the Department of Urology, University of Cambridge and the NHS Centre for Reviews and Dissemination, York. The purpose is to develop an algorithm for haematuria, and it is possible that CT scan will be identified as the gold standard against which other investigations will be tested.
3.4(iii) Haematuria & Bladder – Treatment

Problems to be addressed
The challenge is to increase the use of day surgery to make the experience more convenient for patients and free in patient capacity.

A range of solutions
Ipswich (Superficial bladder tumour laser treatment as day case) set up a day case service for superficial bladder cancers coupled with a nurse led service which also actively follows up patients with detrusor instability. This will not only improve patient treatment but reduce drug and clinic costs substantially. (For full details of these projects go the CD)

Superficial bladder tumour laser treatment as day case – An example from Ipswich

Project Manager – Paul Bloomfield
Clinical Lead – Mr John Parry

Problem
There are a significant number of patients with superficial bladder tumours in need of treatment. These were previously admitted and stayed in hospital for one or two days. By using a holmium yag laser, these patients can now be treated by means of a flexible cystoscope as day cases.

Solution
Patients requiring ablation of recurrent superficial bladder tumours are now treated under topical anaesthesia with laser as a day case. A consultant urologist performs this procedure in the urology operating theatre. At present, one session is conducted each month.

One urologist had sufficient experience of laser surgery to undertake this work. A laser was leased on a sessional basis. One operating list per month was earmarked for laser surgery. Due to legal and safety requirements associated with laser usage and the de-contamination of the flexible cystoscopes, it was decided to perform the treatment in the urology operating theatre.

In order to avoid the use of an inpatient bed and theatre recovery facilities, patients are admitted to the day surgery unit where a urology nurse specialist admits them and takes them to theatre in a wheelchair. Back in the day surgery unit, post operative advice is given followed by discharge.

Outcomes
All the outcomes have been positive except that having to lease the laser prevents its extended use for TURP patients.

● Anaesthetic time released for other surgery
● Ward beds released creating capacity (Table below)
● Day surgery unit better utilised
● Improved throughput on lists
● Shorter waiting time for patients

Bed days saved

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(For full details of these projects go the CD)
3.4.(iv) Haematuria & Bladder – Follow up

Problems to be tackled
The challenge lies in developing new roles to help undertake the increasing surveillance role for bladder cancer patients.

A range of solutions
Airedale (Separation of diagnosis and surveillance (bladder cancer – including nurse cystoscopist)) has developed a specialist nurse role to lead in the work of cancer patient surveillance. Nursing staff at Airedale and Bradford University have taken a prominent national role in developing and sharing a competency framework for flexible cystoscopy. The trust is now a pilot site for the development of a national cystoscopy framework with Skills for Health.

Stockport, Tameside & Glossop (Holistic bladder cancer care pathway) have undertaken a major redesign of the whole bladder cancer patient’s journey including expanding roles and ensuring rapid communication with GPs when bad news has been given.

Ipswich (Nurse-led telephone follow up Nurse-led telephone follow up Nurse-led telephone follow up) has developed telephone follow up services for bladder cancer patients. (For full details of these projects go the CD)

Separation of diagnosis & surveillance (bladder cancer – including nurse cystoskopist) – An example from Airedale

Project Manager – Linda Beckett
Clinical Lead – Mr Ian Appleyard

Problem
The need to streamline services for Airedale patients became evident as waiting times for non-urgent urological patients began to increase, resulting in delayed diagnoses with potentially serious consequences. The main cause of the delay was the development of fast track referrals for suspected cancer patients compounded by the ever-increasing expansion of cancer review patients. It became evident that there was a need to separate long term monitoring of diagnosed cancer patients from those who had not yet had a diagnosis.

Solution
Two nurses have been trained through a competency based training package developed by the clinical teams in the trust. The nurses performed cystoscopies initially on surveillance patients but have now progressed and are doing diagnostic cystoscopies. The surveillance patients have all had cancer and undergone bladder surgery. Diagnostic patients have presented with frank or microscopic haematuria. The nurse cystoscopists have also graduated to doing meatal dilatation, taking of biopsies and stent removal.

The urology nurse specialist holds a weekly major cancer follow up clinic. The clinic is protocol driven for post kidney, bladder and prostate surgery patients.

Prior to having a urology nurse specialist in post, the major cancer follow-ups were seen in a mixed clinic of varying conditions. This new clinic ensures all the cancer follow up patients are seen in this clinic which has ensured a more streamlined pathway and the patients receive the help and support which was sometimes lacking in mixed clinics. Patients have more time to speak to the nurse about their care. The nurse has the consultant on hand in the new cancer referrals clinic.

Outcomes
● Waiting times have decreased.
● Patient and staff satisfaction is high.
● Referral from GP to treatment times have decreased.

Waiting time for flexible cystoscopy

May 27th to October 28th 2004
3.5 The renal pathway

Challenges
This section focuses upon renal stones. We describe three major studies in Birmingham Heartlands, Addenbrooke’s and Derriford Hospitals. Current advice from Prodigy (DOH clinical governance advice) describes renal disease incidence as follows:
- Kidney stones are common in industrialised nations; up to 15% of Caucasian men and 6% of women will develop one stone, with recurrence in about half these people (Bihl & Meyers2001).
- The incidence of renal colic is thought to be increasing; higher incidence being associated with economic development, possibly due to an increase in dietary protein and salt.
- The incidence of renal colic is highest in middle age.
- Multiple recurrence is higher in those with primary hyperparathyroidism, renal tubular acidosis, cystinuria, a combination of different metabolic abnormalities, and those who have recurrence within a short period of time.

As rates of renal colic increase, the problem addressed by these projects is the speedy diagnosis and treatment of renal colic and renal stones while at the same time avoiding patients having to wait for days as inpatients for diagnostic tests.

What Action On Urology projects examined
Both Birmingham Heartlands and Addenbrooke’s addressed the issue of using CT as modality of choice over IVU. Heartlands (CT for Renal Colic in A&E) tested this in the A&E setting and Addenbrooke’s (GP direct access to radiology for renal colic) in the outpatient setting.
Derriford Hospital, Plymouth (Renal stone pathway redesign including EWSL), examined the way they deliver the renal pathway with particular reference to the regional mobile lithotripsy service. They also developed the role of a renal specialist nurse.

What targets can be addressed by applying these examples?

Applying the lessons from these projects will help address the following of the ‘10 High Impact Changes’:

✔ Number 2 – Improve patient flow across the whole NHS system by improving access to key diagnostic tests
✔ Number 3 – manage variation in-patient discharge thereby reducing length of stay
✔ Number 4 – manage variation in the patient admission process
✔ Number 10 – redesign and extend roles in line with efficient patient pathways
✔ IP & OP waiting time targets
✔ A&E Targets
3.5 (i) Renal Stones – Referral – A & E

Problems to be tackled
Patients attending A&E are traditionally admitted and await IVU examination. This involves:
- A delay for patients before examination
- A bed is occupied while they wait

Birmingham Heartlands (CT for Renal Colic in A&E) examined the use of CT

CT for Renal Colic in A&E – An example from Birmingham Heartlands

**Project Manager** – Linda Freeman  
**Clinical Lead** – Mr Sean Morris

**Problem**
Prior to the project, patients presenting in A & E with renal colic would be admitted to await IVU investigation.

**Solution**
These patients are now receiving CT immediately (when radiology can be accessed) or within 12 hours. CT investigation is less invasive for patients, less time consuming and has a higher sensitivity and specificity than IVU. The project will also release bed capacity, as fewer renal colic patients will require admission.

The change happened through collaboration between A&E, Radiology and Urology Directorates. Draft protocols for re-designing the pathway for renal colic patients were written then agreed by the clinical lead from each area (A & E, Urology and Radiology)

A key aspect was the involvement of IT. It was vital that a system was devised that would pull existing data from radiology and A & E IT systems. IT were unable to respond for some time.

**Outcomes**
- In the first 12 months of the project 423 patients underwent CTKUB through this project. 109 were discharged from A&E.
- The procedure was strongly preferred by patients & supported by staff
- The bed occupancy for patients with renal colic fell from 2.8 to 2.2 days per patient.
- Costs were cheaper per patient for CT
  - IVU £71 per patient (£86 out of hours)+ bed days occupied
  - CT £45 per patient (£60 out of hours) + significantly reduced bed days
- The number of other investigations carried out fell from 16/100 to 10/100 patients.
3.5 (ii) Renal Stones – Referral – GP

Problems to be tackled
Addenbrooke’s GP direct access to radiology for renal colic chose to tackle the same problem of renal colic patients waiting in beds with CT as the treatment of choice but applied it to GP referrals giving them direct access to CT.

A range of solutions
See Birmingham Heartlands Renal project above.

GP direct access to radiology for renal colic – An example from Addenbrooke’s

Project Manager – Linda Clarke
Clinical Lead – Mr William Turner

Problems
● Patients were referred to Urology without any prior imaging to diagnose a urological condition.
● Patients were being admitted and utilising bed days awaiting imaging to confirm their diagnosis.
● There was no consistency in the imaging used to diagnose patients with suspected renal colic.

Solutions
The aim was to develop
● Primary care direct access to radiology for renal colic &
● CT as the investigation of choice
A new protocol driven system of management for renal colic patients was developed in partnership with radiology and primary care. It included

- New protocol for the management of suspected Renal Colic
- Provide fast track direct access to radiology for primary care
- Commence Spiral CT as the preferred method of diagnosing Renal Colic
- Direct referral from radiology to urology for confirmed cases.
  
  The change was implemented with little or no resistance.
- Consultant leads from urology, radiology and accident and emergency had ownership of the project and were motivated to make the change.
- Capacity was available within CT Scanning.
- The concept had been presented to a GP symposium a year earlier with a positive response.
- “In-house” management of the project. The service manager facilitated the project thus resulting in no resistance to change which may have arisen if an external project manager had been the project manager.
- The diagram below identifies the key actions that were undertaken to deliver the project:

Outcomes
1. The CT outpatient option is much cheaper for the PCT – via the national tariff CT total £406 (tariff rates – CT £69: OP £337) versus emergency admission at £943 -£2029
2. In the first 6 months of 2004/5, Urology has seen a 13% reduction in outpatient referrals compared to the first 6 months of 2003/4. The change in referral pathway for renal colic may have contributed to this reduction.
3.5(iii) Renal Stones – Treatment

**Problems to be tackled**
Providing a high standard of EWSL treatment & associated information

**A range of solutions**
Derriford Hospital Plymouth found that the EWSL results that they were getting from their mobile visiting service were less than optimal. They redesigned the pathway and created a new role of Stones Nurse.

---

**Renal stone pathway redesign including EWSL – An example from Plymouth**

**Project Lead – Jane Gosling**
**Clinical Lead – Mr A Dickinson**

**Problem**
A previous audit had shown the trust’s results from ESWL were unimpressive.

**Solution**
The trust initially hoped to look at the whole pathway for stone disease patients. The project actually focussed on two aspects – ESWL treatment and patient information.

By redesigning the pathway and by using a specialist nurse to co-ordinate the service, it is hoped that the next audit will show improvements.

**Outcomes**
- Project has streamlined the patient’s journey when presenting in either A & E or Admissions Ward.
- It has improved the assessment and management of patients with acute retention of urine.
- Utilised hospital beds more efficiently by reducing the need for an in-patient stay.
- Improved assessment strategy including diagnostics whilst encompassing the skills of the clinical nurse specialist.
- New patient information leaflets have been produced for several aspects of stone management.
- Further benefits are anticipated eg.

1. Re-organisation of Outpatient Clinic profiles.
2. Re-organisation of other aspects of Specialist Nurse role.
3. Expected reduction in number of KUB X-rays as reduced waiting times between decision to treat and achieved treatments.

- The project has given the opportunity to explore the needs of a “forgotten” group of patients. It has generated interest from Medical Physics, Chemical Pathology, Radiology and Nephrology so further service improvements or research are likely to occur in the future.
In conclusion – constructive themes & instructive failures

Our Action On urology sites have gained a huge amount of experience and insight into what works and what does not work in making service design changes. We asked them what they had learned and what they would not do again.

The good news
The good news was that nearly all of our projects found the experience satisfying and rewarding. Some projects were not successful but the large majority achieved their aims. Participants have shared their work with others in the national learning set all the way through.

Understanding & dealing with constraints
They all said that it was important to understand the constraints upon development. They singled out the following

Get help with managing organisational change
- Good communication was a major issue for everyone
- Many sites stressed the need for early discussion with PCTs to ensure that the new service would be acceptable.
- Many looked for greater understanding of change management & organisational development
- Consultation on change was particularly challenging as patient partnership forums bedded in and scrutiny committees took on their new role.
- SW London describe their experience of consulting with large numbers of organisations
- The lesson learned by everyone was that it always takes much longer than you think it will.

Primary / secondary care location of work
- There are no longer any clear boundaries between what should be done in primary and what in secondary care.
- It is essential for dialogue to take place between primary and secondary care and for shared agreement on the direction of travel.
- The rise in referrals cannot be absorbed – referral management is essential.
- Changing referral patterns can be a long slow business so a great deal of time is needed.
- Royal West Sussex could not persuade their PCT to fund their GPvSi because take up had been slow

A shrinking workforce pool
- Many projects developed new roles. There is now a very complex national picture of role development and much needs to be done to systematise it. All were clear that new roles need to reflect new service needs.
- The Ashford project began a very extensive communication exercise with radiologists and urologists

Tariff – payment by results
- Those of our projects who are already using the national tariff were acutely aware that it can act as a powerful lever or constraint in designing new services.

Some practical lessons from work on clinical pathways

Continence & Catheter Care pathways
- Engaging everyone who has a stake in continence services was a lesson learned by many. Ipswich tried to find a solution in secondary care alone and had to retrace its steps. It is now progressing towards a really integrated service as a result.

Prostate pathways
- Dartford and Bath found limited community nursing support to be a constraint in sending home TURP patients early.

Haematuria & Bladder pathways
- Many specialist nurses are undertaking cystoscopy. Patient satisfaction ratings were high but there was an urgent need to create nationally transportable qualifications.
Appendix A

Membership of the action on urology national steering group

Nick Evans, Chairman
Jennifer Fenelon, National Programme Director, Action On Urology
Dr Mary Archer, Patient
Richard Barker, Director of Business and Development, Newcastle upon Tyne Hospitals
Dr John Connolly, GP with a specialist interest in Urology, Bradford
Dr Colin Evans, Uro-radiologist, University Hospital of Wales
Eileen Fairclough, Director of Modernisation, NW London SHA
Mr Mark Fordham, Consultant Urologist, National Clinical Lead Action On Urology & Cancer Services Collaborative
Gilmour Frew, National Urology Programme Manager, Action On Urology & Cancer Services Collaborative (until September 2004)
Jane Gosling, Nurse Consultant, Plymouth
Dr Patricia Harndon, Consultant Histopathologist Leeds Urological Histopathology representative, Royal College of Pathologists
Mr Mark Harrison, Consultant Urologist, National Clinical Lead Action On Urology
Dr Ian Jack, Former PEC Chairman, North Devon PCT
Lynn Kirkwood, Former President BAUN and Specialist Urological Nurse, Weston Super Mare
Mike Lockett, Patient (from June 2004)
Emma Prichard, National Programme Manager Action On Urology (from November 2004)
Mr Paddy O’Reilly, Consultant Urologist, Stockport and President Elect of BAUS
Alan Robson, Wating Times Policy Lead, Department of Health
David Rowlands, Patient (until June 2004)
Bill Stevenson, Director of Modernisation, Peterborough Hospitals.
Jackie Younger, Lead Workforce Designer, Changing Workforce Programme
Steering Group Administrator – Mrs Ruth Cowley, Associate Programme Manager, Action On Urology

Appendix B

Alphabetical list of Action On Urology sites – work strands

To access the associated documents on the CD please click here

<table>
<thead>
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<th>Action On Urology National Team</th>
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<tbody>
<tr>
<td>National Programme Director – Jennifer Fenelon</td>
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<tr>
<td>Programme Manager – Emma Prichard</td>
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<td>Associate Programme Manager – Ruth Cowley</td>
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<td>Clinical Lead – Mark Fordham</td>
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<td>Clinical Lead – Mark Harrison</td>
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<td>Database Developer – Dr Janice Roper</td>
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Participating Organisations

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<tr>
<th>Lead Trust(s)</th>
<th>ACTION ON UROLOGY WORK STRANDS BY TRUST</th>
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<tbody>
<tr>
<td>Addenbrooke’s + Hitchin</td>
<td>1. GP direct access to radiology for renal colic</td>
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<tr>
<td>NHS Trust South Cambs + Huntington PCTs Norfolk, Suffolk &amp; Cambs SHA</td>
<td>2. Integrated female incontinence pathway incorporating .MDT.</td>
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<td>Clinical Lead – Mr William Turner</td>
<td>3. One stop haematuria clinic</td>
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<td>– Nurse-led prostate assessment</td>
<td>4. Domiciliary intravesical chemotherapy</td>
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<td>– Andrology in primary care</td>
<td>5. PSA tracker software + nurse-led telephone follow up</td>
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<td>– Nurse-led cystoscopy</td>
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<td>– Sonographer – led ultrasound</td>
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<td>– Domiciliary intravesical chemotherapy</td>
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<td>– CT for renal colic in A&amp;E</td>
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<td>– Nuclear medicine</td>
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<td>– Ultrasound by Urologists</td>
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<td>– Promoting direct electronic referral</td>
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<td>– One stop haematuria clinic (bladder cancer – including N cystoscopist)</td>
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<th>Participating Organisations</th>
<th>Lead Trust(s)</th>
<th>ACTION ON UROLOGY WORK STRANDS BY TRUST</th>
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| East Berks | East Berks | 1. GPvS service for LUTS, andrology and vasectomies  
| | Project Manager-Jenny Jones | 2. Avoidance of emergency admission for blocked catheters  
| | Natasha Kennedy | 3. Ambulance Service category C calls analysis  
| | Clinical Lead – Mr Omer Karim | 4. Nurse led follow up for stable prostate cancer |
| Ipswich Hospital | Ipswich | 1. Rapid access ultrasound from primary care  
| | Clinical Lead – Mr John Farr | 2. Direct referral to nurse/physio for LUTS/incontinence  
| | Project Manager – Paul Bloomfield | 3. Nurse & sonographer led TRUS & biopsy  
| | | 4. Superficial bladder tumour treatment as day case  
| | | 5. Detrusor instability treatment protocol  
| | | 6. Nurse-led telephone follow up |
| Royal W Sussex +W Sussex PCT | Royal W Sussex | GPvS prostate assessment service  
| | Project Manager – John Grenfell | Clinical Lead – Mr Philip Adcock |
| SW London | St Georges | Integrated rapid diagnostic outpatients in a primary care setting  
| | Clinical Lead – Mr Ken Arson | Project Manager – Jane Roper |
| | Project Manager – Suzanne Denley | Clinical Lead – Mr Rick Brough |
| Stockport NHS Trust | Stockport NHS Trust | 1. Holistic bladder cancer care pathway  
| | Project Manager – Jack Short | 2. Integrated continence service  
| | Clinical Lead – Mr Simon Carter | 3. Referral management system  
| | | 4. Vasectomies in primary care  
| | | 5. Catheter care in the community |
| West London | West London | Whole health economy urology referral system  
| | Project Manager – Jack Short | Clinical Lead – Mr Simon Carter |
| York Health Services & Harrogate NHS Trust | York Health Services | 1. Streamlined pathway from referral to diagnosis  
| | Project Manager – Kathy Richardson | 2. Provide extended community-based services  
| | Banks & Catherine Barnford | 3. Booked admissions & use of short stay facility |
| | Clinical Lead – Mr Graeme Unwin | 4. Outpatient and treatment whole system redesign including –  
| | | continuing service for male patients ultrasound referral management theatre scheduling |
| NE Wales Health Economy | NE Wales Health Economy | 1. Outpatient and treatment whole system redesign including –  
| | Clinical Lead – Jude Leslie | continuing service for male patients ultrasound referral management theatre scheduling |
| | Clinical Lead – Mr F.S. Anandaram |  
| | |  

#### Appendix B – Alphabetical index of projects

**Clinical Lead** – Mr P.S. Anandaram

**Project Manager** – Jude Leslie

**NE Wales Health Economy** + N Wales Cancer Network

**Clinical Lead** – Mr F.S. Anandaram

1. Outpatient and treatment whole system redesign including – continuing service for male patients ultrasound referral management theatre scheduling

**Associate National Pilot Sites**

- **Birkbeck, Wallasey & Wirral PCT**
  - Project Manager – Deborah Oliverhead
  - Lead – Sue McGorry
  - Work strand: Integrated continence pathway redesign

- **Bolton**
  - Project Lead – Vicky Welsby
  - Work strand: A structured approach to catheter care

- **Bradford**
  - Project Lead – Mr Rajiv Puri
  - Work strand: Improved visual information for patients

- **Darlington & Gravesham**
  - Project Manager – Diane Pearce
  - Work strand: Redesign of TURP pathway

- **Good Hope Hospital**
  - Project Lead – Mr Michael Foster
  - Work strand: PSA support including telephone follow up

- **Lancashire Teaching Hospitals**
  - Project Manager – Julie Cornwell
  - Work strand: Nurse-led telephone follow up for prostate cancer

- **North Berks & Oxfordshire**
  - Project Manager – Mr Rajiv Puri
  - Work strand: Improved visual information for patients

- **Rotherham**
  - Project Lead – Louisa Ashford
  - Work strand: Hospital/community outpatient liaison

- **Wolverhampton Hospital Trust**
  - Project Lead – Tessa Morgan
  - Work strand: Redesign of pathway for acute retention of urine

- **South Derbyshire**
  - Project Manager – Pat Smith
  - Work strand: Integrated continence project

- **South Tees**
  - Project Manager – Sarah Danieli
  - Work strand: Outreach nurse service for catheters

- **UCLH**
  - Project Lead – Mr Mark Fenney
  - Work strand: Rapid information transfer from MDT

- **United Bristol**
  - Project Manager – Kate Conlon
  - Work strand: Improved visual information for patients

- **Whips Cross Hospital**
  - Project Manager – Alix Gibb
  - Work strand: Patient perspective on services

- **Whips Cross Hospital**
  - Project Manager – Alison Stock
  - Work strand: Planning discharge effectively (No case study submitted)
### Action On urology matrix of work strands

<table>
<thead>
<tr>
<th>Generic systems</th>
<th>Continence &amp; catheter care</th>
<th>Prostate</th>
<th>Haematuria &amp; bladder</th>
<th>Renal</th>
<th>Primary care/referral</th>
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- **Primary care/referral**
- **Diagnostics**
- **Treatment**
- **Discharge & follow up**
### Generic
- Colchester: Assessment & diagnosis closer to the patient’s home – all streams
- Bath: Promoting direct electronic referral
- E Berks: Ambulance service Category C calls analysis
- Ipswich: Rapid access to ultrasound from primary care
- Stockport: Referral management system
- N E Wales: Whole system redesign – referral management
- West London: Whole health economy unsolicited referral system

### Continence/catheter
- Addenbrooke’s: Integrated female incontinence pathway incorporating MDT
- Bolton: A structured approach to catheter care
- Colchester: Assessment & diagnosis closer to the patient’s home – Nurse-led urodynamics
- E Berks: Avoidance of emergency admission for blocked catheters
- Ipswich: Direct referral to urophysio for UUT or incontinence
- Rotherham: Redesign of pathway for acute retention of urine

### Prostate disease
- Colchester: Assessment & diagnosis closer to the patient’s home – Nurse-led prostate assessment in primary care
- Royal West Sussex: GPwSI prostate assessment service
- York: Streamlined pathway from referral to diagnosis

### Haematuria/bladder
- Addenbrooke’s: One step haematuria clinic with CT
- Airedale: Step up approach to creating one stop haematuria clinic
- Colchester: Assessment & diagnosis closer to the patient’s home – Sonographer-led ultrasound in primary care

### Renal disease
- Addenbrooke’s: GP direct access to radiology for renal colic
- Birmingham Heartlands: CT for renal colic in A&E
- Colchester: Assessment & diagnosis closer to the patient’s home – nurse-led prostate assessment in primary care
- Colchester: Assessment & diagnosis closer to the patient’s home – andrology in primary care
- E Berks: GPwSI service for LUTS, andrology and vasectomies
- Ipswich: Nurse and sonographer-led TRUS & biopsy
- Royal West Sussex: GPwSI prostate assessment service

### Outpatients and diagnostic
- Addenbrooke’s: GP direct access to radiology for renal colic
- Ashford & St Peter’s: Ultrasound by biologists
- Bath: GPwSI led prostatic biopsy
- Birmingham Heartlands: CT for renal colic in A&E
- Colchester: Assessment & diagnosis closer to the patient’s home – nurse-led prostate assessment in primary care
- Colchester: Assessment & diagnosis closer to the patient’s home – andrology in primary care
- E Berks: GPwSI service for LUTS, andrology and vasectomies
- Ipswich: Rapid access to ultrasound from primary care
- Ipswich: Nurse and sonographer-led TRUS & biopsy
- Royal West Sussex: GPwSI prostate assessment service
- SW London: Integrated rapid diagnostic outpatients in a primary care setting
- N E Wales: Whole system redesign – ultrasound
- Queen Elizabeth Woolwich: Hospital community outpatient liaison
- York: Streamlined pathway from referral to diagnosis

### Treatment
- Bath: Community based approach to pre-operative assessment
- Bath: Reducing length of stay for TURP
- Bolton: A structured approach to catheter care
- Darford & Graveshame: Redesign of TURP pathway
- N E Wales: Whole system redesign – theatre scheduling
- E Berks: GPwSI service for LUTS, andrology and vasectomies
- Ipswich: Superficial bladder tumour laser treatment as day case
- Rotherham: Redesign of pathway for acute retention of urine
- Royal Wolverhampton: Hospital at Home for TURP & telephone follow up
- Southern Derbyshire: Integrated continence project
- Stockport: Vascular services in primary care
- York: Baked admissions & use of short stay facility
- York: Improve management of urology patients in the community

### Follow-up and communication
- Queen Elizabeth Woolwich: Hospital community outpatient liaison
- United Bristol: Improved visual information for patients
- Bradford: Improved visual information for patients
- Winchester & Eastleigh: Patient perspective on services

### South Tees: Outreach nurse service for catheters
- Stockport: Catheter care in the community
- York: Prolifer extended community-based services

### Airedale: Separation of diagnosis and surveillance (prostate cancer)
- Barnet: Nurse-led follow up & hormone treatment for prostate cancer
- Bath: PSA trial: softwakc nurse-led telephone follow up
- E Berks: Nurse-led follow up for stable prostate cancer
- Good Hope: PSA support including telephone follow up
- Ipswich: Nurse led telephone follow up
- Lancashire: Nurse led telephone follow up for prostate cancer
- Royal Wolverhampton: Hospital at Home for TURP & telephone follow up
- York: Prolifer extended community-based services

### Plymouth: Renal stone pathway redesign including EWSL

### York: Prolifer extended community-based services

### Airedale: Separation of diagnosis and surveillance (bladder cancer – including nurse cystoscopy)
- Ipswich: Superficial bladder tumour laser treatment as day case
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### Plymouth: Renal stone pathway redesign including EWSL
Helpful websites about service improvement

To access the associated documents on the CD please [click here](#).

### Urology service improvement – helpful websites – general

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<td>Service Improvement Radiology</td>
<td>MA Diagnostic Team</td>
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<td>Royal College of Radiologists</td>
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<td>Professional Advice</td>
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<td>DH Health &amp; Social care planning framework 2005/6 – 2007/8</td>
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<tr>
<td>DH Financial systems</td>
<td>“Payment by Results – preparing for 2005” New system for Foundation trusts from April 2004 and all trusts from April 2005</td>
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<td>“The NHS Improvement Plan – putting People at the Heart of Public Services” Follow up to NHS plan – sets out priorities for now to 2008</td>
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<td>Service Redesign General</td>
<td>The Modernisation Agency Service Redesign</td>
<td>“10 High Impact changes” Ten groups of interventions which would yield high returns in terms of care delivery</td>
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<td>Service Redesign Access</td>
<td>MA Access (CPAT)</td>
<td>Key Steps in improving access for patients: towards a fully booked NHS</td>
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<td>Service Redesign Treatment Centres</td>
<td>MA “Cutting Edge” Magazine</td>
<td>News from the Modernisation agency’s treatment Centre Programme</td>
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<td>MA – Research into Practice</td>
<td>“Engaging individual staff in service improvement” Gollop et al</td>
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<td>Service Redesign Managing demand</td>
<td>The Modernisation Agency Demand management</td>
<td>DH &amp;NHS Confed “The Medway Experience” – how to apply capacity &amp; Demand techniques to bed management and “The NHS Modernisation Agency’s Improvement Leaders” Guide”</td>
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<td>MA “Improvement Partnership for Hospitals”</td>
<td>Cross system look at use of resources</td>
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<td>“The NHS as an innovative organisation: a framework and Guidance on the management of Intellectual property in the NHS” How CEOs can achieve income generation from intellectual property generated from innovations PDF download. Go on to DH website (<a href="http://www.dh.gov.uk">www.dh.gov.uk</a>) and enter this title.</td>
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