Urology Sub-group

Design Workshop Report

scottish access collaborative

DIGITAL HEALTH & CARE INSTITUTE

Scottish Access Collaborative Approach

The aim of the Scottish Access Collaboarative is to sustainably improve waiting times for patients waiting for non-emergency procedures.

The Cabinet Secretary for Health and Sport launched the Scottish Access Collaborative in November of 2017. This will be closely aligned with the Regional Planning, Realistic Medicine, Elective Centres Programme and extant Performance Management and Clinical Priorities, Delivery Activities and Programmes. In the complex landscape of healthcare planning and delivery the Access Collaborative will focus on developing collaborations which build on existing work streams and networks to sustainably balance demand and capacity. The Collaborative is led by Professor Derek Bell, Chair of the Academy of Medical Royal Colleges, and Paul Hawkins, Chief Executive of NHS Fife and is made up of a range of professional bodies including the Scottish Academy of Medical Royal Colleges, patient representatives and service leaders. The Collaborative has developed six fundamental principles which will shape and prioritise the way services are provided in the future. These principles are described in this report in the context of the findings.

A key strand of the Collaborative's work is the delivery of the Specialty Sub-Group programme, in which a range of experts in clinical specialties undertake a cycle of design-led workshops with the support of the Digital Health and Care Institute.

The Digital Health and Care Institute (DHI) was commissioned to design workshops aimed at producing high level mapping of each clinical area and identifying clinically led and patient centred sustainable improvements. The findings from these workshops will form the basis of a speciality-led Access Collaborative programme delivering solutions to help scheduled care services to sustainably meet the challenges of the future.

The DHI was established as a collaboration between the University of Strathclyde and the Glasgow School of Art and is part of the Scottish Funding Council's Innovation Centre Programme. It is part funded by Scottish Government. DHI support innovation between academia, the public and third sectors and businesses in the area of health and care.

For more information on the workshops please see the Collaborative's blog:

http://bit.ly/accesscollaborative

Contributors

Health boards involved

- NHS Highland
- NHS Ayrshire and Arran
- NHS Forth Valley
- NHS Lothian
- NHS Tayside
- NHS East

DHI team

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Roles involved

- SG Programme manager
- Consultant Urologist
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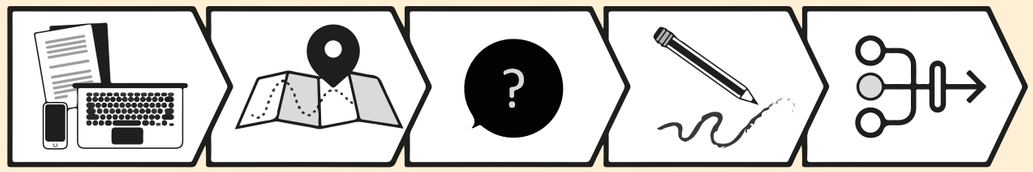
- Clinical Service Manager
- Consultant Urology Surgeon
- General Manager
- Clinical Lead
- Service manager
- National Lead Nurse/Service Improvement Manager
- Specialist Nurse
- Access Collaborative Planning Manager
- Consultant Andrology and Female Urology
- Programme Manager
- Patient Representative
- Surgical Unit
- Consultant Urological Surgeon/WoSCAN Regional Lead Clinician
- Programme Manager Liaison Lead SG
- Scottish Government Policy
- Project Manager

Executive Summary

Members of the Urology Speciality Sub-Group came from 20 different specialists areas and 6 different NHS Board areas, giving the Sub-Group both a broad geographic and functional reach. The first step for the workshops was to identify common Urology patient symptoms, noting their importance. Pathways were mapped for each symptom and areas to focus on agreed. Further discussion around these focus areas led to suggestions for sustainable improvement. These ranged from additional targeted patient information to support self-management and opt in for treatment, virtual consultations and dedicated vetting in secondary care, to direct referral for diagnostic tests from primary care and nationally accepted referral guidelines which are easy to access and follow and can be adapted taking into account local variation. Work to further scope these improvements will be under taken in the coming months allowing a prioritisation process to take place through the Scottish Access Collaborative (SAC).

Future work will involve national support to ensure the Urology community, along with primary care partners are supported to make the necessary changes to ensure efficient and effective patient pathways are achieved. It is envisaged that the work areas will be taken forward either through the Urology community itself or for broader issues which are not specialty specific, be achieved through the SAC Combined Action Group (CAG).

November 2018



Clinical Foreword

The Scottish Access Collaborative has brought together many stakeholders involved in the management of patients with urological conditions. These workshops have allowed patients, clinicians, nurses and managers to share their views on the challenges the specialty faces in providing timely access to services. There was an enthusiasm for sharing best practice across many regions and a willingness to engage in the design-led process to map out the patient journey for several common conditions. The output from the workshops pointed to many areas of potential improvement in existing pathways both in the primary care sector and the secondary care centres. Innovative ideas for the delivery of high quality care in a more patient centered way were also outlined. We hope that many of these ideas will lead to effective and meaningful improvement for patients accessing urological services across Scotland.

Steve Leung MD, FRCSEd (Urol)
Consultant Urological Surgeon

Implementation Support

The aim of the Modern Outpatient Programme is to support the development of a Modern Outpatient service which, aligned with the principles of the SAC, will support effective and faster service change to ensure patients are able to access healthcare in a timely manner. This national Programme is well placed to action the outputs from the Urology workshops; supporting clinical teams to test innovative ways of working and how positive improvements proven to enable the provision of high-quality care for patients, can be shared and implemented at scale across Scotland.

Katie Cuthbertson
Director Modern Outpatient
Programme Scottish Government

Scottish Access Collaborative Principles

I.

Patients should not be asked to travel unless there is a clear clinical benefit, and that any changes should not increase the workload for primary, secondary or social care in an unplanned/ unresourced way

II.

All referrals should either be vetted by a consultant/senior decision maker or processed via a system wide agreed pathway – value vetting

III.

Referral pathways (including self-management) should be clear and published for all to see

IV.

Each hospital and referral system should have a joint and clear understanding of demand and capacity

V.

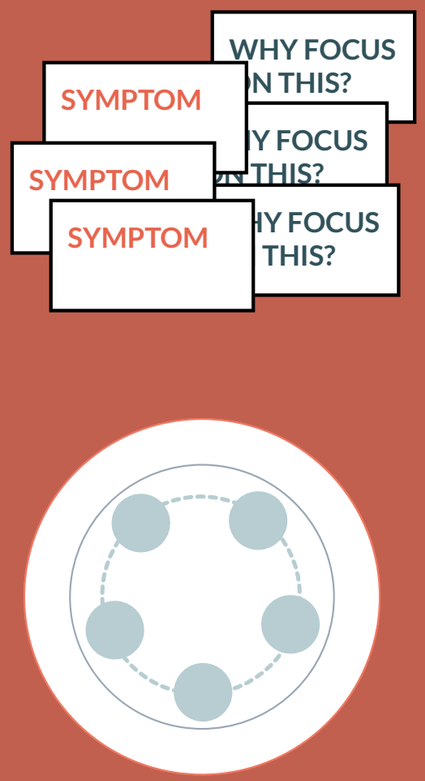
Each local system should have a clear understanding of access to diagnostics as part of pathway management

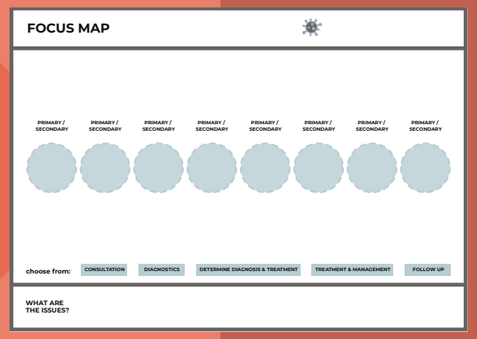
VI.

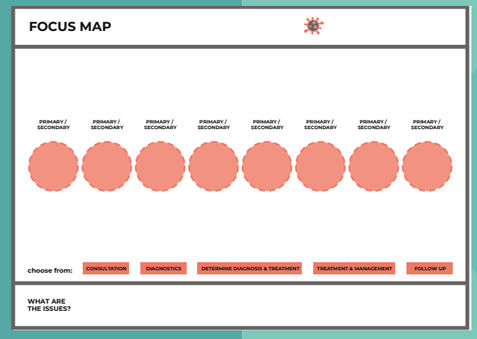
Improved and published metrics including how we record and measure virtual/ telehealth/ tech-enabled care

Contents

Design Approach







I. III. V.
II. IV. VI.

WORKSHOP 1

We look at which symptoms a clinical area works with most, and prioritise which to take forward and why. We map the current landscape and pathways for each priority symptom.

The DHI team uses the discussions and maps to distill the key challenges the group identified on each pathway. Each challenge is communicated on a focus map.

WORKSHOP 2

We explore the key challenges by taking into account patient feedback, and using the diverse range of expertise and experience in the group. We start identifying opportunities and map out ideas.

From these discussions, the DHI team distills the key ideas and insights into a set of proposed changes.

WORKSHOP 3

We add detail to the proposed changes. We also cross-check and prioritise the proposed changes against the Scottish Access Collaborative Priniciples.

DISCOVER & DEFINE

EXPLORE & DEVELOP

Symptom Profiles

The cycle of design-led workshops started with the participants agreeing on a small number of symptoms they felt were of the highest priority and could deliver maximum improvement. A map was produced describing how these symptoms moved through current Urology services from initial consultation to eventual discharge. What follows are the five symptom profiles defined for this study. Each profile has been defined with its volume of presentation, a common definition, and crucially a rationale for why this is a symptom of interest and something to focus on.

This word cloud reflects the relative frequency of the most commonly used words in a group of Urology referrals from Fife. The data was collected from more than five thousand referrals and was taken from the 98 character field in SCI Gateway. While the word cloud was used for reference only it does support the broad choices of symptoms made in the workshops.

Visible blood in urine

Visible blood in urine, also known as gross haematuria, describes a presence of red blood cells in the urine. It often appears without other symptoms. Often the cause is harmless however, it can indicate a serious diagnosis.

Small volume in primary care and large volume in secondary care

Why focus on this?
This is a symptom that is directly referred to secondary care and constitutes a high volume of patients in secondary care. It can lead to multiple diagnoses however in a number of cases it is an indicator of cancer.

Urine leakage

Urine leakage, also defined as urinary incontinence, is the loss of bladder control.
The symptom ranges from occasionally leaking urine when coughing or sneezing, to needing to urinate so suddenly that the patient is unable to reach the toilet in time.

Small volume in secondary care and large volume in primary care

Why focus on this?
The symptom is one of the biggest symptoms in terms of presentation in primary care. It is dealt with well in primary care however when being referred into secondary care it has multiple routes in, including through Gynaecology.

Undiagnosed flank pain

Undiagnosed flank pain is discomfort in the upper abdomen or back and sides. It can be experienced as achy and dull, or a cramp-like and sharp pain.

Variable prevalence

Why focus on this?
There are significant regional variations in how this symptom is dealt with and it takes up a significant amount of repeat appointments in general practice.

Erectile dysfunction

Erectile dysfunction, also known as impotence, is the inability to get and keep an erection firm enough to have sexual intercourse. Erectile dysfunction can be caused by both emotional and physical disorders.

Medium volume

Why focus on this?
This was chosen because there is a medium volume of presentations in secondary care and there are times when it could be better dealt with in primary care, in the community or patients could self-manage. The pathways vary considerably across regions and can be poorly defined. The number of patients with this condition is rising.

Lumps and bumps

Lumps and bumps are localized swollen areas on or under the skin. Depending on the cause the lumps and bumps may vary in size and form.

Small volume

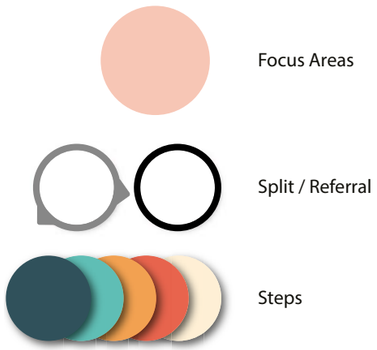
Why focus on this?
Although the volume of patients with this symptom is small within secondary care this group do include cancer patients in urgent need of treatment.

Focus areas

The second step in the workshops involved a series of collaborative mapping sessions using tools designed to explore the current landscape. The visual and hands on tools helped the group to identify assumptions and insights about current Urology services. While mapping these services for each of the five different symptoms discussed above, the group highlighted regional differences and explored and shared best practice. After identifying and locating key areas on this map, the group collaboratively prioritised what to focus on. This then provided an end-to-end system context for the next step of generating ideas for sustainable improvements.

Following what emerged from the workshop, the DHI team translated the group's discussions and maps into one map illustrating the focus areas.

Map key



Focus Areas

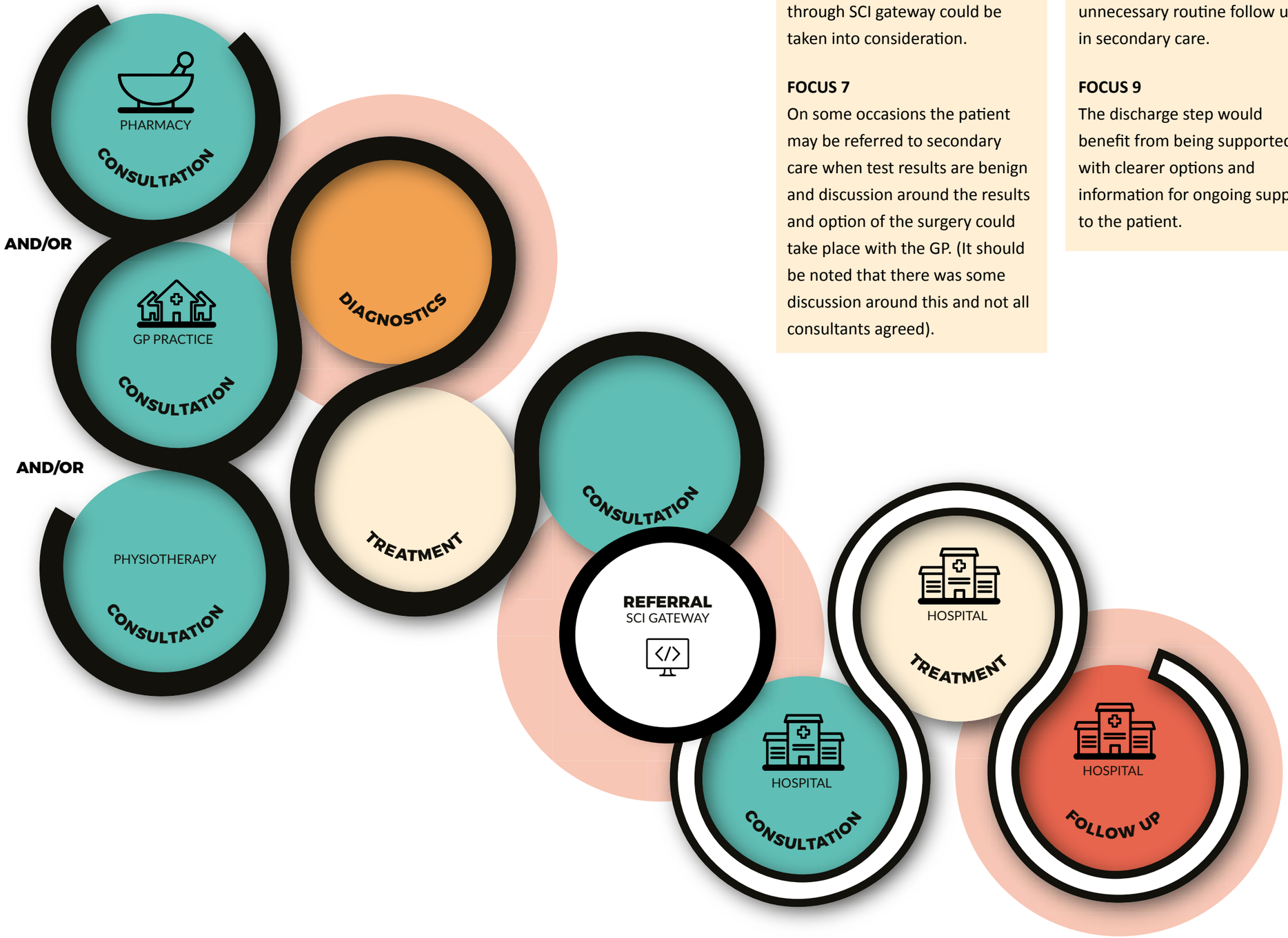
FOCUS 1
There are a large number of referrals into secondary care for conditions where treatment and / or further diagnostics could be tried or started within primary care.

FOCUS 2
GP appointments add limited extra value where symptoms could be managed effectively by the pharmacy. A GP appointment is however necessary if a referral is required.

FOCUS 3
There is a lack of standard high quality information for patients. Some information the patient may find is in fact advertising.

FOCUS 4
There is a lack of awareness of alternative pathways and community services such as Well Man clinics.

FOCUS 5
More and better patient information and history to accompany referrals would make vetting quicker and more efficient.



FOCUS 6
Referral guidelines published through SCI gateway could be taken into consideration.

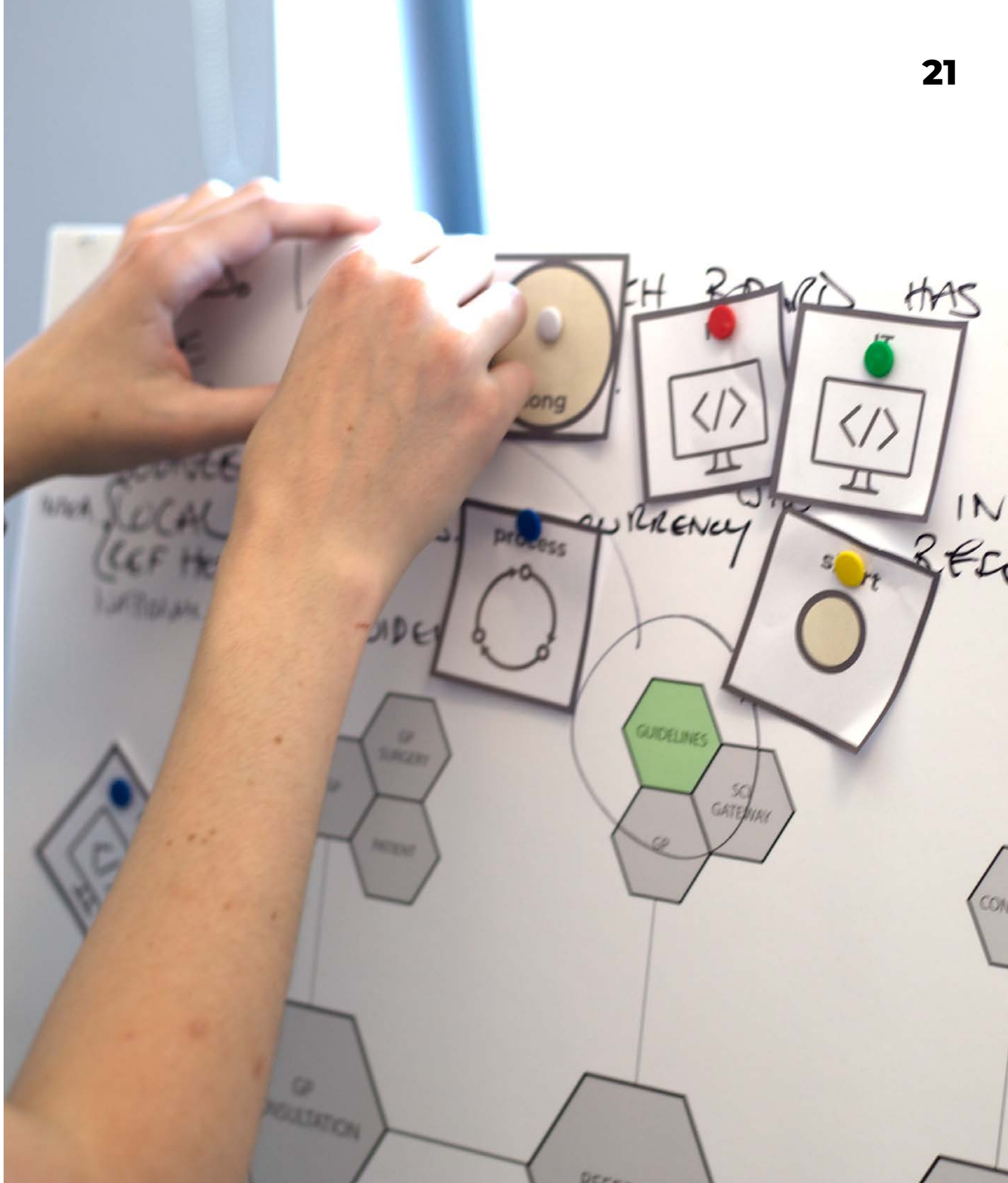
FOCUS 7
On some occasions the patient may be referred to secondary care when test results are benign and discussion around the results and option of the surgery could take place with the GP. (It should be noted that there was some discussion around this and not all consultants agreed).

FOCUS 8
There are some unnecessary routine follow ups in secondary care.

FOCUS 9
The discharge step would benefit from being supported with clearer options and information for ongoing support to the patient.

Outputs and Actions

The group started to uncover a number of improvement opportunities while mapping key areas within the current Urology service. These improvements have been cross-referenced with the six principles set out by the Scottish Access Collaborative. The following summary also includes a set of other ideas which emerged during the discussion but did not relate directly to the symptom maps. It should be noted that some opportunities for improvement will have a greater impact when implemented together with another option. For example, improvements in vetting coupled with agreed referral guidelines would have a significant effect on the volume of referrals into secondary care.



A.
Direct Diagnostic Referral from Primary Care

SAC Principles

I.

Summary

For certain diagnostic tests, in this case CT scan and Ultrasound, patients would be better served if the tests are ordered while the patient is still in the care of primary care services. Currently some primary care services do follow this protocol but it is not consistent across Boards and therefore some patients are waiting longer for tests and in some cases patients are unnecessarily attending appointments in hospital, prior to being referred for diagnostics.

Output and Actions

The recommendation would be that these diagnostic tests are brought forward in the patient pathway. For patients presenting with Flank Pain or with ‘Lumps and Bumps’, primary care would examine and then order a CT scan and Ultrasound (respectively), prior to the patient being referred to hospital.

Impact

Direct diagnostic referral will prevent some patients (tests come back as negative for kidney stones or malign lumps) from unnecessary hospital appointments, saving travel, and freeing up appointments in secondary care for more complex cases. Our work has found that patients who are referred to hospital have a higher expectation of care. The ‘knock-on effect’ of this can be a higher chance of eventual surgery and, in the case where no further action is taken, a feeling by the patient that they have experienced a poor standard of care. This option was discussed in relation to Flank pain and patients with a ‘Lump or Bump’.

B.
Appropriately Resourced Senior Vetting

SAC Principles

I. II. IV.

Summary

Vetting in secondary care is vital to reduce the number of unnecessary presentations in secondary care and improving patient experience. Investing in dedicated time for vetting by a senior decision maker can save time and resource and make patient journeys more efficient. Ultimately it comes down to the availability of information that clinicians can use to determine the most appropriate next steps for the patient, this might not be a face to face appointment. If this information is available and there are clear pathways, then vetting can be much more effective. Currently there is variation in how vetting is managed and resourced, with some hospitals specifically resourcing vetting as part of a job plan, while others need to 'work it in' to their day. This can lead to a lack of time to properly vet, resulting in some unnecessary or inappropriate appointments in hospital.

Output and Actions

The idea is that all hospitals allocate dedicated time for vetting. This task might be shared across the team or done by a smaller number of senior decision makers on behalf of the department.

Impact

Dedicating time for vetting results in fewer unnecessary hospital appointments for patients, reducing their travel time and freeing up appointments in clinics. The knock-on effect will be reduced waiting times for those who really do need to be seen in hospital. Good quality vetting also means that those who do come to hospital are more likely to be sent to the most appropriate clinic and see the most appropriate person, significantly improving patient experience, and avoiding non-value-added appointments. Having dedicated vetting will improve the vetting experience for staff, many of whom struggle to fit it into their working day.

C.
Virtual consultation

SAC Principles

I. V. VI.

Summary

For symptoms relating to, but not exclusively concerning benign Lumps and Bumps, Erectile Dysfunction, and Urine Problems, patients are sometimes seen in hospital for reassurance only, to discuss options, or to check how treatment is progressing. In many cases these are avoidable face to face appointments which have resulted in unnecessary visits to the hospital for patients. However, there was not full agreement, it was suggested that virtual consultation can be used to avoid patients coming to hospital for a face to face appointment. In the case of benign Lumps and Bumps (which accounts for a large number of cases), virtual clinics can be used to explain and check with patients if they want to have a particular intervention or not over the phone before they come to hospital. The group recognised running a virtual clinic requires adequate scheduling and allocation of clinical time. It does not remove patients from the referral pathway, but there is the potential to prevent patients having to come in to clinic, save money on travel and resources, and will potentially give more clinical time for complex cases. Currently some clinics do offer a virtual consultation, for example with follow up appointments with cancer patients to check progress after surgery.

Output and actions

The idea is that in the case of non-urgent patients who are referred to secondary care, properly vetted referrals can trigger a virtual consultation where appropriate. An example of this could be where all treatment options in primary care have been tried without response or diagnosis, and the hospital appointment is to discuss which limited further options would apply, in particular invasive surgery. For follow up appointments a similar process would apply, where cases are triaged to virtual where appropriate. It is recognised that virtual consultation is challenging to set up and does little to reduce the volume of appointments. Yet, if properly managed, it has the potential to allow more patients to be seen in a set amount of time.

Impact

Virtual consultation prevents patients having to travel to hospital unnecessarily, patients or the hospital do not have to incur the cost of travel, and patients can more easily fit the appointment into their day potentially saving time off work or family commitments. Dealing with a higher volume of appointments per clinic could reduce waiting times and free up time for more complex cases. Additionally, in the case of patients referred to general Urology with limited information, virtual consultation can collect more information from the patient about the condition and direct them to the appropriate clinic. However, fuller patient clinical information will make for a more effective virtual consultation. In addition, virtual consultations have the potential to release outpatient capacity to see more complex cases.

“Why should patients travel for 2 or 3 hours for a 5-minute follow up appointment?”

- Quote from Urology workshop.

D.

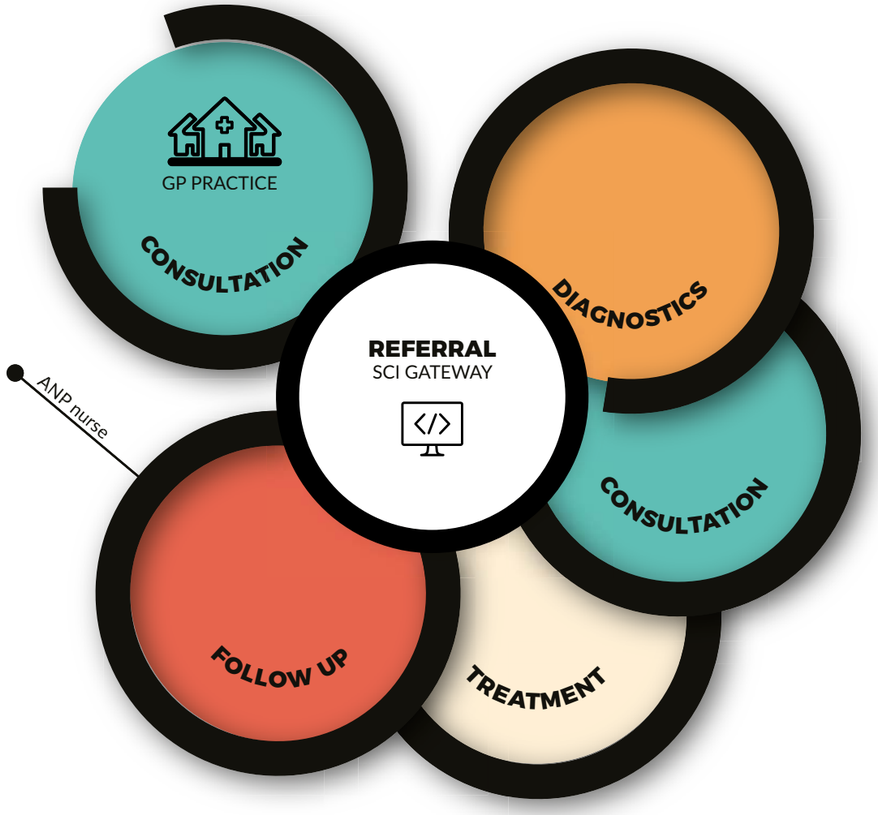
Better Self-Management Information and Community Pathways for GPs

Summary

For symptoms that can be initially managed in primary care, such as erectile dysfunction and urine problems, there needs to be appropriate guidance to enable GPs to ask the right questions and access the evidence based treatments before referring patients to secondary care.

SAC Principles

I. III. V.



Output and Actions

There is an opportunity to utilise more community services and provide more signposting support for GPs. GPs can start treatment for these conditions, and there are pathways to follow before a patient is referred to hospital, Local Guidelines can help. At a local level, secondary care need to work with primary care and community services to look at national guidelines, understand what can and cannot be done for patients with these symptoms, and develop support and pathways for patients to follow before they are referred to secondary care. Collaboration with all stakeholders is key to developing clear, realistic guidelines, and the pathways to follow. It was felt that any follow up appointments for patients who do present to either primary or secondary care could usefully be carried out by an Advanced Nurse Practitioner or by community services.

Impact

Good, realistic, guidelines linked to local service capacity empower GPs to start patients on treatments before they are referred to hospital. The effect is that only the patients who need to go to secondary care, meaning those who have already tried the available options, will be referred. Patients will have fewer appointments, many who currently present in secondary care unnecessarily would not have to at all. This will result in less travel for patients and more time for consultants for more complex cases. The knock-on effect would be a reduction in waiting time for those patients who need to attend appointments in secondary care as there will be a reduction in demand.

“I would say that if you have gone through good guidelines then if you are at the hospital then you need to see a specialist”

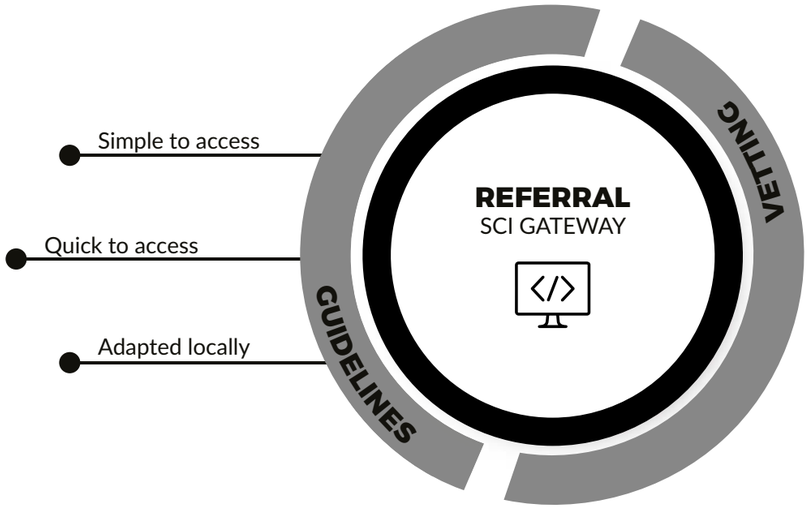
- Quote from Urology workshop.

E.

The development of National Referral Guidelines which are Simple, Quick and Easy to Access and could be Adapted Locally

SAC Principles

I. III. IV. V.



Summary

It was recognised that good guidelines support a better patient experience and reduce the number of secondary care appointments yet can create a lot of work for GPs. Primary care referrals containing appropriate information is crucial to enabling high quality vetting. Time to do the vetting is important but if poor information comes in about the patient, then this will lead to poor vetting no matter how much time the consultant/ senior decision maker has. Guidelines that advise a series of tests and treatments prior to referral to secondary care are a heavy workload for GPs, but are beneficial for the patient. Following guidelines in full needs the support of the full primary care capacity. It was recognised that, for example, guidelines for erectile dysfunction and urine problems would require GPs to take on extra work, including giving advice and signposting as well as tests such as dip tests.

Output and Actions

The idea is that an agreed set of national guidelines that take into consideration self-management and local provision be developed. To support this, it was suggested that guidelines within primary care could be revised and supported accordingly. For example, it could be that for some elements of the guidelines, a practice nurse or other health professional could be allocated the work rather than the GP. As part of the collaborative effort to develop guidelines and pathways for these symptoms, the idea is that the allocation of roles for each step of the guideline is considered and designated to the most appropriate person.

Impact

Guidelines that are followed in full should prevent unnecessary secondary care appointments for patients who don't need to be there, improving patient experience and reducing waiting times. The additional burden guidelines impart on primary care can prevent effective use of the guidelines. The effect of allocating appropriate tasks to appropriate people is that guidelines are followed fully and patients are only referred to secondary care if necessary.

"It is about looking at the guidelines and saying who needs to do the different things in the guidelines."
- Quote from Urology workshop.

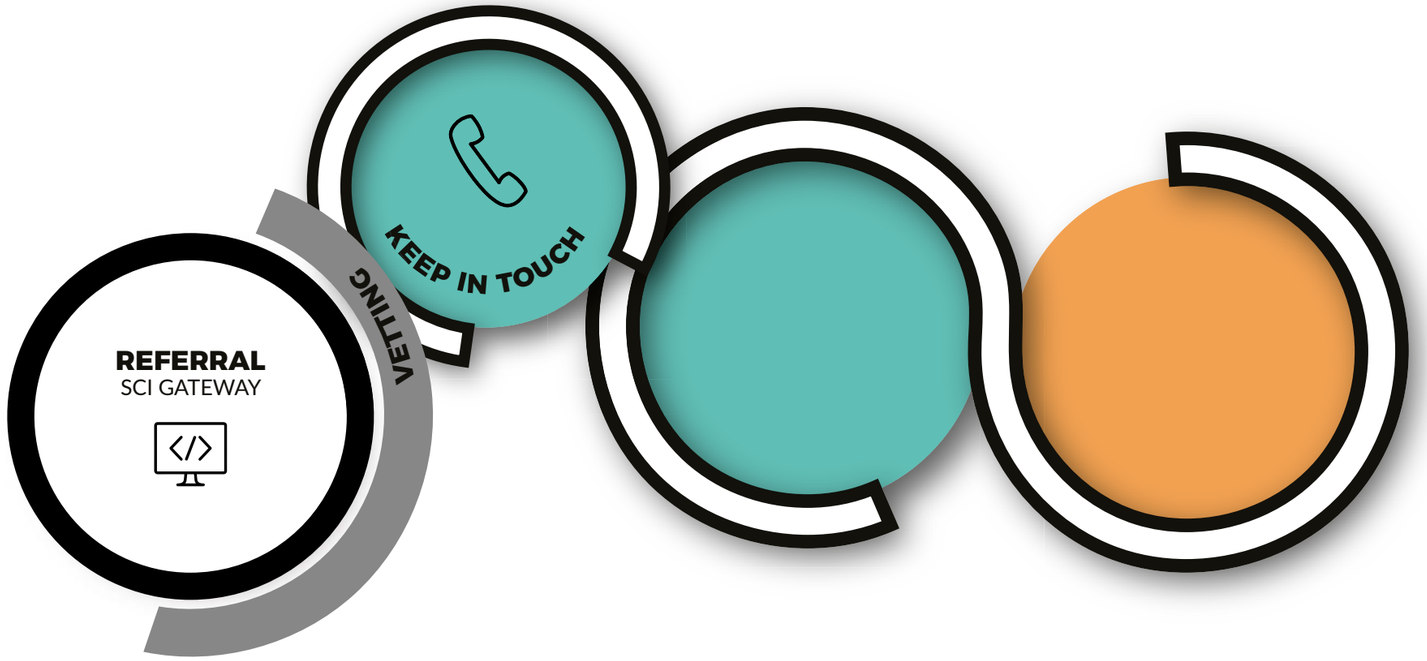
F.
Keep in Touch Calls

SAC Principles

I. VI.

Summary

There are long waiting times for benign conditions in Urology and sometimes patients can feel forgotten, or in some cases their symptoms get better and therefore do not need to be seen. Keep in Touch Calls would be a way to let patients know they are not forgotten, and at the same time check if symptoms are getting better or worse and if the patient still wants to come to hospital. Currently some but not all hospitals will contact the benign Urology cases in between their referral to secondary care and their appointment to 'check in' and affirm the appointment requirement.



Impact

Keep in Touch Calls will improve patient experience for those on long waiting lists by letting them know they are not forgotten. They have the potential to prevent patients from contacting their GP to check status of their referral, and importantly could prevent unnecessary appointments reducing patient travel and freeing up hospital appointments. Sometimes cases of this type result in DNAs due to changes in patient circumstance, therefore there is the potential to reduce the number of appointments where the patient does not attend. It could also have an element of re-triaging patients who have been waiting significant lengths of time for a Urology appointment. It would allow for re-assessment of the patient's symptoms as well as, reassuring the patient that they are not "forgotten".

Output and Actions

The idea is that Keep in Touch Calls be made part of a regular job plan as a strategy to manage waiting lists and improve patient experience.

G.

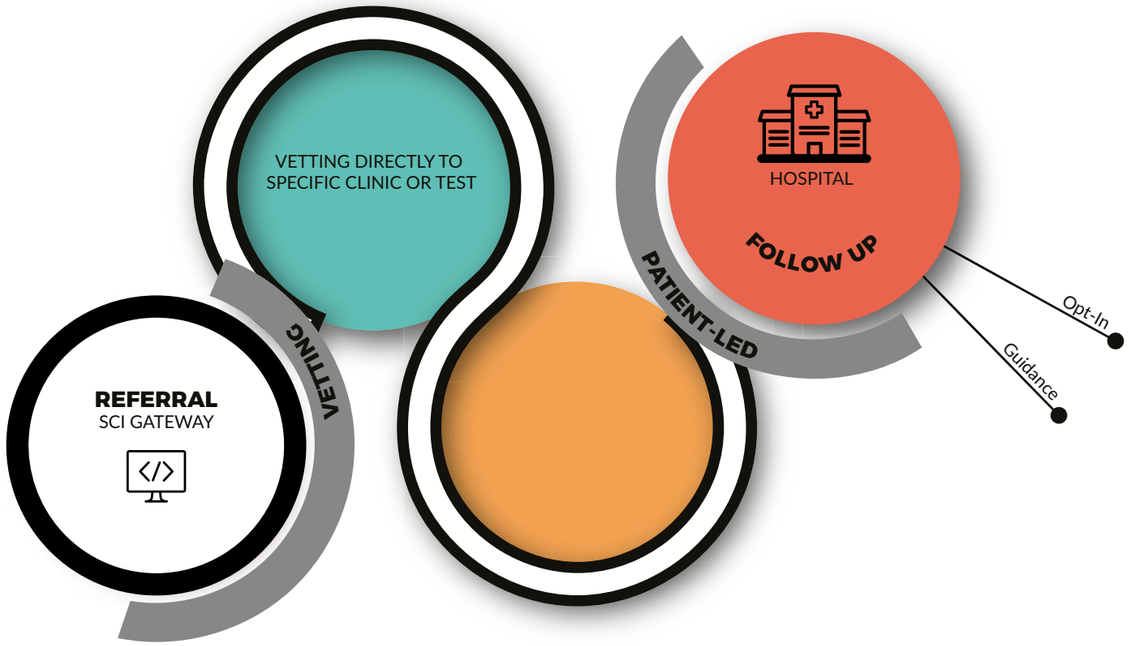
Option of Self-Management and Opt-In Follow Up with Guidance on Discharge

SAC Principles

I. III.

Summary

For many symptoms that can be managed by the patient, follow up appointments in either primary or secondary care are unnecessary and an additional step in the patients' pathway that has little value to them. Currently, some patients can end up in a default loop of treatment followed by review, without any knowledge of their current condition, or addressing their wishes.



Output and Actions

The idea is that patients that have been seen by a clinician and have an agreed treatment plan put in place, are given good quality guidance on discharge on how to manage their condition. In addition, rather than a default follow up being provided, they are given the option to opt in for a follow up appointment if and when it is required.

Impact

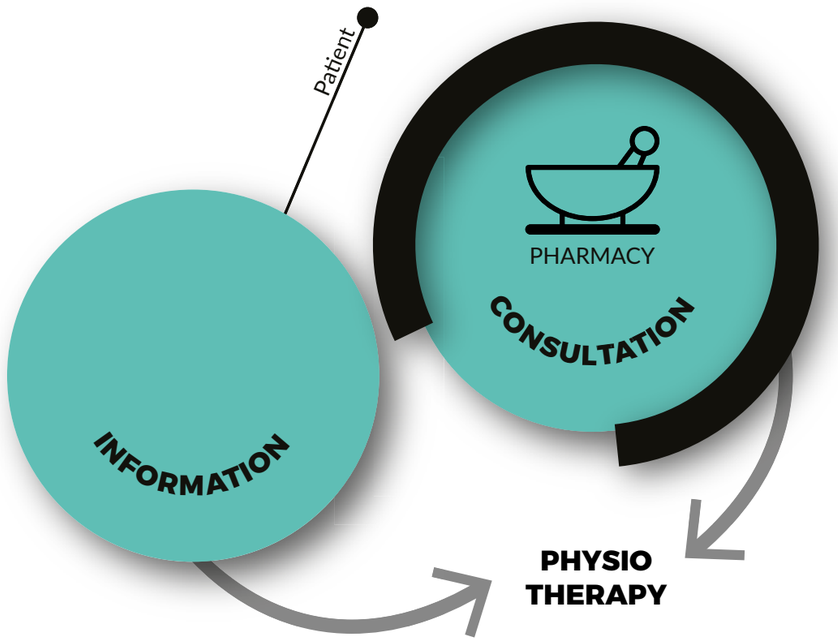
Discussions in the workshops indicated that offering good guidance at discharge, linked with the option for opt-in to follow up, can reduce the number of follow up appointments. This would result in fewer appointments for patients, more time in clinic for more pressing cases, and less travel and inconvenience for patients.

H.

Better Information and Access to Information about Self-Management Options and Support for Community Services for Patients before GP Consultation

SAC Principles

III. V.



Summary

For many symptoms, such as erectile dysfunction and urine problems, there are very effective options for self-management treatment and community based services, such as physiotherapy. The issue is that for some patients there are a lack of accessible information sources about treatments and services, or barriers to accessing services without going through primary or secondary care.

Output and Actions

The idea is to develop information and protocols to support better ‘pre-primary care’ options. For example, it was agreed that it would be beneficial to look at the option of patient and/or pharmacy direct referral into physiotherapy. This option would have to be further examined to ensure the number of referrals would not outstrip the available number of physiotherapists.

Impact

Increasing the number of patients enabled to self-manage conditions will result in fewer appointments, freeing up primary and secondary care capacity and speeding up patients’ treatment and management. Bypassing primary and secondary care to access community services such as physiotherapy could shorten waiting times for patients to access care and free up primary and secondary care appointments for more pressing cases.

Other Ideas

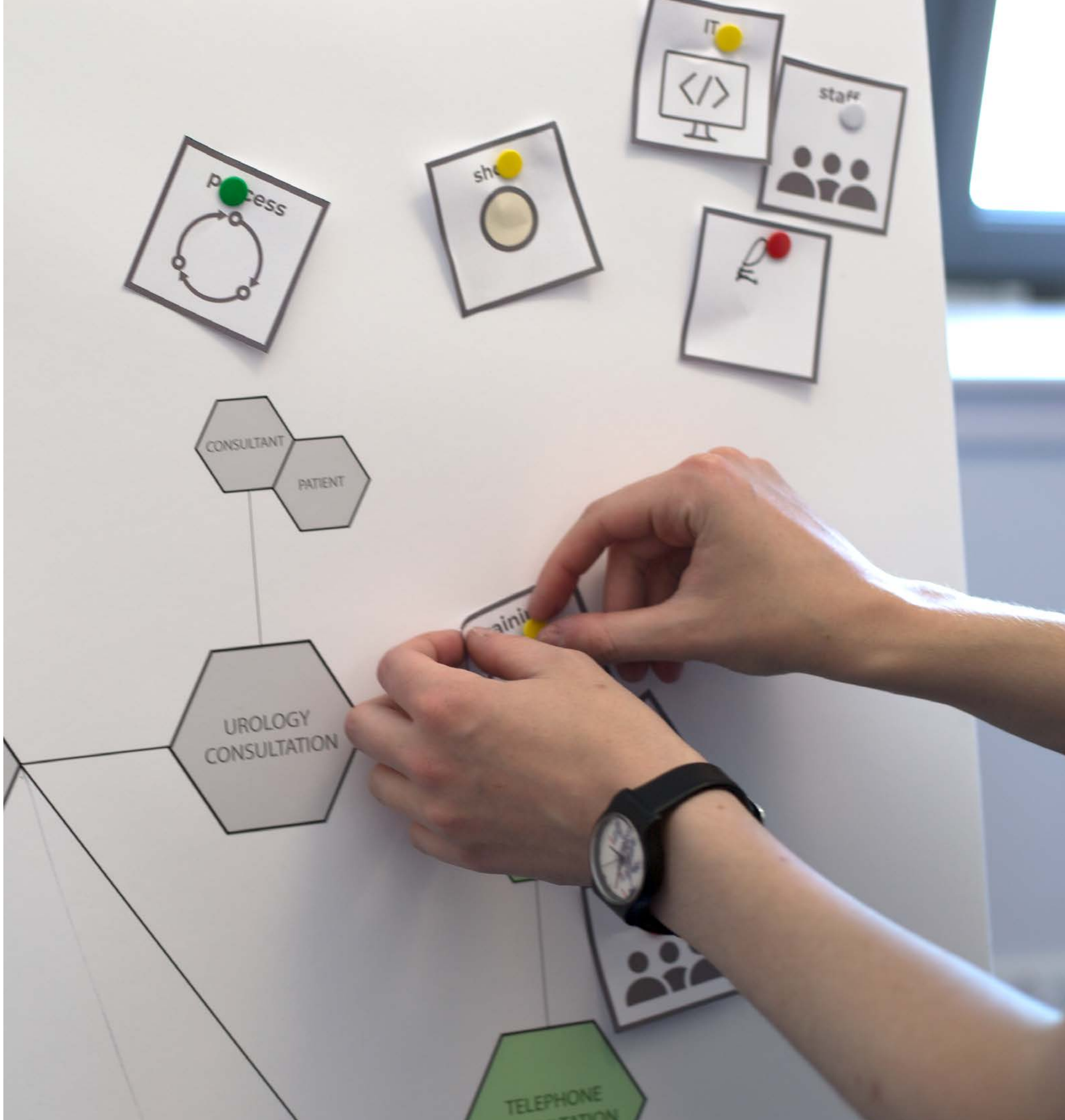
Before a patient is contacted by the hospital, they will receive a text saying: ‘this number will contact you..’ so you are sure the patient knows who will contact them and what number they will be calling from.

Creation of a one stop clinic with General Medicine for Flank Pain to jointly consider the pathway the patient is placed on. (Specific to undiagnosed Flank pain)

Pathways vary regionally and would benefit from being discussed and agreed nationally. (Specific to undiagnosed Flank pain)

Long waiting times can alter the patients’ expectations of treatment and make conservative options less successful. (Specific to Erectile dysfunction)

A forum could be created to share best practice between regions in Scotland.



Next Steps

The Urology Speciality Sub-group workshops generated broad agreement on the areas most likely to make a difference to patients presenting with urological symptoms. The recommendations detailed in this report will now be taken forward with national support via the Urology community itself, or where the issue is not specialty specific, through the SAC Combined Action Group (CAG). The CAG's purpose is to address cross-cutting areas of challenge.

This further work will begin immediately and bringing together primary and secondary care will work to achieve efficient and effective patient pathways for patients.

A.
Direct Diagnostic Referral from Primary Care

B.
Appropriately Resourced Senior Vetting

C.
Virtual Consultation

D.
Better self-management information and community pathways for GPs

E.
The development of national Referral Guidelines which are simple, quick and easy to access and could be adapted locally

F.
Keep in Touch Calls

G.
Option of self-management and opt-in follow up with guidance on discharge

H.
Better information and access to information about self-management options and support for community services for patients before GP consultation

Scottish Government
Riaghaltas na h-Alba
gov.scot

DHI is a collaboration between:
THE GLASGOW SCHOOL OF ART
University of Strathclyde Glasgow