

Nottingham and Nottinghamshire ICS

Urological Health

Clinical and Community Services Strategy

February 2021

This information has been placed in the public domain in order to benefit patients across the country as we believe the experience and approach may be useful for others, however we request that acknowledgement to the work in Nottinghamshire is made and referenced in all materials. This helps us to understand the wider impact benefits of our programme. Please cite 'this work has been informed by the Nottingham and Nottinghamshire ICS' when referencing.

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The Integrated Care System (ICS) ambition across Nottinghamshire is to both increase the duration of people's lives and to improve the quality of those additional years, allowing people to live longer, happier, healthier and more independently into their old age. The aim of the Clinical and Community Services Strategy (CCSS) is to support the system to achieve this by shifting the focus of our health and care delivery from reactive, hospital based treatment models to a pro-active approach of prevention and early intervention, delivered in people's homes or in community locations where this is appropriate with a long term view of beyond 5 years.

Some of the biggest risks and determinants to poor health across England also increase the risk of cancer. These include smoking, diabetes, obesity, but there are also inequalities found in areas of greater deprivation, cultural diversity and poor social and mental health wellbeing.

The NHS Long Term Plan (LTP) makes strong reference to ensuring improvements in cancer outcomes are made. There is an ambition to raise the proportion of cancers diagnosed at stages 1 and 2 from around half to three quarters of cancer patients by 2028. This Urological Health review seeks to align with national direction, maintain focus on local provision of Urology services and also acknowledges several programmes of work that are underway, including the ICS Cancer workstream and work of the East Midlands Cancer Alliance (EMCA). The review aims to ensure social care, mental health and well-being of those with a cancer diagnosis, or suspected cancer, and their families, is considered in providing equitable care and access across the Nottingham and Nottinghamshire ICS population.

This urological health service review has been undertaken as part of the ICS CCSS work stream. It has been supported by clinical experts and stakeholders in the development of place based service models for the future, to support the long term needs of our existing citizens. The review also focuses on embedding prevention in our population over the next 5-10 years, by shifting our culture from one of illness to one of healthier lifestyles and self-care.

The strategy identifies major stages in the journey of those with cancer and stresses a need to reorganise the way in which these services are delivered, from prevention through to longer term management. A whole pathway approach in the provision of urological health services is crucial in order to maximise the clinical outcomes for patients, their quality of life and experience of urological health services.

Fundamental themes have been identified along with key transformational opportunities and potential impacts have been developed which include: prevention and education strategies to promote wellbeing, healthy living and independence; improved access & shared communication about patients' past medical history from secondary care settings to community and primary care; appropriate treatments for adults with cancer from across the ICS; standardise access to services through improved integration between secondary and primary care including a strong focus on mental health care.

A transformational 'Bridge to the Future' highlights current service offers across the ICS and identifies some potential long term next steps that can be taken to achieve the identified opportunities with proposed timelines and the expected outcome for our citizens of Nottinghamshire.

The recommended next steps are vital in keeping the momentum of change in the future offer of improved prevention and better mental wellness for our citizens; providing the right tools for our population to support their wellbeing; providing strong communication links for our staff is vital to enable them to provide the best care for our citizens; the most appropriate models of care in hospital settings, neighbourhood and home need to be provided equitably across the ICS and be provided using best evidence, flexibly and in a patient centred holistic way for them to fulfil their maximum potential throughout their lifetime.



Background and Purpose

In Nottinghamshire we have made great progress in improving people's health and wellbeing. Today, we can treat diseases and conditions we once thought untreatable. However, our health and care system faces change and this will impact on our services, for example, the growing prevalence of long-term health conditions places new strains on our system. There is inequality evident in both the location of services and in access to services. In some areas, it is easier to access a GP or than in others, or to find things to do to enable citizens to stay active and fit.

The ICS ambition across Nottinghamshire is to both increase the duration of people's lives and to improve those additional years, allowing people to live longer, happier, healthier and more independently into their old age.

The requirement for a CCSS came from the recognition that to achieve this ambition the system has to change as a whole, rather than just in its individual acute, primary care, community and social care elements. It is recognised that only by working together to describe changes in how care is provided across the system, rather than through individual organisations, will we deliver the scale of change required.

The ICS Clinical and Community Services Strategy

The aim of the CCSS is to support the system to achieve this by shifting the focus of our health and care delivery from reactive, hospital based treatment models to a pro-active approach of prevention and early intervention. This should be delivered closer to people's homes or in community locations where this enables better prevention, more supported self-care and earlier intervention to support citizens. The Strategy recognises that achieving this change is a long term programme that will be delivered over the next 5 years and beyond. This is also to enable a necessary long term investment in the health and care buildings and infrastructure in the system.

An overall CCSS whole life model framework has been developed to focus on the need to support people through their lives from living healthy, supporting people with illness and urgent and emergency care through to end of life care. Citizens can experience different parts of the system at different stages in their lives. With the development of the overall Strategy framework the next phase of work is to review the 20 areas of service across the ICS that collectively form approximately 80% of the volume of clinical work in the ICS. This will ensure that overall the Strategy is described as a coherent whole and generates a programme of change for the whole ICS. This review of urological health Services provides the opportunity to be such a review and is part of the third phase of work.

NHS Long Term Plan

The NHS LTP is clear that to meet the challenges that face the NHS it will increasingly need to be more joined up and coordinated in its care; More proactive in the services it provides; More differentiated in its support offer to its individuals.

The ICS has focused on describing 5 areas of focus for the delivery of the NHS LTP. These requirements are reflected in each of the service reviews that collectively will describe the CCSS

- 1. Prevention and the wider determinants of health** - More action on and improvements in the upstream prevention of avoidable illness and its exacerbations
- 2. Proactive care, self management and personalisation** - Improve support to people at risk of and living with single and multiple long term conditions and disabilities through greater proactive care, self-management and personalisation
- 3. Urgent and emergency care** - Redesign the urgent and emergency care system, including integrated primary care models, to ensure timely care in the most appropriate setting
- 4. Mental health** - Re-shape and transform services and other interventions so they better respond to the MH and care needs of our population
- 5. Value, resilience and sustainability** - Deliver increased value, resilience and sustainability across the system (including estates)

| | |
|--------------------------|---|
| <p>Approach</p> | <p>This strategy has been developed through an open and inclusive process which weaves together the expertise of clinicians and care experts with commissioners and citizens in determining the future shape of services across the system. There have been a variety of stakeholder and service user events to develop a clinical and community services model. An extensive system wide piece of work is taking place across a minimum of 20 services. The CCSS Programme Board have reviewed these services against a range of quantitative and qualitative criteria and agreed the third phase of seven service reviews. These include Gastroenterology, Depression and Anxiety, Heart Health, Colorectal, Urological Health, Oncology and End of Life Care.</p> <p>This document discusses the approach, scope, the key issues and potential transformational opportunities within urological health services across the ICS. Health, social care, public health and the voluntary sectors have all been considered through reviewing the current service offer across the ICS. The service review was taken over approximately 14 weeks and there were two workshop held with stakeholders from across the ICS. An evidence review pack was developed which considered national and local best practice to inform the development of potential themes and new models of care where transformational change may take place across the ICS in the future.</p> |
| <p>Scope</p> | <p>For the purpose of the urological health review, the following focus was agreed:</p> <p>In scope:</p> <ul style="list-style-type: none"> • Adults - including teenage and young adults (TYA) using adult services • Modalities • Common cancers – Breast, Lung, Colorectal, Prostate – performance and data • Late Effects • Post Treatment Care – including community and home • Therapies – Interventional and support therapies, including psychological support <p>Out of Scope:</p> <ul style="list-style-type: none"> • Surgical treatments • Specialised commissioned services (RT is in-scope) • Paediatrics |
| <p>Engagement</p> | <p>The urological health service review has been supported by a tailored urological health Steering Group involving stakeholders and clinical experts from across the ICS. They have provided expert advice, guided, confirmed and challenged assumptions throughout the period of review and connected to other workstreams. This group has formed part of the governance process along with the CCSS Programme Board.</p> <p>Two virtual workshops have been held enabling a wide breadth of stakeholders (Oncologists, GPs, CNS, allied health professional (AHP), Pharmacists, Heads of Service, Commissioners and others) to be proactively involved in re-evaluating current service offers across the ICS, in developing potential themes and agreeing transformational change for the future Clinical and Community Services Strategy.</p> <p>Patient engagement has enabled confirm and challenge of assumptions and play an active part in the co-design of any future service changes across the ICS.</p> |

| | |
|------------------------------------|--|
| Strategy Development | This Strategy Document consists of five key elements. These have been developed through a process of design and iteration at the workshop and steering group meetings and includes key stakeholders from across the system. The strategy has been developed with reference to the Evidence Review document and the patient focus group that has been held. |
| Priorities for Change | The work of the Steering Group and the workshop stakeholders identified and confirmed four key areas of focus that need to change in the ICS for urological health. These were based on a review of the current issues facing the ICS and the views of the Steering Group and workshop attendees. Some service user experience has also been incorporated into the development of the strategy. |
| Proposed Future Care System | <p>Following the initial engagement, at subsequent steering group meetings, attendees started to develop the future care system for urological health to address the Priorities for Change. The future care system is described against two dimensions:</p> <ul style="list-style-type: none"> • Location split between - Home (usual place of residence) – Hospital (including both acute and MH) with 24/7 medical presence – Neighbourhood representing all community/primary care and ambulatory care settings • Urgency split between - Emergency/Crisis requiring a service provided 24/7 to avoid crisis or risk to life – Urgent requiring a service 7/7 but not 24/7 to meet urgent care needs – Planned/Scheduled reflecting any arrangement where an appointment is agreed between a professional and a citizen <p>The intention of the system model is to focus future care delivery closer to home and also with greater levels of scheduled care to best use the available resources and reduce demand on urgent and emergency care services. The new system to address the Priorities for Change is presented for each location and then summarised overall for the ICS.</p> |
| Transformation Proposal | <p>The Transformation proposal describes the key initiatives or programmes that are required to deliver this new mode. As described earlier, for urological health services, some of these programmes need to be developed in more detail. Namely,</p> <ul style="list-style-type: none"> • Priority – What is the priority of the initiative in the view of the steering group and workshop attendees • Alignment – At what level of the system should we aim for a consistent approach for each initiative? This was split into two categories: <ul style="list-style-type: none"> ▪ Alignment to achieve <u>consistency</u> - In most instances this is ICS or Integrated Care Provider (ICP) level where with the greater value is perceived to be in an overall consistent approach. ▪ Alignment for <u>delivery</u> of the proposal - There are some instances where the recommendation is for delivery to be at ICP level, alternatively, it is at Primary Care Network (PCN) level where differential delivery would benefit the needs of very local populations • Enabling Requirements – What is required to enable each Programme to deliver? This includes workforce, technology, estate or service configuration. There are also requirements of culture or finance and commissioning to allow the system to work together differently • Benefits and Costs – Where available, the key benefits of the initiative at system level are summarised |
| Service Vision | The 'Bridge to the Future' was generated at a further virtual steering group meeting. It summarises the current challenges for the urological health system in the ICS now (Priorities for Change), what the ambition is and the outline steps to get there. Progress with the 'Bridge to the Future' and the partnering vision can be returned to with stakeholders as the work develops to review progress. |

Prevention & Self-Care

Risk Factors

Education and
Awareness

Detection and Diagnosis

Screening/ Early
Diagnosis

Late presentation/
Health
Inequalities

Treatment & Condition Management

Capacity &
Access

Community
Urology

Cross System
MDT

Whole System Approach

Continence

Integrated
pathways

Care Homes,
UTIs

Prevention & Self-Care

Smokers are 4 times more likely to develop bladder cancer

NHS

Likelihood of smoking is **4 times higher** in England's most deprived areas than least deprived and likelihood of childhood obesity **twice** as likely.

Office for National Statistics

1/3 of bladder cancers are caused by smoking



Being overweight increases risk and aggressiveness of prostate cancer

NICE

One in four nursing home patients admitted to hospital are dehydrated.

NICE

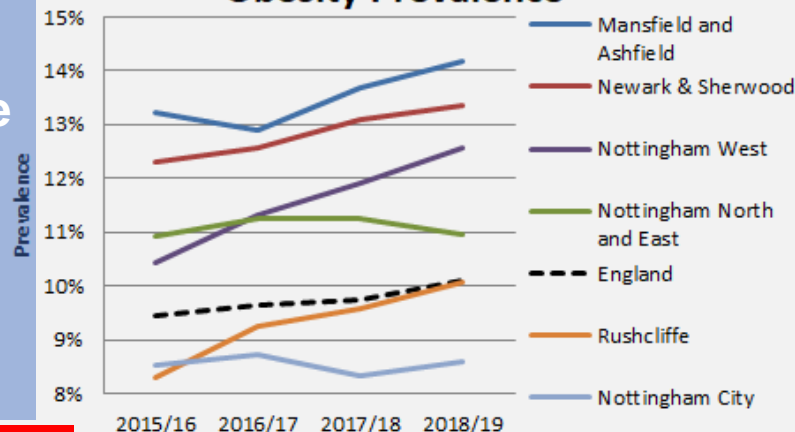
Mansfield & Ashfield have one of the highest obesity rates in England

PHE Fingertips

Morbidly Obese
30,080 people (BMI>40kg/m²) have a reduced life expectancy of 8-10 years.
(4,725 of these people have BMI>50)

eHealthscope

Obesity Prevalence



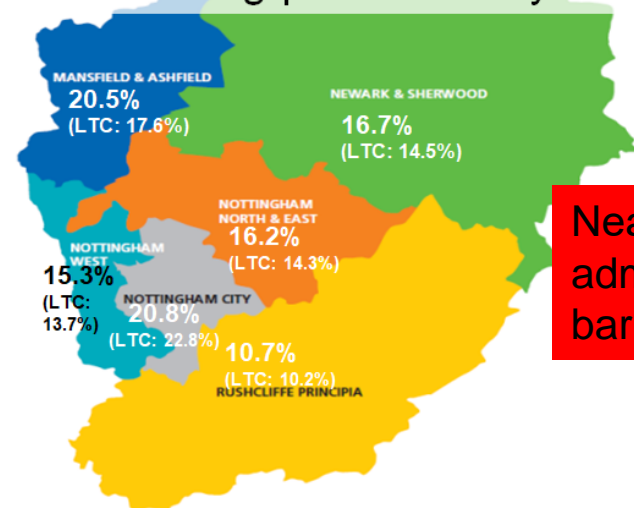
Nearly DOUBLE England's admission rate yet half the bariatric surgery

NHS Digital

| ENGLAND |
|--|
| NHS England Midlands and East (North Midlands) |
| Nottinghamshire |

| Admissions (primary/secondary diagnosis obesity) 2018/19 | Admissions per 100,000 (primary/secondary diagnosis obesity) 2018/19 | Bariatric Surgery Admissions 2018/19 | Bariatric Surgery Admissions per 100,000 2018/19 |
|--|--|--------------------------------------|--|
| 875,663 | 1,615 | 7,011 | 13 |
| 31,500 | 3,165 | 60 | 6 |

Department of H&SC ambition for 12% smoking prevalence by 2022



Detection and Diagnosis

In the UK, about 1 in 8 men will get prostate cancer at some point in their lives.

Prostate Cancer UK



Most men with early prostate cancer have no symptoms at all.

Prostate Cancer UK



Most Black men **aren't aware** they have an increased risk of prostate cancer

Prostate Cancer UK

In the UK, about 1 in 4 Black men will get prostate cancer at some point in their lives.

Prostate Cancer UK

African and African Caribbean men are more likely to develop prostate cancer at a younger age. NHS England

Death rate of prostate cancer is twice as high in Black men.

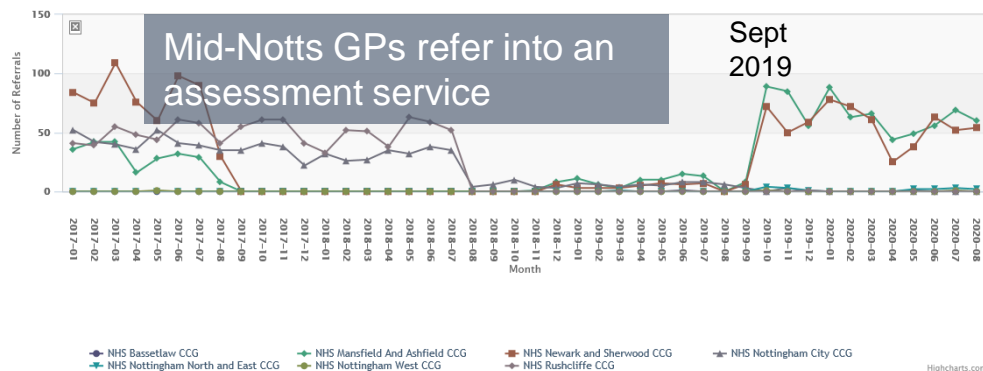
NHS England

About 3 in 4 men with a raised PSA level will not have cancer. The PSA test can also miss about 15% of cancers

NHS

Treatment & Condition Management

e-Referrals to Assessment Service: All CCGs from 2017-01 to 2020-08
Specialty: Urology

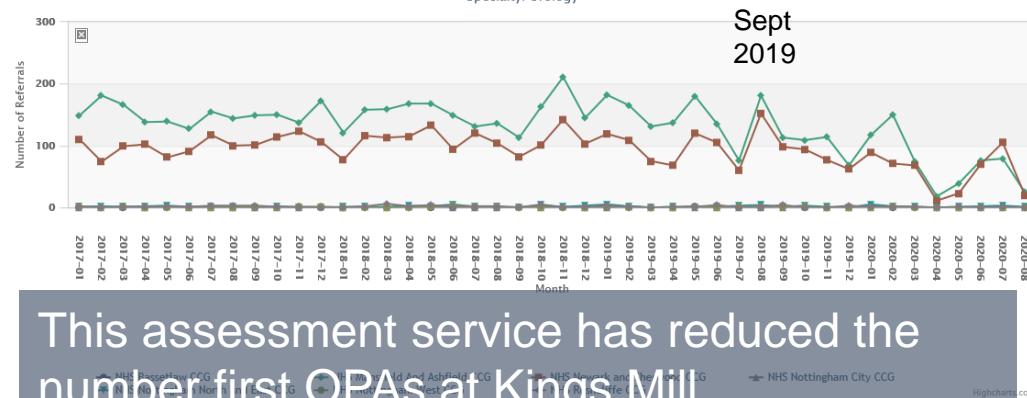


UROLOGY OUTPATIENTS

New to FUP ratio in the ICS at 2.28 is slightly above the National mean of 2. GIRFT

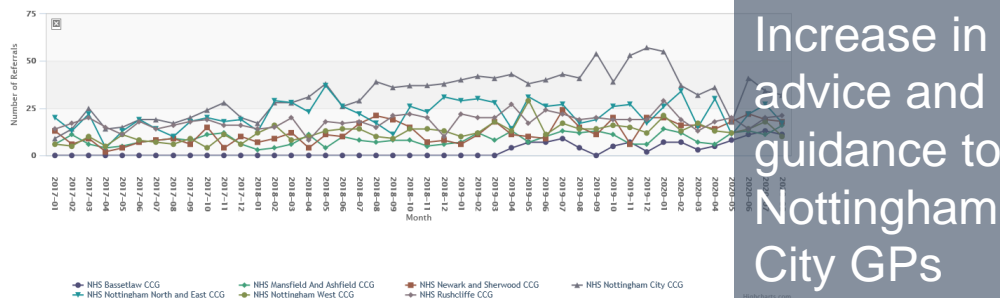
| | FA | | FUP | |
|-----------|----------|------------|----------|------------|
| | Activity | Cost | Activity | Cost |
| 2016/2017 | 13,473 | £2,449,229 | 28,279 | £3,331,480 |
| 2017/2018 | 12,190 | £2,060,344 | 28,307 | £2,383,030 |
| 2018/2019 | 13,438 | £2,273,519 | 31,595 | £2,635,552 |
| 2019/2020 | 12,460 | £1,971,578 | 29,734 | £2,734,251 |

e-Referrals to First outpatient: All CCGs, Sherwood Forest Hospitals NHS Foundation Trust from 2017-01 to 2020-08
Specialty: Urology



This assessment service has reduced the number first OPAs at Kings Mill.

e-Referrals to Advice & Guidance: All CCGs from 2017-01 to 2020-08
Specialty: Urology



A recent study showed that nurse led phone call follow-up clinics can be effective for patients with prostate cancer.

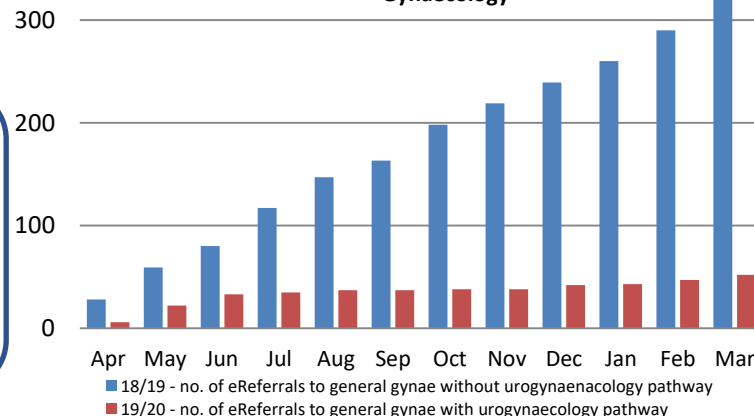
- 87.2% patients found the service convenient
- 75.6% found it informative
- 95.3% found it preferable to attending the outpatient department.

Whole System Approach

7 structured drink rounds a day when introduced in 4 care homes **UTIs requiring antibiotics reduced by 58%** and **UTIs requiring hospital admissions reduced by 36%** BJM reducing urinary tract infections in care homes by improving hydration

One in four nursing home patients admitted to hospital are dehydrated.
NICE

Cumulative Graph Showing Nottingham City Uro-gynaecology/ Prolapse e-Referrals to First Out Patient Speciality: Gynaecology



UTIs were the condition with the highest emergency admission rate in 2012/13

Reducing admissions associated with UTIs is important because every avoided uncomplicated admission has a potential minimum **saving of £1331 per day** in the NHS. NHS Improvement national tariff

NHS England

Nottingham N&E are in the lowest quintile for antibiotic guardians per head of population, Nottingham West and Rushcliffe the second worst quintile. Mansfield & Ashfield in contract are in the best quintile.

Quintiles: Best Worst Not applicable

Antibiotic Guardians per 100,000 population per calendar year by CCGs 2018

Crude rate - per 100,000

| Area | Count | Value | 95% Lower CI | 95% Upper CI |
|-----------------------------------|-------|-------|--------------|--------------|
| England | 6,375 | 11.5* | 11.2 | 11.8 |
| North Midlands NHS region | 359 | 9.8* | 8.8 | 10.9 |
| NHS Mansfield And Ashfield CCG | 44 | 22.0 | 16.0 | 29.5 |
| NHS Nottingham City CCG | 43 | 13.1 | 9.5 | 17.6 |
| NHS Newark & Sherwood CCG | 12 | 9.9 | 5.1 | 17.3 |
| NHS Nottingham West CCG | 7 | 6.2 | 2.5 | 12.8 |
| NHS Rushcliffe CCG | 7 | 6.0 | 2.4 | 12.4 |
| NHS Nottingham North And East CCG | 3 | 2.0 | 0.4 | 5.8 |

The review identified 4 key areas of focus highlighting potential areas of change which include:

- Prevention and Self-Care (with emphasis on risk factors leading to urological health conditions and education and awareness to promote self-management and prevention);
- Detection and Diagnosis (reviewing screening and early diagnosis. Focus on late presentation and health inequalities);
- Treatment and Condition Management (with a emphasis on capacity and access, collaborative working to support community urology and cross system MDT);
- Whole System Approach (ensuring the organisation and delivery of services is consistent through a multi-agency approach that includes 3rd sector organisations and charities supported through local authorities. Well interfaced systems so providers know their patients for a connected urological health care system).

Prevention and Self-Care

Prevention has been a common theme in most of the service reviews and in terms of urological health, there are also the common risk factors that can contribute to the development of certain urological conditions such as kidney or prostate cancer. For prevention, therefore, avoiding the high risk factors that can cause these urological cancers needs to be considered. These high risk factors include diabetes, obesity, smoking, hypertension, genetic make-up and lifestyle choices.

Prostate cancer is one of the most common cancers amongst men. If men that have a relative with prostate cancer, they are twice as likely to develop it themselves, whilst those with 2 or more relatives with prostate cancer are 4 times more likely to be diagnosed – this risk increases again if the family members were diagnosed at under 65 years of age.

There are many benign urological condition, the prevalence of which can be reduced through improved education and awareness and by acting on the advice and guidance that can show us how to reduce the risk of contracting these, such as keeping hydrated.

A 3-tier approach to education can help with raising awareness and promote self-care for improved prevention.

- Educate the population so that they are aware of the risk factors and able to avoid or reduce risks
- Educate the healthcare professionals (HCP) to be knowledgeable and confident with brief interventions, ensuring the making every contact count (MECC) principle is exploited across all patients identified in specific risk groups (such as black men being at higher risk if prostate cancer)
- Educate the patients to promote self-management of their health or conditions to actively reduce outpatient appointments through lifestyle and behavioural changes, encouraging the use of catheter passports, or other material – self-management education is important for person-centred care and helps informed decision making and promotes healthy behaviours (attending appointments, using all medications) resulting in better clinical outcomes and lower rates of hospitalisation
- HCPs need to consistently raise awareness and can also promote inclusiveness and have information in different languages and formats they should recognise and target high risk groups with early advice on good hydration, (monitoring of elderly) and local support for urinary incontinence, self-care, alert with signs of urinary tract infections (UTI), etc.

Secondary prevention is also important for those patients with early signs or a diagnosis of a urological health condition, and entails provision of the best advice on managing a condition to help reduce deterioration. Self-management via medication and developing lifestyle changes can also help with secondary prevention.



Detection and Diagnosis

Urological conditions can affect the urinary tracts of men and women, including the kidneys, ureters, bladder and urethra, but also includes the male reproductive organs.

To aid early diagnosis for those at higher risk or for those showing early symptoms of some of these conditions, having routine checks early can be helpful. This may start with a physical examination of the suspect areas, but may also include blood tests, urine tests, flow rate or urodynamic test to check for bladder neck narrowing, strictures in the urethra or enlarged prostate. Some of these conditions can be treated quite effectively with support from therapists or specialist continence nurses or medication such as alpha-blockers.

There is no real evidence to suggest benefits from prostate cancer screening using prostate specific antigen (PSA) levels in the blood, however, for 50 to 69 year olds of those tested showing raised levels of PSA, 1 in 4 has been found to have prostate cancer, when tested under the right conditions. 15% of men with prostate cancer will also show normal levels of PSA and so may be missed at an earlier stage of its development.

Screening options for prostate cancer include digital rectal examinations or DRE, however, there is no UK policy or guidance in using this to screen for prostate cancer. However, NICE do suggest that a DRE should be considered to assess for prostate cancer in men at higher risk with lower urinary tract symptoms, retention, or haematuria and accompanied with a PSA.

Health Inequalities in urological health conditions do exist, for instance, Black men have double the average risk of being diagnosed with prostate cancer, but awareness is low in Black communities reflecting in poorer outcomes and patient experience for Black men. Local data also demonstrates health inequalities that show patients living in areas of high socio-economic deprivation are diagnosed at a late stage of cancer and so increasing mortality for this population.

Treatment choices may also be an important factor for those patients with comorbidities.

Treatment and Condition Management

In Doncaster, the 100 Day Challenge they improved access to appropriate and timely community care for catheterised patients and those with continence problems, and saw an 18% increase in referrals to community services, with an 18% reduction at the same time to specialist outpatient clinics and average referrals from hospital to community increased by 370%. Every patient seen in the community preferred it and rated the service as excellent, with a resulting 53% of patients now seen at home with most of the others seen close to home by the community teams. This also showed an improved awareness of the urology community services for the GPs. Locally, we have some of these teams in place, but what's required to exploit similar opportunities is Cross System MDTs

With cross system MDTs (primary and secondary care), it can help address some of the capacity issues in secondary care by optimising the use of skills and expertise of medical and non-medical staff in the MDT, hence supporting some of the workforce challenges. For the patients it allows access to appropriate treatment and care more quickly, which should result in fewer appointments and improved patient satisfaction and outcomes.

Physiotherapy has a vital role to play in continence care. Evidence has shown pelvic floor muscle training can be more effective than pharmaceutical management (as reflected in NICE Guidance, 2018).

When patients with continence issues are seen in a multidisciplinary clinic they are able to access appropriate support easily and benefit from the expertise of consultants, specialist nurses and physiotherapists in one visit. This improves access to care and reduces the number of appointments necessary for each patient. Attendance rates should improve, along with compliance with physiotherapy. This means recovery should be quicker and patient satisfaction should increase. An overall reduction in the number of appointments helps to increase clinic capacity and should lead to reduction in waiting times for urgent and routine appointments.



Whole System Approach

For a uro-gynaecology pathway model this could include urinary incontinence, recurrent UTIs, bladder pain and pelvic organ prolapse (weakening of the muscles that support the pelvic organs called the pelvic floor), over-active bladder and exercises to help.

With the existing continence teams for both city and county, there is an opportunity to deliver patient and carer education as incontinence can be reversed in some cases, but also providing increased support to reduce long-term care requirements where independence may be lost and elderly patients end up in care homes. Through improved awareness and support, this can also help avoid the need for social care input in some cases.

The ICS population require equitable access to services, where appropriate – clearly acute hospital appointments require travel, but through integrated pathways there are opportunities to provide more care closer to home as detailed in the previous theme and a lot of this area is linked to both community urology and cross system MDTs.

Care Homes, Catheterised patients, UTIs

A focus for Care Homes has been to have a GP via the PCNs support them directly to include weekly or fortnightly visits where appropriate (although this practice may have changed during the pandemic), which is something that has improved more recently. This will also extend to support from pharmacy and a dietitian. This will provide the much needed support for the non-medical workforce in care homes, both with ongoing education and training on things like hydration – 7 structured drinks around the day, but also in early recognition of UTIs avoiding routine antibiotics to prevent resistance build up and avoiding sepsis and crisis or emergency care management.

Urinary catheters are used to help people that have difficulty urinating naturally, although some patients may have them inserted pre or post surgery. In male patients, catheterisation can be traumatic and pose a risk of infection. Catheterisation of male patients with enlarged prostate or other obstructive conditions in the lower urinary tract can be difficult. Risk of failed catheterisation can induce stress and pain for the patient, sometimes with injury to the urethra, potentially causing a urethral stricture requiring surgical reconstruction with problematic subsequent catheterisation. Working closely with acute urology, community continence teams can better manage the care of patients that are or require catheterisation. This collaborative, integrated approach to cross- organisational working should be encouraged across the ICS.

6. Proposed future care system

Home

Planned/Scheduled

Urgent – 24 hours

Emergency/Crisis – 4 hours

Prevention & Self-Care – Risk Factors, Education and Awareness

- No identified red flag people. Continence service (blood in urine, blood in stools not investigated – these need to be redirected appropriately)
- Promote awareness through National hydration day, national continence week.
- Continence vicious cycle, feel if they drink less it makes the problem go away – counter intuitive – education needed
- Care home incontinence training. Not mandatory, trained nurse only one on duty. Training delivered in central point in the City. County?
- Radio Nottingham for awareness. PHE – what colour is your wee – recommended fluid intake.
- Urine dipping part of continence setting. Baseline assessment – can pick up diabetes etc – raise awareness
- Some elderly patients inappropriately treated – urine dip but asymptomatic – shouldn't be treated with antibiotics
- Information available in media – accuracy and reliability is important – who is responsible for maintaining this information. Signposting.
- Think kidney campaign – leaflets, excellent website, TV commercials.

Sustainable by:

- **Raise awareness to improve prevention and self-care – some basic areas**

Detection and Diagnosis – Screening / Early Diagnosis, Late presentation/ Health Inequalities

- Assessment process, assessment and diagnosis at any stage. Patient could have had symptoms for weeks or years of some conditions.

Sustainable by:

- **Awareness and appreciate of the need to offer education and awareness of what is normal to prevent development of a condition long term.**

Treatment & Condition Management – Capacity & Access, Community Urology, Cross System MDT

- Have access to Uro-gynae MDT for patients struggling to support. Incontinence patients failing to respond to usual interventions but requiring ongoing treatment – need to consider Botox, surgery etc.

Sustainable by:

- **Collaborative care to provide earlier intervention.**

Whole System Approach – Continence, Integrated pathways, Care Homes UTIs

- Integrated pathways – establish the right pathway across Nottinghamshire ICS to bring whole ICS into line.
- Need for increased support in care homes. Used to have team of nurses that used to go in this stopped due to funding some time ago.
- Incontinence pad provision. Care home nurses assess the patient, but these nurses can't do bladder scans (due to homes not having the scanners as expensive). Assessment received, symptoms indicate need for the scan then the outreach nurse goes out to do the scan. Essential piece of equipment – can the homes have their own scanner – or share scanners between sister homes in a locality. In Nottingham City unaware of any care homes that have a bladder scanner. (identify if patient unable to empty their bladder).

Sustainable by:

- **Improves quality of care in nursing and care homes, prevents admission**

Prevention & Self-Care

- Catheter outreach nurse – can go out to undertake bladder scans and re-catheterise – if don't drink enough catheter blocks. (Catheter should last 12 weeks, often last 8 weeks). Mon-Fri. Difficult catheterisation – distressed patient, can't pass urine at all, pain, frank haematuria (lots of blood in the urine). If district nurse can't fix then patient admitted to hospital.
- Catheter problems where someone is in pain. District nurse allocated to care. Night and evening service. District nurse Mon-Sat.

Sustainable by:

- **Provides quick response enables earlier intervention and support to avoid crisis services**

Colour KEY to information source: Steering Group/ Workshop 1 Evidence Document/ Guideline Patient Focus Groups

NOTE: In further developing and implementing the proposals set out above as part of our focus, each partner organisation within the ICS will continue to ensure that they comply with their statutory duties and system/organisational governance processes, particularly (but not limited to) those relating to patient and public involvement; equality and inequality analysis

6. Proposed future care system

Neighbourhood

Planned/Scheduled

Urgent – 24 hours

Emergency/Crisis – 4 hours

Prevention & Self-Care – Risk Factors, Education and Awareness

- Education and information – some patients may be in receipt of leaflets around fluids, bladder retraining, so a degree of self-care can occur before they are referred. Can go from one extreme to another in terms of drinking and hydration issues.
- Digital platforms like PKB can perhaps be used to promote healthy living to cover a host of services – awareness is key.

Sustainable by:

- **Raise awareness to improve prevention and self-care – some basic areas**

Whole System Approach

- Most catheterised patients know when and who to call – some patients may not get response needed urgently because they have not known who to call over the weekend – numbers are usually clear in the catheter passport – the catheter passport needs to be consistently promoted and used
- UTI – visiting a pharmacist, if they suspected UTI they would refer on – 3 out of 4 UTI symptoms would go away

Sustainable by:

- **Provides quick response enables earlier intervention and support to avoid crisis services**

Detection and Diagnosis – Screening / Early Diagnosis, Late presentation/ Health Inequalities

- GPs tend not to go out to see patients – increased risk with COVID makes it less likely for GPs to turn up – variation exists across GP surgeries, but even worse trying to get GPs to care homes – may be a problem that continues after COVID because it has stopped happening to some degree already.

Sustainable by:

- **Awareness and appreciate of the need to offer education and awareness of what is normal to prevent development of a condition long term.**

Treatment & Condition Management – Capacity & Access, Community Urology, Cross System MDT

- Regular MDTs already existing with acute urology clinician – once patients have been passed up to acute, they tend to stay under the clinicians care, but then maybe passed back for catheter or similar patients
- Some patients do come back for community clinic patients – so some of these are seen before surgery for prehabilitation then again post-surgery (prostate removal)

Sustainable by:

- **Collaborative care to provide earlier intervention.**

Treatment & Condition Management

- Retention patients may be facilitated to urology in an emergency, if catheterisation cannot be done (existing patients) – so usually more an emergency rather than routine – training of teams on how to facilitate these emergencies also takes place

Sustainable by:

- **Provides quick response enables earlier intervention and support to avoid crisis services**

Whole System Approach – Continence, Integrated pathways, Care Homes UTIs

- No formal training or accreditation and it can be extremely dangerous if not done right. Need succession plan in place for CityCare nurse approaching retirement – this appears to be a risk
- City Hospital (urologist) supported community with non-routine catheters and turned them around quickly – so could do with some formalisation of this role and training to align to it
- Some people end up in residential care due to continence, but not a main reason. Continence can be the straw that breaks the camel's back in terms of accumulative problems and the carers then consider care homes
- A lot can be done with continence problems, but it can take time – a certain amount of self-care is required
- Continence appears not to be a priority for many HCPs, but awareness is strongly promoted
- Continence products are the end result of not being able to improve the issue – there is a limited number of pads given each day
- Prescription service – includes catheter related equipment, no continence prescription service in mid-Notts - but have BC in development to apply for this
- City has a women's physio service in the continence team but not in south Notts but have not felt it's been needed
- Routine continence clinics are in place and community nurses across city and county will go for continence assessments in people's homes if they're housebound

Sustainable by:

- **Improves quality of care in nursing and care homes, prevents admission**

Whole System Approach

- In county try to avoid ED admissions where possible, through nursing cover changing catheters, but some routine changes are still done in urology in secondary care (not necessarily ED)

Sustainable by:

- **Provides quick response enables earlier intervention and support to avoid crisis services**

Whole System Approach

- Outreach nurse – in place with CityCare can assist with some emergencies such as catheter changes, (sometimes routine, but sometime in an emergency) – only one member of staff WTE, but when not on duty this reverts to ED – GPs would not necessarily have this level of training to change complex catheters – the outreach nurse is an experience urology nurse.

Sustainable by:

- **Provides quick response enables earlier intervention and support to avoid crisis services**

Colour KEY to information source: Steering Group/ Workshop 1 **Evidence Document/ Guideline** Patient Focus Groups

NOTE: In further developing and implementing the proposals set out above as part of our focus, each partner organisation with in the ICS will continue to ensure that they comply with their statutory duties and system/organisational governance processes, particularly (but not limited to) those relating to patient and public involvement; equality and inequality analysis

6. Proposed future care system

Acute or MH Hospital

Planned/Scheduled

Urgent – 24 hours

Emergency/Crisis – 4 hours

Prevention & Self-Care – Risk Factors, Education and Awareness

- Raising awareness, targeting health inequalities and BAME communities.

Sustainable by:

- Raise awareness to improve prevention and self-care – some basic areas

Detection and Diagnosis – Screening / Early Diagnosis, Late presentation/ Health Inequalities

- Community clinics to address health inequalities in range of locations - nurse practitioner and HCA support DRE – digital rectal exams, results fed into 2WW community – engagement
- Rapid pathway – PSA on 2WW, MRI to detect prostate concern – discharged or biopsy (template) MRI reduce number of templates.
- Triage and advice and guidance is available
- Benign and diagnostics requirement e.g. stones – clarity
- Cystoscopy/US.

Sustainable by:

- Awareness and appreciate of the need to offer education and awareness of what is normal to prevent development of a condition long term.

Treatment & Condition Management – Capacity & Access, Community Urology, Cross System MDT

- Ideal one stop clinic – MRI am/ template and diagnosis. (challenges radiology for reporting
- Virtual and nonF2F/videoconferencing – IT equipment
- Day surgery opportunity to expand TURP as day case rather than IP.
- Uro-gynae pathway seek information

Sustainable by:

- Collaborative care to provide earlier intervention.

Colour KEY to information source: Steering Group/ Workshop 1 Evidence Document/ Guideline Patient Focus Groups

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6. Proposed Future Care System

Level of Care

Availability

4 hours
or less

24/7

Urgent
Care/
within 24
hours

7 days

Scheduled

Appt
based

Acute/ MH Hospital

- Benign detection and diagnosis - reduction in emergency presentations through development of pathway to reduce patient admissions via ED – availability of ureteroscopy for ED presentation

- Early sight and management of some urgent cases in urology rather than presentation through ED – with initial management in primary care, e.g. renal colic, retention

- Scope to train additional grades to conduct cystoscopy for simple procedures, or microscopic haematuria, etc. to help with capacity challenges
- Improve consistency in following haematuria, PSA, UTI pathways across all settings – through better adherence to national guidance
- Integrating care supporting follow up in community through a multidisciplinary approach
- Day surgery opportunity to expand transurethral resection of prostate (TURP) as day case rather than IP with nurse led telephone follow up clinics as an option (Dudley 100 day challenge report)
- Closer working between hospitals to promote development of day-case services for less complex cases (TURP, outflow obstruction surgery) e.g. in Newark

Neighbourhood

- Widen training offer to teams to help facilitate emergencies for retention patients where catheterisation is not appropriate
- Outreach urology nurse post to be accessible across ICS to support assistance with some emergencies (such as complex catheter changes)

- Embedding ICS wide use of Catheter passport to ensure patients are fully apprised of contact points and service offers
- Improve use of pharmacist to advise on potential UTIs

- Adapt existing best practice of continence and catheter pathways to deliver across all areas of the ICS - need to build on strengths of City and South Notts continence services to provide access across the whole of the ICS – with a consistent approach
- Improving access to community clinics and specialist continence services across the ICS to include structured prehab and post-surgery care, access to physiotherapists (pelvic floor, etc.) –
- Full clinical support across catheter pathways - making effective use of catheter passports across the region within integrated pathways to allow people to be seen at the location most appropriate to them
- Develop improved follow up of kidney cancer in community – make use of proposed rapid diagnostic centres to do chest x-rays, regular ultrasounds – integrated approach to ensure patients are not lost to follow up
- Scope to develop advance roles in the community to support management of more conditions early in their inception in primary/ community settings

Home

- Catheter outreach nurse to support via bladder scans, able to re-catheterise when blocked (ensuring longevity of catheters are realised) – offer across ICS extended to 7 days with escalation plan out of hours - extended to support for care homes including access to bladder scans – mobile solution, continence and catheter support
- Appropriate professional support (e.g. PCNs to support district nurse) service available across ICS to respond to catheter problems causing pain, frank haematuria – adapting existing evening and night model

- Providing education, training and support for carers and patients to promote self-care and self-management of continence issues to prevent placement in care homes
- Where people are in care homes, expanding training and education to care home staff to manage residents avoiding referrals to clinicians in community and acute hospital



Prevention, education and awareness:

- Raise awareness of risk factors through early education in schools - smoking, diet, hydration
- Secondary prevention, training and support in managing incontinence issues, catheter care, self-management to prevent deterioration of a condition
- Targeting areas of inequality

High Priority

For the most common urological health conditions many people know little about them, or the impact they can have on the livelihoods of those or the families of those that develop them. Whilst generic education programmes about healthier living and identifying serious health conditions early, are helpful for prevention of some of the common LTCs, these education programmes do not necessarily raise awareness of the some of the common urological conditions. However, existing awareness campaigns include:

- Blood in Pee
- Movember for prostate cancer awareness
- Nutrition and hydration week

Although for one month each year, this includes prostate cancer, which is one of the most common cancers in the UK and the most common in men, there remains less awareness raising work on the specific risk factors for prostate cancer in public health programmes (*Prostate Cancer UK, 2014*). To maintain good urological health, the messages raised in such campaigns need to be raised consistently through the year.

In raising awareness and educating the population and workforce on urological risks, targeted programmes are required if to be effective for the ICS population, starting with education in schools where lifelong good lifestyle habits can be developed to prevent some of the common urological conditions – first and foremost to simply maintain good hydration. Education on specific areas of urological health should be tailored for the ICS citizens, for the care workforce and also for the patients to improve self-management as secondary prevention, reducing admissions for recurrent issues that can be managed at home, if better educated.

In the UK, studies have shown prevalence of any incontinence averages out at around 40% for women and 10% for men. The NHS estimates that between 3 and 6 million people in the UK have some degree of urinary incontinence. Despite having specialist continence services across the ICS, far more can be done to help manage incontinence, starting with education and training of the wider workforce that support and care for people that may have urinary incontinence, perhaps as a comorbidity and this is an area where secondary prevention can be promoted well around product availability and self-care, catheter care, extending advice and guidance to carers. With this level of prevalence if incontinence, many cases will end up under the direct care of doctor led or specialist secondary care services, evidence shows the majority of problems are best dealt with by specialist nurses and physiotherapists in community settings. This should include open access to patients and promoting this so patients and GPs are aware that patients can self-refer to community services.

Black men are twice as likely to develop prostate cancer in the UK and given there are only 3.3% Black ethnic groups in England and Wales (*Gov.UK, Census 2011*), this is disproportionately high. Awareness of prostate cancer is low in Black communities and more support is needed for this group to improve the reported poorer NHS experiences for Black men with prostate cancer (*Prostate Cancer UK, survey June 2012*).

Impact & Benefit

- Reduced prevalence in longer term through raised awareness
- Reduce ED admissions through earlier detection and diagnosis
- Directing patients away from doctor led services and avoidable referrals to secondary care
- Improved patient outcomes
- Equitable access through reduction of inequalities across hard to reach groups

Alignment – For prevention, education and awareness the consistency should be aligned at an ICS level, with delivery aligned to each ICP



Consistent and Equitable Community Continence Service:

- Access to needed support , including continence pads, catheter support
- Working with PCNs and GPs to ensure care homes are supported
- Raising the profile of continence due to the impact it has on patients' lives that have issues with incontinence

High Priority

There are currently three specialist continence services in the ICS: City, South and Mid-Notts teams and the way in which they are organised across the ICS is complex. In South-Notts and City the continence services are now integrated into pathways that span primary and secondary care and all referrals to the specialist continence clinics come through the continence advisory service, as the referral method. This has prevented direct access to these clinics through primary care which ensures the majority of patients get the right referral to the right treatment in the continence clinics. The advantages of this include patients being seen in the continence clinics much sooner, allowing savings on the prescribed continence products that are provided and also allows savings on avoiding unnecessary referrals and unnecessary treatments in secondary care. Hence, when patients are referred to secondary care, they are better prepared to gain from the benefits of specialist interventions. This is not currently done in Mid-Notts, however, the scope to introduce a similar service here will allow the same benefits to be generated. This approach provides cost savings, improved care with reduced referrals to secondary care and a more integrated system between all regions of the ICS. Some of this alignment work between teams has started, particularly on the formulary of products, but this lost some of the momentum as a result of the pandemic and so a greater push to get equity of provision for all patients in the ICS is needed.

Efficiency controls on prescribed high cost continence products, demonstrated a £400k savings by the city specialist continence service through rationalisation, where patient and carer education was also enhanced. With training and support for carers to manage incontinence with their patients, the system can also prevent avoidable placements into care home. There will be cases where this may be avoided, with equitable access at home or locally. Some of the teams are contracted to provide training and support for staff in a number of nursing homes, helping to prevent avoidable presentation to ED and possible admission. Pads are also provided to nursing homes, so district nurses do not need to order products. There is also support provided to nursing and care homes, which includes issues with the prescription service, where prescriptions are provided for people in nursing and care homes and people living in their own homes.

It is clear the specialist continence service cover diverse urological health needs for many patients across the ICS, yet the profile of continence remains modest with little support in improving equity of care across the ICS. By improving the alignment between continence teams in urological health and urology this can help integrate across settings covering primary care, secondary care and community care, with more focus on provision closer to home. This is mentioned further in the fourth proposal.

With the challenges of promoting consistent and equitable community continence services, the teams and service could benefit from ICS wide support in developing an accredited training and education programme through the university, which could change the way the services are viewed in the future. There is a risk of the service diminishing with poor support in succession planning as it is difficult to make new roles attractive enough without education and accreditation part of the role development. Overall, Nottingham and Nottinghamshire do provide an excellent service for the ICS population

Impact & Benefit

- Integrated continence pathways across the ICS in which patients are seen sooner
- Cost savings potential through rationalising use of continence products (e.g. £1.1m reduced to £700k in the City service)
- Patient safety in review and suitability of products in addition to the cost savings in managing the over-prescribing
- Support for care homes and community district nursing teams , reducing emergency attendance or admission
- Effective continence support through unified pathways across whole ICS, with opportunity to exploit multi-skilled working across the service

Alignment – To achieve equity in service provision from the specialist continence service, a programme of work should be planned with consistency aligned to the ICS, with unified approach for more local delivery at ICP level



Pathways avoiding A&E, e.g. renal colic, retention:

- Early identification
- Consistently followed pathways as per national guidelines to reduce ED admissions
- Links between community and acute teams specifically for catheterised patients

**Medium
Priority**

Renal colic is thought to be one of the most severe pain conditions that is commonly presented and diagnosed in the accident and emergency (A&E) department. For renal colic and similar conditions, such as acute urinary retention, it is important primary care teams work closely with the acute hospital teams in aligning to the pathways that work best across the ICS. There was a national variation in the management of conditions like renal colic and retention, so local teams were expected to identify solutions to ensure the patients were treated well and promptly (*GIRFT, National Specialty Report, 2018*).

Currently, the patients closer to NUH suspected with renal colic and assessed by their GP or an out-of-hours GP, will be directed to the GP at QMC who can usually have a CT requested swiftly. If a stone is found, a call can be made to the urology ward, with the patient sent across for treatment. The pathway managed through SFH is slightly different in that a GP would refer to A&E without the guarantee of a fast pass to CT and whilst this may be entirely appropriate, there is an opportunity to avoid A&E rework and model SFH for renal colic and acute urinary retention on NUH, which may also provide a quicker route for the patient to be seen by urology, whilst aligning the pathway across the region. The feasibility of this needs more assessment and should be reviewed by referring GPs and the A&E clinicians. If fast access to CT is available and can work with the GP24 service at SFH, this can avoid patients going to ED.

By establishing multidisciplinary continence clinics, there is an opportunity to upskill the community teams through continuous learning and coordinated working. This can help with improved community management of catheterised patients with complex issues that are usually referred back to level 3 for acute specialist input.

Impact & Benefit

- Potential to reduce presentations and admissions via ED through aligned models across the ICS
- Help with capacity challenges through upskilling

Alignment – Minor pathway adjustments for prevention of A&E presentation or rework should be to a level of consistency aligned to each of the ICPs, with a delivery model linked to each PCN for local access assured.

ICS wide integrated working:

- Partnership working across settings
- Review options to provide day case surgery for less complex procedures at Newark

**High
Priority**

Integrated pathways enable patients to be seen in the best place at the right time, and allow earlier referrals to community services. Streamline referral from within the system between SFH and NUH – most of specialised cancer work happens at NUH as opposed to SFH and there are occasions where late referrals can lead to 104 day harms occurring as a result of the late referral which may be better managed through multidisciplinary working across all pathway settings, including between SFH and NUH, but with primary care too.

There can be benefits from an improved triage system, and referrals should be vetted and screened so that the most appropriate type of appointment and most appropriate clinic and location can be allocated by clinician to improve the efficiency of pathways across the ICS. This needs to consider both virtual and F2F appointments, in both general clinics or specialist clinics and level of urgency. This would support reducing unnecessary appointments.

With full clinical support, embedding the use of catheter passports (as recommended in NICE guidance) in integrated pathways, can not only help track the patients that are catheterised, but also highlight where the passports are not being used, because decisions can be enhanced if catheter passports are fully utilised. Catheter passports also promote patient and carer support with education and self-management detailed within them, including up to date clinical information enabling increased self-care and when required, information on them can help other HCPs signpost the patient to the right place at the right time.

Prehab is another area being developed, largely for cancer pathways, and presents an opportunity to help connect urology and urological health, with community teams brought on board much earlier. Partnership working with patients supported pre-surgery, during cancer treatment and post surgery can help improve their outcomes (prehab/ rehab model).

PTO ...

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ICS wide integrated working:

- Partnership working across settings
- Review options to provide day case surgery for less complex procedures at Newark

**High
Priority**

Continued ...

More opportunities can be explored to retain some routine elective procedures at SFH or perhaps move some to Newark (e.g. cystoscopy), whilst this may not provide the care closer to home, this may be a way to explore how to help alleviate some of the pressure from the backlog of benign work that has resulted from COVID pressures. It also helps maintain some of the treatments in Mid-Notts, preventing transfer of patients to NUH where this can be avoided through effective ICS-wide pathways. By making effective use of all of the estate across the system for urology and in particular Newark, where there is available capacity, for example all appropriate routine procedures to be delivered at Newark, to maximise use of that capacity to free up resource at KMH and NUH for more complex work – where currently a more complex, multi-functional resource is used to carry out straightforward work. Whilst this may need some investment at Newark it helps to broaden the scope of work that can be delivered there. This may include some nurse training and some equipment. This can build on existing clinics and scope of operations already performed at Newark.

Impact & Benefit

- More efficient pathways to effect improved patient experience and outcomes
- Improve capacity for complex procedures at KMH and City hospital
- Help tackle backlog of benign work resulting from COVID pressures

Alignment – To provide an ICS wide integrated approach to service provision, all organisations should be aligned for consistency at the ICS level. The delivery of this way of working and collaboration should be aligned to an ICP level.

Effective patient follow on planning:

- GP discharge plans detailed in urology care pathways
- Risk stratified follow up
- Patient initiated follow up

**Medium
Priority**

In line with the NHS LTP to reduce outpatient appointments (OPA) by 1/3, there may be scope to reduce routine follow up (FU) appointments in urology. Currently, a number of routine FU appointments tend to be booked where patients are discharged without a plan for GP follow up and this is an area where OPAs can be reduced through effective discharge planning. Rather than bring patients back to the urology clinic for FU, patients should be discharged with a clear plan for the GP to follow, which may be to simply alter the medication after 6 weeks. Then book the patient for a test after a further 6 weeks if the patient is still troubled. This will have already reduced one OPA. A lot of these straightforward things to follow should be formalised in care pathways following NICE Guidance. If these are followed correctly, GPs can try adjustments before considering referrals back for an OPA and the only patients that should be seen in FU OPAs are those where there is a potential risk, anyone else should follow a remedial plan from the clinician who should only be contacted if it does not work, in which case the GP should refer back.

The other route back for an OPA should be a patient initiated FU where it links to a medical condition which is not predicted to cause them any harm but links to their quality of life and the GP is provided with a clear plan with criteria for referral back included in the discharge letter. Examples where this would apply include a benign condition where the patient may be asked if they wish to have a surgical procedure and are discharged and they initiate the follow up if they decide to go ahead; or patients with lower urinary tract symptoms with a series of different medications or treatments that they can try that can be facilitated by the GP with the urologist's plan of action in place, again with criteria for referral back; patients with recurrent UTIs that require referral back – i.e. benign urological conditions where the treatment is aligned to the patients' quality of life and their decision to have something done as opposed to a potentially dangerous problem that requires clinician review through periodic FU monitoring.

Impact & Benefit

- Reduction of urology OPAs, in line with NHS LTP

Alignment – The consistency of this proposal should align at an ICS level, with delivery aligned at an ICP level

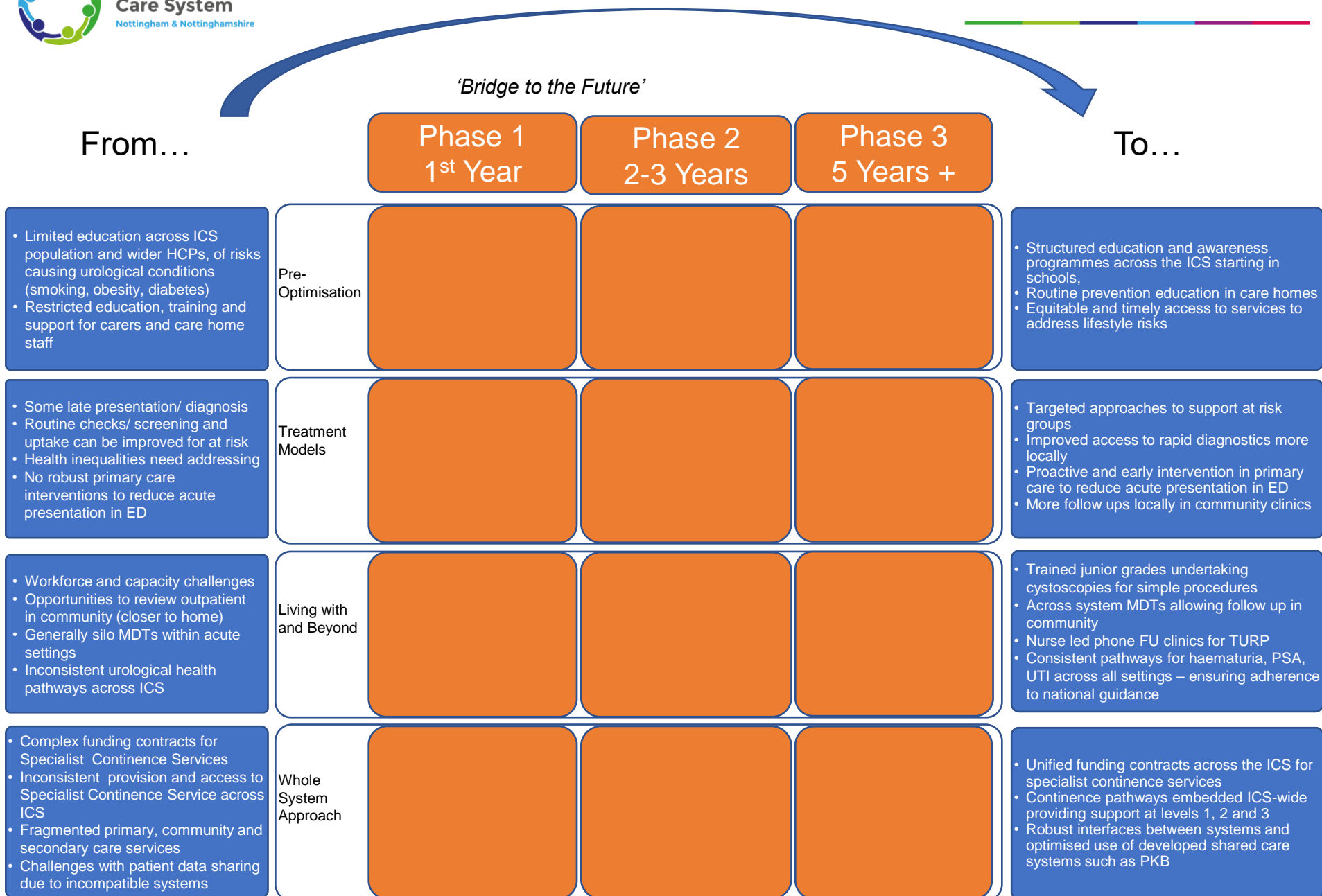
7. Urological Health Transformation Proposal

| Transformation Proposals | Priority (High/ Med/ Low) | Alignment (ICS/ ICP/ PCN) | | Workforce | Technology | Estate/ Configuration | Culture | Finance/ Commissioning | Benefits (*Less than £20,000 per QALY is cost effective) |
|--|------------------------------------|------------------------------|----------|--|--|---|---|--|---|
| | | Consistency | Delivery | | | | | | |
| Prevention, education and awareness: <ul style="list-style-type: none"> Raise awareness of risk factors through early education in schools - smoking, diet, hydration Secondary prevention, training and support in managing continence issues, catheter care, self-management to prevent deterioration of a condition Targeting areas of inequality | High | ICS | ICP | <ul style="list-style-type: none"> PH to lead on education programmes in schools Work with midwifery staff to early input to prevention (e.g. pelvic floor exercise) is most useful Involve pharmacists routinely to advise and support potential UTIs Active programmes to identify areas of inequality | <ul style="list-style-type: none"> Raising awareness by making use of media platform Apps such as PKB – target groups where inequalities exist Information available in range of languages and formats to suit | | <ul style="list-style-type: none"> Capacity limits to some extent dealing with the cause and by use of products, they end up dealing with the symptoms Wider education of HCPs to take responsibility Promote self-care and self-management | <ul style="list-style-type: none"> Develop pathway to reduce | <ul style="list-style-type: none"> Reduced prevalence in longer term through raised awareness Reduce ED admissions through earlier detection and diagnosis Improve self-care Improved patient outcomes Equitable access through reduction of inequalities across hard to reach groups |
| Consistent and Equitable Community Continence Service: <ul style="list-style-type: none"> Access to needed support , including continence pads, catheter support Working with PCNs and GPs to ensure care homes are supported Raising the profile of continence due to the impact it has on patients' lives that have issues with incontinence . | High | ICS | ICP | <ul style="list-style-type: none"> Structured training for staff aligned to agreed pathways (to cover mid-Notts gap) DNs to be upskilled to cover continence as they will be first contact for carers and will need to support Psychological therapy access to support patients with continence issues Balance between supporting care homes and training care home staff | <ul style="list-style-type: none"> RECAP – NHS Website that has information on healthcare products, so using a continence code provides access to information for the patient and product information on – another platform (cf. PKB) but fairly useful for care homes where larger numbers can benefit Same system or interfaced systems are a must to help with seamless care Embed ICS wide use of catheter passport | <ul style="list-style-type: none"> Lack of primary/ community care clinic space – create space in community hubs across PCNs | <ul style="list-style-type: none"> Need to raise profile of Continence to improve recruitment and retention Need support from some of the larger groups – Association of Continence, issue is this area of care has been cut Contracted to provide training, products (pads) and continence service to care homes; CityCare train Integrated Care Home Service staff (they have access to CityCare training) and then go on to train the care home staff in City | <ul style="list-style-type: none"> Need to simplify continence contracts across the ICS Identify ways to support level 3 (acute care) Medicines optimisation includes specialist stoma prescribing – same process but different providers results in inefficiencies | <ul style="list-style-type: none"> Cost savings on rationalising use of continence products (e.g. £1.1m reduced to £700k) Patient safety in review and suitability of products in addition to the cost savings in managing the over-prescribing Effective continence support through unified pathways across whole ICS |
| Pathways avoiding A+E, e.g. renal colic, retention: <ul style="list-style-type: none"> Early identification Consistently followed pathways as per national guidelines Links between community and acute teams specifically for catheterised patients | Medium | ICP | PCN | <ul style="list-style-type: none"> Widen training offer to teams to help facilitate emergencies for retention patients where catheterisation is not appropriate Outreach urology nurse post to be accessible across ICS to support assistance with some emergencies (such as complex catheter changes) Train additional grades to perform simple cystoscopy or microscopic haematuria | <ul style="list-style-type: none"> IT systems access through improved interfacing across all settings – SystmOne in community – need to simplify access to patient data across settings | | <ul style="list-style-type: none"> National guidelines accessible to all to prevent local interpretations where patients may not be referred timely or to the right place Clear pathways to help define 1* care to acute contact, e.g. retention issues | | <ul style="list-style-type: none"> Reduce ED presentations and hospital admissions Help with capacity challenges through upskilling |
| ICS wide integrated working: <ul style="list-style-type: none"> Partnership working across settings Review options to provide day case surgery for less complex procedures at Newark | High | ICS | ICP | <ul style="list-style-type: none"> Cross system MDT to better manage patient care across appropriate setting, including FU closer to home Outreach urology nurse post accessible across ICS – succession planning needed for post | | | <ul style="list-style-type: none"> Care not closer to home, but will be able to have procedure done sooner | <ul style="list-style-type: none"> Commissioning of additional surgery in KMH/ Newark | <ul style="list-style-type: none"> Improve capacity for complex procedures at City hospital Help tackle backlog of benign work resulting from COVID pressures |
| Effective patient follow on planning: <ul style="list-style-type: none"> GP discharge plans detailed in urology care pathways Risk stratified follow up Patient initiated follow up | Medium | ICS | ICP | <ul style="list-style-type: none"> Urology All community urological health workforce to align to consistent pathways of care detailing routine follow up in Consistent approach to referrals for level 3 support as per uro-gynaecology pathway | | | <ul style="list-style-type: none"> Follow Urogynae pathways across ICS including community follow on care | | <ul style="list-style-type: none"> Address some of the theatre capacity challenges |

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| | |
|-------------------|--|
| Workforce | <p>Enhancing the future health and social care for urological health services, requires the following main considerations for workforce:</p> <ul style="list-style-type: none"> • Need to consider succession planning in some areas, such as urology outreach nurse specialist that provides support to community teams – current post holder is close to retirement and this potentially leaves a big support gap – need to consider generic succession plan • Cross pathway working (Primary and secondary and community care) for clinicians and primary care practitioners with specific development and expansion of local successful models delivering care through expertise in MDTs • Widespread training of healthcare professionals (HCPs) to empower them to provide appropriate advice or signposting for prevention of LTCs healthy living, self-help and early detection, with more specificity for urological health • Working with generic therapists and specialised therapists to develop a programme of integrated care through prehab and rehab for urology |
| Technology | <p>The main areas in which technology can effect transformation for urological health include:</p> <ul style="list-style-type: none"> • Digital integration - If it is accepted that a single IT system may not be deliverable in the long term then focus should be on connecting existing systems successfully – more to do with access and permissions through improved interfacing • Support existing App developments/ promotions for signposting self-care resources or local services – based on NHS App/ PKB • Improve use of existing IT resources, e.g. RECAP product range on NHS website for continence products – need to make people aware these types of resources exist |
| Estate | <ul style="list-style-type: none"> • Lack of clinic space in primary care/ community setting for continence teams to work from – would benefit from establishing a specific hub/ space in each PCN |
| Culture | <ul style="list-style-type: none"> • To drive a culture change we need shared and integrated use of workforce across organisations to enable the sharing of resources as there are limited staff groups and expertise, with the introduction of multi-agency approaches this should improve education across the workforce • In the continence arena, much more can be done on product rationalisation through treating the cause and not the symptoms • Through improved education more HCPs can take responsibility to promote self-care and self-management • Joint working to help people in a different way – liaison between professionals to support person-centred care • Need improved use of national guidelines across the ICS • More of the providers (including primary care) to align to uro-gynaecology pathway |

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Conclusions

The review of urological health services as part of the development of a Clinical and Community Services Strategy for Nottingham and Nottinghamshire ICS has been undertaken using a co-design model where key stakeholders have collaboratively worked together to shape a vision for the future care system. Although the work has progressed working remotely and holding virtual meetings, engagement was limited mainly a result of COVID response and pandemic pressures. Patient engagement was not possible for this review, but this would prove beneficial and will be revisited as time allows or should be undertaken prior to any implementation work to confirm the proposals. The four key themes for improvement identified are:

Prevention and Self-Care (with emphasis on risk factors leading to urological health conditions and education and awareness to promote self-management and prevention);

Detection and Diagnosis (reviewing screening and early diagnosis. Focus on late presentation and health inequalities);

Treatment and Condition Management (with a emphasis on capacity and access, collaborative working to support community urology and cross system MDT);

Whole System Approach (ensuring the organisation and delivery of services is consistent through a multi-agency approach that includes 3rd sector organisations and charities supported through local authorities. Well interfaced systems so providers know their patients for a connected urological health care system).

The review describes a future care system in optimal care settings and with care provided at different levels of urgency and envisages 3 high priority and 2 medium priority programmes to transform care:

High – Prevention, education and awareness

High – Consistent and equitable community continence service

Med – Pathways avoiding A&E

High – ICS wide integrated working

Med – Effective patient follow-up

To achieve these there are a range of enabling requirements for the ICS across workforce, technology, estate, culture and financial systems. Collectively these initiatives can help transform and provide long term health improvement and sustainability in the area of urological health services in the Nottingham and Nottinghamshire ICS.

Next Steps

This strategy sets the future direction of development for urological health care in the ICS and it is proposed it will shape future work of the ICS in a number of ways:

- The identified priorities and programmes should be used to inform commissioning ICS, ICP and PCN activity
- The enabling activities require development and inclusion in the relevant ICS workstreams to inform their work programmes
- The impact on estate and configuration changes require inclusion in a programme of pre-consultation business case development alongside the service changes recommended from other reviews, although the impact for urological health is less specific in relation to community hub space
- The aggregate impact of the collective suite of service reviews should be used to shape focus of future service provision in acute/ MH and community settings in the ICS

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11. List of Common Abbreviations

| | | | | | |
|-------------|---|-------------------|---|----------------|---|
| 1°, 2° Care | Primary, Secondary Care | EMAS | East Midlands Ambulance Service | NNU | Neonatal Unit |
| 2WW | Two-week-wait | EMCA | East Midlands Cancer Alliance | Notts. | Nottinghamshire |
| A&E | Accident and Emergency | EMRAD | East Midlands Ambulance Radiography | NRC | National Rehabilitation Centre |
| A&G | Advice and Guidance | ENCH | Enhanced Health in Care Homes | NRCP | National Register of Certified Professionals |
| ACE | Adverse Childhood Experience | EoL | End of Life | NRT | Nicotine Replacement Therapy |
| ACP | Advanced Care Practitioner | eSCR | Electronic Shared Care Record | NUH | Nottingham University Hospitals |
| ADHD | Attention Deficit Hyperactivity Disorder | ESD | Early Supportive Discharge | O ₂ | Oxygen |
| AF | Atrial Fibrillation | ESDT | Early Supportive Discharge Teams | OCCEF | Ophthalmic Common Clinical Competency Framework |
| AI | Artificial Intelligence | F2F | Face to Face | OCT | Optical Coherence Tomography |
| AK | Actinic Keratosis | FeNO | Frasntonal Exhaled Nitric Oxide | OOH | Out of Hours |
| AMD | Age-related Macular Degeneration | FT | Foundation Trust | OPM | Office of Public Management |
| ANP | Advanced Nurse Practitioner | FTE | Full Time Equivalent | OTC | Over-the-Counter |
| App | Application | FU | Follow Up | PCN | Primary Care Network |
| APPG | All Party Parliamentary Group | GBD | Global Burden of Disease | PCP | Personalised Care Plan |
| ARTP | Association for Respiratory Technology and Physiology | GOC | General Optical Council | PCR | Patient Care Record |
| ASC | Autism Spectrum Conditions | GOS | General Ophthalmic Service | PH | Public Health |
| AT | Assistive Technology | GP | General Practitioner | PHE | Public Health England |
| ATAIN | Avoiding Term Admission Into Neonatal units | GPRCC | General Practice Repository for Clinical Care | PHM | Population Health Management |
| BAD | British Association of Dermatology | GPwER | General Practitioner with an Extended Role | PHO | Public Health Organisations |
| BAME | Black, Asian and Minority Ethnic | GRASP-COPD | Guidance on Risk Assessment on Stroke Prevention for COPD | PID | Project Initiation Document |
| BB | Better Births | H&SC | Health and Social Care | PKB | Patient Knows Best |
| BCC | Basal Cell Carcinoma | HCP | Healthcare Professional | PN | Practitioner Nurse |
| BEH | Behavioural and Emotional Health | HES | Hospital Episode Statistics | PR | Pulmonary Rehabilitation |
| BF | Breast Feeding | HES | Hospital Eye Service | PSNC | Pharmaceutical Services Negotiating Committee |
| BFI | Baby Friendly Initiative | HNA | Holistic needs assessment | PwER | Pharmacist with Extended Role (in skin health) |
| BLF | British Lung Foundation | HV | Health Visitor | QALY | Quality Adjusted Life Years |
| BMI | Body Mass Index | IAPT | Improving Access to Psychological Therapies | QIPP | Quality, Innovation, Productivity and Prevention |
| BMJ | British Medical Journal | ICP | Integrated Care Partnership | QMC | Queen's Medical Centre |
| BP | Blood Pressure | ICS | Integrated Care System | RCEM | The Royal College of Emergency Medicine |
| BSG | British Society of Geriatrics | ICT | Information and Communication Technology | RCN | Royal College of Nursing |
| BTS | British Thoracic Society | IT | Information Technology | RCOG | Royal College of Obstetricians and Gynaecologists |
| CAMHS | Child and Adolescent Mental Health Service | IUC | Integrated Urgent Care | RCOphth | Royal College of Ophthalmology |
| CAS | Clinical Assessment Service | IUT | In-Utero Transfer | RDC | Rapid Diagnostic Centre |
| CBT | Cognitive Behaviour Therapy | KMH | Kings Mill Hospital | RNIB | Royal National Institute for the Blind |
| CCG | Clinical Commissioning Group | LD | Learning Disability | ROI | Return on Investment |
| CCSS | Clinical and Community Services Strategy | LMNS | Local Maternity and Neonatal System | RoSPA | Royal Society for the Prevention of Accidents |
| CES | Cranial Electrotherapy Stimulation | LNU | Local Neonatal Unit | ROVI | Rehabilitation Officer for Visually Impaired |
| CFS | Clinical Frailty Scale | LOC | Local Optical Council | RTT | Request To Treatment |
| CGA | Clinical Geriatric Assessment | LoS | Length of Stay | RTT | Radiotherapy |
| CoC T&F | Continuity of Care Task and Finish | LTC | Long Term Conditions | SALT | Speech and Language Therapy |
| CoO | College of Optometrists | LTOT | Long Term Oxygen Therapy | SaToD | Smoking at Time of Delivery |
| COPD | Chronic Obstructive Pulmonary Disease | LTP | Long Term Plan | SBLCB | Saving Babies Lives Care Bundle |
| COVID19 | Corona Virus Disease 2019 | LTV | Long Term Ventilation | SC | Social Care |
| CPR | Cardio-Pulmonary Resuscitation | LV | Low Vision | SCC | Squamous Cell Carcinoma |
| CQUIN | Commissioning for Quality and Innovation | MBCT | Mindfulness Based Cognitive Therapy | SEND | Special Educational Needs and Disabilities |
| CUES | COVID Urgent Eye-care System | MDT | Multi-Disciplinary Team | SFH | Sherwood Forest Hospitals |
| CVD | Cardio Vascular Disease | MECC | Make Every Contact Count | SIGN | Scottish Intercollegiate Guidelines Network |
| CVI | Certification of Vision Impairment | MgSO ₄ | Magnesium Sulphate | SPA | Single Point of Access |
| CYP | Children and Young People | MH | Mental Healthcare | STP | Sustainability and Transformation Partnership |
| CYPF | Children, Young People and Families | Mid Notts. | Mansfield & Ashfield, Newark & Sherwood | TC | Treatment Centre |
| DASV | Domestic Abuse and Secual Violence | MMR | Measles, Mumps, Rubella | TIA | Trans-Ischaemic Attack |
| DNA | Did Not Attend | NCGPA | Nottingham City General Practice Alliance | TTO | To Take Out |
| DoS | Directory of Service | NCH | Nottingham City Hospital | TYA | Teenage and Young Adults |
| ECG | Electrocardiogram | NGO | Non-Government Organisations | UC | Urgent Care |
| ECLO | Eye Clinic Liaison Officer | NHFT | Nottinghamshire Healthcare Foundation Trust | UCC | Urgent Care Centre |
| ECT | Electroconvulsive Therapy | NHS | National Health Service | UEC | Urgent and Emergency Care |
| eCVI | Electronic Certification of Vision Impairment | NHSE | National Health Service England | UECDI | Urgent and Emergency Care Digital Integration |
| ED | Emergency Department | NHSI | National Health Service Improvement | UTC | Urgent Treatment Centre |
| EFI | Electronic Frailty Index | NICE | National Institute for Health and Care Excellence | VCSE | Voluntary, community and social enterprises |
| ELBG | Ear Lobe Blood Gas | NICU | Neonatal Intensive Care Unit | VI | Visual Impairment |
| EM ODN | East Midlands Operational Delivery Network | NIDA | National Institute of Drug Abuse | WHO | World Health Organisation |

Data Sources

British Medical Journal
British Journal of Cancer
Local Data from NUH, SFH, Social Care, CCGs, GPRCC, eHealthscope
Cancer Research UK
National Institute for Health and Care Excellence
NHS England
NHS Health and Social Care Boards
NHS Long Term Plan
Office of National Statistics
Public Health England
World Health Organisation