



Right person, right place, first time

Transforming elective care services **urology**



Learning from the Elective Care Development Collaborative

NHS England INFORMATION READER BOX

Directorate		
Medical	Operations and Information	Specialised Commissioning
Nursing	Trans. & Corp. Ops.	Strategy & Innovation
Finance		

Publications Gateway Reference: 000448

Document Purpose	Resources
Document Name	Transforming elective care services: Urology
Author	Elective Care Transformation Programme
Publication Date	10th April 2019
Target Audience	CCG Clinical Leaders, Care Trust CEs, Foundation Trust CEs, Medical Directors, NHS Trust Board Chairs, NHS England Regional Directors, NHS England Directors of Commissioning Operations, Allied Health Professionals, GPs, Emergency Care Leads
Additional Circulation List	CCG Accountable Officers, CSU Managing Directors, Directors of PH, Directors of Nursing, Communications Leads
Description	
Cross Reference (if applicable)	N/A
Superseded Docs	N/A
Action Required (if applicable)	N/A
Timing/Deadlines (if applicable)	N/A
Contact details for further information	Linda Charles-Ozuzu Director - National Elective Care Transformation Programme Email: england.electivecare@nhs.net
Document Status	This is a controlled document. Whilst this document may be printed, the electronic version posted on the intranet is the controlled copy. Any printed copies of this document are not controlled. As a controlled document, this document should not be saved onto local or network drives but should always be accessed from the intranet.

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Introduction

The national context and challenges facing elective care services in England

The national urology challenge

The Elective Care Development Collaborative

Overview of ideas described in this handbook

Essential actions for successful transformation

1. Rethinking referrals:

a. Standardised referral pathways and structured templates

2. Maximising the role of shared decision-making and self-management support:

a. Self-management education and information

b. Catheter passport

3. Transforming outpatient appointments to better meet patients' needs:

a. Multidisciplinary continence clinic

b. Alternative consultation methods

Contents

click  to return to this page

Introduction	4
The national context and challenges facing elective care services in England	5
The national urology challenge	6
The Elective Care Development Collaborative	7
Overview of ideas described in this handbook	8
Essential actions for successful transformation	9
1.  Rethinking referrals:	
a. Standardised referral pathways and structured templates	11
2.  Maximising the role of shared decision-making and self-management support:	
a. Self-management education and information	14
b. Catheter passport	18
3.  Transforming outpatient appointments to better meet patients' needs:	
a. Multidisciplinary continence clinic	21
b. Alternative consultation methods	24
Taking transformation forward	27

Introduction

The national context and challenges facing elective care services in England

The national urology challenge

The Elective Care Development Collaborative

Overview of ideas described in this handbook

Essential actions for successful transformation

1. Rethinking referrals:

a. Standardised referral pathways and structured templates

2. Maximising the role of shared decision-making and self-management support:

a. Self-management education and information

b. Catheter passport

3. Transforming outpatient appointments to better meet patients' needs:

a. Multidisciplinary continence clinic

b. Alternative consultation methods

Introduction

This handbook is for commissioners, providers and those leading the local transformation of urology elective care services. It describes what local health and care systems can do to transform urology elective care services at pace, why this is necessary and how the impact of this transformation can be measured. It contains practical guidance for implementing and adopting a range of interventions to ensure patients see the **right person, in the right place, first time**.

The list of interventions is not exhaustive and reflects those tested in the third wave of the Elective Care Development Collaborative using the 100 day methodology. Specialties in this wave included cardiology, ENT and urology. This handbook is just one of the resources produced following this wave. Further handbooks, case studies, resources, discussion and methodology can be found on the [Elective Care Community of Practice](#) pages.

Interventions are grouped by theme within this handbook and include 'how-to' guides. The success of interventions designed to transform local elective care services should be measured by changes in local activity following implementation of the intervention and performance against the Referral to Treatment (RTT) standard. Patient and professional outcome and satisfaction should also be measured ([NHS Improvement, 2018](#)).

You can learn about the interventions tested in previous waves (MSK, gastroenterology, diabetes, dermatology and ophthalmology) and find all the handbooks on [our webpages](#).



Introduction

The national context and challenges facing elective care services in England

The national urology challenge

The Elective Care Development Collaborative

Overview of ideas described in this handbook

Essential actions for successful transformation

1. Rethinking referrals:

a. Standardised referral pathways and structured templates

2. Maximising the role of shared decision-making and self-management support:

a. Self-management education and information

b. Catheter passport

3. Transforming outpatient appointments to better meet patients' needs:

a. Multidisciplinary continence clinic

b. Alternative consultation methods

The national context and challenges facing elective care services in England

The NHS is experiencing significant pressure and unprecedented levels of demand for elective care.

Around 1.7 million patients are referred for elective consultant-led treatment each month. Between 2011/12 and 2016/17, referrals rose annually by an average of 3.7% per year.

Over the twelve months to December 2018, growth in GP referrals decreased by 0.4%. Total referral growth in 2018/19 was 1.6% at December 2018, against planned growth of 2.4%.

This represents a significant achievement in redesigning pathways across primary and secondary care and implementing interventions across the elective pathway, to reduce avoidable demand and ensure that patients are referred to the most appropriate healthcare setting, first time.

At the end of December 2018, 86.6% of patients were waiting less than 18 weeks to start treatment (meaning elective care services, on average, were not meeting the 92% constitutional standard for referral to treatment). Approximately 4.2 million patients were waiting to start treatment and of those, 2,237 patients had been waiting more than 52 weeks.

Timely access to high-quality elective care is a key priority under the NHS Constitution.

The [NHS Long Term Plan](#) sets out the ambition to provide alternative models of care to avoid up to a third of outpatient appointments. In 2017/18 there were 119.4 million outpatient appointments, which is almost double the number in 2007/08. Patient attendance at these appointments has decreased from 81.6% in 2007/08 to 78.4% in 2017/18. There has been an increase in occasions where the patient 'Did Not Attend', but a more marked increase in hospital and patient cancellations. This makes the redesign of elective care services a must-do for every local system, calling for better demand management that improves patient care (clinically and from a quality of experience perspective) while improving efficiency. Technology offers digitally-enabled possibilities in primary and outpatient care to achieve this transformation.

The Friends and Family Test (FFT) results for January 2019 show that overall satisfaction with outpatients' services remains high, with 94% of 2,787,280 respondents saying that they would recommend the service to a friend or family member; 3% saying they would not recommend the service, and the remaining 3% saying either 'neither' or 'don't know'. It is important to take steps to ensure that patient satisfaction remains high.

Introduction

The national context and challenges facing elective care services in England

The national urology challenge

The Elective Care Development Collaborative

Overview of ideas described in this handbook

Essential actions for successful transformation

1. Rethinking referrals:

a. Standardised referral pathways and structured templates

2. Maximising the role of shared decision-making and self-management support:

a. Self-management education and information

b. Catheter passport

3. Transforming outpatient appointments to better meet patients' needs:

a. Multidisciplinary continence clinic

b. Alternative consultation methods

The national urology challenge

Urology referrals to secondary care have risen by nearly 20% over the last 20 years and now account for 5% of all outpatient appointments ([NHS Digital, 2017](#)). Urology has proven to be one of the most innovative surgical specialties and is one of the first specialties to use 'keyhole' surgery routinely ([British Association of Urological Surgeons, 2018](#)).

There are over 750,000 episodes of care each year ([GIRFT, 2018](#)) and emergency admissions due to a urinary tract infection (UTI) have almost doubled since 2013 ([NHS England, 2018](#)).

Common reasons for urology referrals include: haematuria; recurrent urinary tract infection; prostate-specific antigen (PSA); loin pain and inguinoscrotal swelling. Improvement in patient experience, outcomes and productivity is expected to continue as minimally invasive surgical techniques, robotic systems and virtual reality training enter mainstream use ([Health Education England, 2017](#)). Some current challenges and opportunities in urology include:

- **Improving referral processes and removing unwarranted variation** so that patients receive assessment, treatment and care in the most appropriate setting, first time. Only 10-12% of patients need surgery ([British Association of Urological Surgeons, 2018](#)).

- **Better pre-op assessment and preparation** to reduce late cancellation of planned operations ([Royal College Of Anaesthetists, 2014](#)) and address the rise in planned operations cancelled for non-clinical reasons ([The Royal College of Surgeons of England, 2017](#)).
- **Addressing lack of capacity** in secondary care, optimising the use of skills and expertise of medical and non-medical staff, with multidisciplinary working across primary and secondary care.
- **Improving processes in outpatient clinics**, focusing on efficient and safe discharge policies, shared care protocols and alternatives to traditional follow-up ([NICE, 2002](#)).
- **Use of technology to increase day surgery cases and treatment in outpatient settings** ([GIRFT, 2018](#)).
- **Improving data collection**, use of IT systems and coding to ensure that intended dates for treatment and individual patient risks can be recorded and also to ensure that all referrers can receive feedback.
- **Supporting patients with co-morbidities** working with other specialties such as gynaecology, geriatrics and general surgery.

The teams in Wave 3 could not address all of these challenges and opportunities during their 100 Day Challenge. However, input from key stakeholders helped to develop the challenge framework for Wave 3 and the ideas the teams have tested.

Introduction

The national context and challenges facing elective care services in England

The national urology challenge

The Elective Care Development Collaborative

Overview of ideas described in this handbook

Essential actions for successful transformation

1. Rethinking referrals:

a. Standardised referral pathways and structured templates

2. Maximising the role of shared decision-making and self-management support:

a. Self-management education and information

b. Catheter passport

3. Transforming outpatient appointments to better meet patients' needs:

a. Multidisciplinary continence clinic

b. Alternative consultation methods

The Elective Care Development Collaborative

NHS England's Elective Care Transformation Programme supports local health and care systems to work together to:

- Better manage rising demand for elective care services.
- Improve patient experience and access to care.
- Provide more integrated, person-centred care.

As part of this programme, the Elective Care Development Collaborative has been established to support rapid change led by frontline teams. In Wave 3 of the Elective Care Development Collaborative, local health and care systems in Dudley, Doncaster, Somerset and West Suffolk formed teams to develop, test and spread innovation in delivering elective care services in just 100 days (the 100 Day Challenge). You can find more about the methodology used [here](#).

The teams used an intervention framework to structure their ideas around three strategic themes:

Rethinking referrals

Rethinking referral processes to ensure they are as efficient and effective as possible means that from the first time a patient presents in primary care, patients should always receive the assessment, treatment and care they need from the right person, in the right place, first time.

Shared decision making

An all age, whole population approach to personalised care means that:

- People are supported to stay well and are enabled to make informed decisions and choices when their health changes.
- People with long term physical and mental health conditions are supported to build knowledge, skills and confidence and to live well with their health conditions.
- People with complex needs are empowered to manage their own condition and the services they use.

This should be considered at every stage of the patient pathway and can be achieved through shared decision making, digital health tools, personalised care and support planning, social prescribing, patient choice, patient activation and personal health budgets.

Transforming outpatients

Transforming outpatients means considering how patient pathways and clinic arrangements (including processes) ensure that patients always receive assessment, treatment and care from the right person, in the right place, first time. This may not be in secondary care. Virtual clinics, technological solutions and treatment closer to home are all possibilities.

Introduction

The national context and challenges facing elective care services in England

The national urology challenge


The Elective Care Development Collaborative

Overview of ideas described in this handbook

Essential actions for successful transformation


1. Rethinking referrals: 

a. Standardised referral pathways and structured templates

2. Maximising the role of shared decision-making and self-management support: 

a. Self-management education and information






b. Catheter passport

3. Transforming outpatient appointments to better meet patients' needs: 

a. Multidisciplinary continence clinic

b. Alternative consultation methods

Overview of ideas described in this handbook

Intervention	The opportunity
 Standard referral pathways and templates	If a standard urology referral form is used, practitioners should have access to relevant guidance and information when making or receiving referrals. Referral quality should be more consistent and the number of unnecessary referrals should reduce. This should mean patients are seen as soon as possible by the right clinician and conversion rates for those referred should increase.
 Patient education and information	If patients have access to better quality information, they can consider their options and make more informed choices. This should increase patient activation and satisfaction and mean that practitioners can work together with patients to achieve the preferred outcome.
 Patient passport	If a catheter passport is used, patients should be more informed about how to manage their own catheter. Communication between health professionals about the patient's plan of care should also be improved. Infection rates should improve and fewer patients should be admitted to hospital with catheter associated urinary tract infections (CAUTI).
 Multidisciplinary team clinic	If patients are seen in multidisciplinary team clinics, they can access appropriate treatment and care more quickly, resulting in fewer appointments. Patient satisfaction and outcomes should improve.
 Alternative consultation methods	If alternatives to consultant led care (such as nurse led clinics or telephone follow-up) are available, this increases clinic capacity and releases consultant time for those with more complex clinical needs. This improves access to care and is often more convenient for patients. It may also reduce the number of outpatient appointments and reduce non attendance (DNA) rates.

Introduction

The national context and challenges facing elective care services in England

The national urology challenge

The Elective Care Development Collaborative

Overview of ideas described in this handbook

Essential actions for successful transformation

1. Rethinking referrals:

a. Standardised referral pathways and structured templates

2. Maximising the role of shared decision-making and self-management support:

a. Self-management education and information

b. Catheter passport

3. Transforming outpatient appointments to better meet patients' needs:

a. Multidisciplinary continence clinic

b. Alternative consultation methods

Essential actions for successful transformation

The actions below are essential for creating the culture of change necessary to transform elective care services and are relevant to the interventions described in this handbook.

Establish a whole system team

Consider who needs to be involved to give you the widest possible range of perspectives and engage the right stakeholders from across the system as early as possible. It is essential to include patients and the public in your work. Find top tips for engaging patients and the public on the [Elective Care Community of Practice](#).

Secure support from executive level leaders

Ensure frontline staff have permission to innovate, help unblock problems and feed learning and insight back into the system. Involving senior clinicians as early as possible is crucial to reaching agreement and implementing changes effectively across organisational boundaries.

The 100 Day Challenge methodology facilitates cross-system working. Working across multiple organisations in this way is essential to establishing effective Integrated Care Systems, which need to be created everywhere by April 2021 ([NHS Long Term Plan, 2019](#)).

Useful resources:

[Leading Large Scale Change \(NHS England, 2018\)](#)

[Useful publications and resources on quality improvement \(The Health Foundation, 2018\)](#)

[100 day challenge methodology \(Nesta, 2017\)](#)

[Principles for putting evidence-based guidance into practice \(NICE, 2018\)](#)

People to involve from the start:

- People with lived experience of using the service
- Patient organisations and representatives (including the voluntary sector)
- GPs and primary care clinical and nursing staff
- Urologists
- Service managers
- Nurse specialists
- Business information analysts
- Administrative team support
- Physiotherapists
- Commissioners
- Local care home representatives
- Appointment booking staff



Throughout the handbook you will find useful tips on who else to involve for specific interventions.

Introduction

The national context and challenges facing elective care services in England

The national urology challenge

The Elective Care Development Collaborative

Overview of ideas described in this handbook

Essential actions for successful transformation

1. Rethinking referrals:

a. Standardised referral pathways and structured templates

2. Maximising the role of shared decision-making and self-management support:

a. Self-management education and information

b. Catheter passport

3. Transforming outpatient appointments to better meet patients' needs:

a. Multidisciplinary continence clinic

b. Alternative consultation methods

Essential actions for successful transformation

Ensure the success of your transformation activity can be demonstrated

SMART (specific, measurable, attainable, realistic, time related) goals and clear metrics that are linked to the intended benefits of your interventions need to be defined right at the start of your transformation work.

Key questions include:

- What are you aiming to change?
- How will you know you have achieved success?

You may wish to use a structured approach such as logic modelling. Consider how you are going to include both qualitative and quantitative data in your evaluation.

Useful resources for evaluation:

[Making data count \(NHS Improvement, 2018\)](#)

[How to understand and measure impact \(NHS England, 2015\)](#)

[Seven steps to measurement for improvement \(NHS Improvement, 2018\)](#)

[Patient experience improvement framework \(NHS Improvement, 2018\)](#)

[Evaluation: what to consider \(The Health Foundation, 2015\)](#)

[Measuring patient experience \(The Health Foundation, 2013\)](#)

Indicators and metrics that may be useful for specific interventions are included in the relevant sections throughout the handbook.

Some suggested indicators that are relevant to most interventions in this handbook are described below:



Benefits	Suggested indicators
Improved patient and staff experience	<ul style="list-style-type: none">• Friends and family test score (FFT)• Patient reported experience measures (PREMs) scores (where available)• Qualitative data focused on your overall aims (through surveys, interviews and focus groups)• Number of complaints
Improved efficiency	<ul style="list-style-type: none">• Referral to treatment time• Waiting time for follow-up appointments• Overall number of referrals• Rate of referrals made to the right place, first time• Cost per referral
Improved clinical quality	<ul style="list-style-type: none">• Patient Reported Outcome Measures (PROMs) scores (where available)• Feedback from receiving clinicians• Commissioning for Quality and Innovation (CQUIN) indicators• Quality and Outcomes Framework (QoF) indicators
Improved patient safety	<ul style="list-style-type: none">• Ease and equity of access to care• Rate of serious incidents

Introduction

The national context and challenges facing elective care services in England

The national urology challenge

The Elective Care Development Collaborative

Overview of ideas described in this handbook

Essential actions for successful transformation

1. Rethinking referrals:

a. Standardised referral pathways and structured templates

2. Maximising the role of shared decision-making and self-management support:

a. Self-management education and information

b. Catheter passport

3. Transforming outpatient appointments to better meet patients' needs:

a. Multidisciplinary continence clinic

b. Alternative consultation methods

1. Rethinking referrals

a. Standardised referral pathways and structured templates



What is the idea?

Standardised urology referral pathways that are informed by best practice ensure that patients see the right person, in the right place, first time.

Structured templates that are available on primary care IT systems and include explicit referral criteria and guidance can support the use of standard referral pathways. They ensure that referrers understand where to direct patients and what information needs to accompany them. They should integrate with the [NHS e-Referral Service](#) (e-RS) wherever possible.

Why implement the idea?

Patients experiencing continence issues are often referred to multiple specialties. It may take several appointments for patients to see the most appropriate specialist. This contributes to increased demand for services and long waiting times for routine appointments.

Standard referral pathways can **reduce unwarranted variation** in the way decisions and referrals are made to urology services.

Structured referral templates that include referral criteria and guidance can **reduce the number of inappropriate referrals, improve the quality of referral information** that accompanies the patient, so avoiding unnecessary delay.

This helps to ensure that **patients** who need to be assessed and treated by specialists receive appropriate treatment as quickly as possible.

Primary care clinicians have easy access to the information they need when making or receiving referrals. This means they have increased understanding of which cases to refer and what information needs to accompany each referral.

Secondary care clinicians receive the necessary clinical and administrative referral details straight away, meaning a decrease in the clinical time necessary to triage each referral, along with associated costs. This may lead to an increased conversion to treatment rate for referrals.

Introduction

The national context and challenges facing elective care services in England

The national urology challenge

The Elective Care Development Collaborative

Overview of ideas described in this handbook

Essential actions for successful transformation

1. Rethinking referrals:

a. Standardised referral pathways and structured templates

2. Maximising the role of shared decision-making and self-management support:

a. Self-management education and information

b. Catheter passport

3. Transforming outpatient appointments to better meet patients' needs:

a. Multidisciplinary continence clinic

b. Alternative consultation methods

1. Rethinking referrals

a. Standardised referral pathways and structured templates



How to achieve success

The sections below include learning from sites in Wave 3 of the Elective Care Development Collaborative:

Work with stakeholders from across the local system to develop the pathways and templates

- **Review existing local pathways and referral forms.** Map the patient journey and seek input from stakeholders (including patients) as soon as possible to understand what is working well and what needs to change.
- **Review example pathways and templates from elsewhere.** Understand what could work well in your service and develop a version relevant to your local context. Examples of standard pathways for common urological conditions can be found in the latest [NICE guidance](#).
- **Develop a smart template on the primary care patient record system that includes explicit referral criteria for specific clinics.** This should prompt the referrer to access relevant guidance when making a referral, thereby optimising opportunities for shared learning. However, try to keep the referral template and questions as simple and relevant as possible.
- **Ensure that referral forms can integrate with local Advice and Guidance systems and patient management systems.** Seek IT expertise from the start to ensure that forms can be uploaded and adjustments made to improve usability (such as automatic pop-ups and pre-population of patient details).

- **Agree key outcome measures and establish a baseline to measure progress against.** Seek input from your stakeholders on the key metrics necessary to demonstrate impact of your intervention.

Metrics to consider for measuring success:



Awareness and uptake (e.g. percentage of referrers using the referral form, percentage of referrals made using the referral form).

Effectiveness (e.g. time spent completing the referral by the referrer, feedback on ease of use).

Quality of referrals made (e.g. time spent reviewing each referral once received, feedback from receiving practitioners on the quality of referrals and accompanying information, number of referrals returned to referrer, conversion rate for GP referrals to first outpatient attendances and from first outpatient attendance to treatment).

Ensure you have considered the perspective of everyone who will be making and receiving referrals. Patient insight is essential to pathway redesign.



Introduction

The national context and challenges facing elective care services in England

The national urology challenge

The Elective Care Development Collaborative

Overview of ideas described in this handbook

Essential actions for successful transformation

1. Rethinking referrals:

a. Standardised referral pathways and structured templates

2. Maximising the role of shared decision-making and self-management support:

a. Self-management education and information

b. Catheter passport

3. Transforming outpatient appointments to better meet patients' needs:

a. Multidisciplinary continence clinic

b. Alternative consultation methods

1. Rethinking referrals

a. Standardised referral pathways and structured templates



Implement the pathways and templates

- **Develop, test and refine on a small scale to demonstrate early impact.** This makes attempting to scale across multiple clinical commissioning group (CCG) or sustainability and transformation partnership (STP) areas much easier.
- **Ensure that the success of the form is measured.** In the early stages of implementation, feedback is key to future refinement. Link the information captured through the key metrics.

Provide useful information for patients

- **Consider the needs of patients using your service and provide appropriate information to help them make shared decisions about their treatment.** It may be useful to refer to NHS England's guidance on [shared decision making](#).

The following standards and guidance may be useful:

[Lower urinary tract symptoms overview \(NICE, 2018\)](#)

[Urinary incontinence overview \(NICE, 2018\)](#)

[Urinary tract infection overview \(NICE, 2018\)](#)

[Urological conditions: general and other \(NICE, 2018\)](#)

[Diagnosis of urinary tract infections: Quick reference tool for primary care \(Public Health England, 2018\)](#)

We know it works

In Doncaster, as part of the 100 Day Challenge, the team worked on improving access to appropriate and timely community care for patients with in-situ catheters and continence problems:

- Newly created pathways and pro formas saw an 18% increase in referrals to community services from 450 to 531. At the same time referrals to specialist outpatient clinics reduced from 458 to 375 (18%).
- Average referrals from hospital to community services increased from a monthly average of seven to 26 (370%).
- 100% of patients seen in the community preferred it and rated the service as excellent.
- 53% of patients are now seen at home and most others in other close-to-home community services.
- GP awareness about urology community services improved.

In Dudley they developed a new referral template to improve NICE guidance compliance (CG97) that is being built into EMIS and rolled out across the region.

You can find the full case studies on the [Elective Care Community of Practice](#).

Introduction

The national context and challenges facing elective care services in England

The national urology challenge

The Elective Care Development Collaborative

Overview of ideas described in this handbook

Essential actions for successful transformation

1. Rethinking referrals:

a. Standardised referral pathways and structured templates

2. Maximising the role of shared decision-making and self-management support:

a. Self-management education and information

b. Catheter passport

3. Transforming outpatient appointments to better meet patients' needs:

a. Multidisciplinary continence clinic

b. Alternative consultation methods

2. Shared decision making and self-management support

a. Self-management education and information



What is the idea?

[Self-management](#) education supports patients to understand and manage their own condition effectively. It is one of the core components of person-centred care and enables patients and health professionals to take 'shared responsibility for health' ([NHS Long Term Plan, 2019](#)). It can be provided in various ways, such as face-to-face sessions (either one-to-one or through local group workshops) or through a digital health approach using apps or online resources such as [NHS.uk](#).

Patient decision aids are tools that support shared decision making ([NHS England, 2018](#)). They provide information about urinary conditions and treatment options in various ways (such as leaflets, questionnaires and videos) and can be accessed either during or outside of consultations with clinicians ([NHS RightCare, 2018](#)). The potential benefits and risks of a procedure can be outlined and discussed ([The Royal College of Surgeons of England, 2016](#)).

Digital tools for self-management can improve communication, enable monitoring of health status and facilitate direct access to patient-held health records and self-management resources.

Self-management education is important for person-centred care and facilitates informed, shared decision making ([The Health Foundation, 2015](#)). This can increase [patient activation](#). Highly activated **patients** report increased confidence and higher levels of satisfaction.

They are more likely to adopt healthy behaviours, attend appointments and use medication effectively. They have **better clinical outcomes** and **lower rates of hospitalisation**, as they know when to escalate their concerns and seek appropriate help. Many patients are keen to access digital solutions across primary and outpatient care ([NHS Long Term Plan, 2019](#)).

[Commissioning self-management support](#) increases the amount and quality of information available. This can give **practitioners and patients** increased knowledge and confidence to have effective shared decision making conversations. This can **reduce the workload** for health professionals and **delay the need for surgical intervention**.

We know it works

A randomised controlled trial in a teaching hospital and district general hospital in London showed that self-management as a first line intervention for lower urinary tract symptoms (LUTS) significantly reduced the frequency of treatment failure and reduced urinary symptoms. Treatment failure only occurred in seven out of 73 (10%) of the self-management group compared to 27 out of 67 (43%) of the standard care group. The mean International Prostate Symptom Score (IPSS) was 10.7 in the self-management group, compared to 16.4 in the standard care group at three months ([Brown et al., 2007](#)).

Introduction

The national context and challenges facing elective care services in England

The national urology challenge

The Elective Care Development Collaborative

Overview of ideas described in this handbook

Essential actions for successful transformation

1. Rethinking referrals:

- Standardised referral pathways and structured templates

2. Maximising the role of shared decision-making and self-management support:

- Self-management education and information

- Catheter passport

3. Transforming outpatient appointments to better meet patients' needs:

- Multidisciplinary continence clinic
- Alternative consultation methods

2. Shared decision making and self-management support

a. Self-management education and information



How to achieve success: implementing self-management education and information

The sections below include learning from sites in Wave 3 of the Elective Care Development Collaborative:

Establish your local offer

It is crucial to involve people with lived experience and members of the public in the development of self-management education and information resources to understand what people want.



- **Make use of available resources.** Review the existing self-management education and support offer locally and nationally, such as the patient information leaflets produced by the [British Association of Urological Surgeons](#).
- **Provide a range of options for people to access self-management education and support.** This may include structured education sessions, support groups, emails, text messages or coaching sessions. Self-management education and patient information is most effective when combined with other forms of support.
- **Decide on the format for any structured education sessions.** Reviews suggest that outcomes are better when health professionals are involved. Peer support following formal or structured education is also very useful.

The following standards and guidance may be useful:

[British Association of Urological Surgeons Information for Patients \(BAUS, 2018\)](#)

[Implementing shared decision making in the NHS: lessons from the MAGIC programme \(Joseph-Williams et al., 2017\)](#)

[Health Literacy toolkit \(Health Education England, 2018\)](#)

[The QIS 2015 Quality Standard \(Quality Institute for Self-Management Education and Training, 2017\)](#)

[Person-centred care in 2017 – Evidence from Service Users \(National Voices, 2017\)](#)

[Supporting self-management: A Summary of the Evidence \(National Voices, 2014\)](#)

[A Practical Guide to Self-management Support – Key Components for Successful Implementation \(The Health Foundation, 2015\)](#)

[Realising the Value: Ten Actions to Put People and Communities at the Heart of Health and Wellbeing \(Nesta, 2016\)](#)

Links to further resources can be found on the [Elective Care Community of Practice](#).

Introduction

The national context and challenges facing elective care services in England

The national urology challenge

The Elective Care Development Collaborative

Overview of ideas described in this handbook

Essential actions for successful transformation

1. Rethinking referrals:

a. Standardised referral pathways and structured templates

2. Maximising the role of shared decision-making and self-management support:

a. Self-management education and information

b. Catheter passport

3. Transforming outpatient appointments to better meet patients' needs:

a. Multidisciplinary continence clinic

b. Alternative consultation methods

2. Shared decision making and self-management support

a. Self-management education and information



Implement, promote and evaluate your education offer

- **Ensure your offer is easily accessible.** There is often a large amount of information available but it is not always easy to access. Create patient information resources in a range of formats, involving clinicians and people with lived experience in the development process. Consider pulling together disparate resources into one information pack. Consider the health literacy of your cohort ([Health Education England, 2018](#)).
- **Ensure that chosen self-management education and information resources are of high quality and are relevant to the needs of local patients.** The best resources for self-management education have often been trialled and evidenced. The Quality Institute for Self-Management Education and Training ([QISMET](#)) [Quality Standard: QIS2015](#) may be useful to check for certified resources. Tailor or adapt resources where necessary to ensure that messages are right within your local context and develop resources where you identify any gaps.
- **Integrate education programmes, information resources and patient decision aids into local referral pathways.** These should include content around the need to review self-management if symptoms change and emphasise that people with learning disabilities or who are not fluent in English might need additional support to self-manage. Self-management education can be offered as part of a person-centred care and support plan.
- **Publicise resources through social media and with urological clinical specialists.** Creating patient decision aids and videos that can be shared online and through social media provides a way for clinicians to easily access content during appointments. It also enables patients to share content with family and friends after their consultation.
- **Evaluate the success of any sessions or resources.** Ensure a survey has been created and circulated to everyone who sees the new material to gauge their reaction to the material, and whether and how it influenced their decision making.

Metrics to consider for measuring success:



- Patient reported outcome measures (PROMs), patient reported experience measures (PREMs) and Friends and Family Test (FFT) scores.
- Patient feedback on the value of the education events and the impact on their confidence to make healthy lifestyle choices.
- Patient feedback on their level of knowledge of how to manage their condition.

Introduction

The national context and challenges facing elective care services in England

The national urology challenge

The Elective Care Development Collaborative

Overview of ideas described in this handbook

Essential actions for successful transformation

1. Rethinking referrals:

a. Standardised referral pathways and structured templates

2. Maximising the role of shared decision-making and self-management support:

a. Self-management education and information

b. Catheter passport

3. Transforming outpatient appointments to better meet patients' needs:

a. Multidisciplinary continence clinic

b. Alternative consultation methods

2. Shared decision making and self-management support

a. Self-management education and information



We know it works

As part of the 100 Day Challenge, West Suffolk focused on improving shared decision making and self-management for women aged 16 to 45 with recurrent urinary tract infections (UTIs). The team identified that 12% of a sample (251 of 2090) were referred unnecessarily to secondary care.

To reduce delays in assessment and treatment of UTIs in primary care, they streamlined dipstick protocols, using them with a clinical information checklist that is completed by the patient and reviewed by a clinician. This enables urine to be tested and, where appropriate, a prescription to be picked up the same day from the GP practice without an appointment.

Along with the urine specimen pack, patients are given a business card that signposts to an online patient information booklet. This contains practical advice about avoiding recurrence of UTIs and supports shared decision making. Posters have also been produced and distributed across 35 GP practices, colleges and outpatient services.

Patients said the booklet was relevant, useful, accessible and helped them manage their condition and feel informed. They felt more able to make decisions about their ongoing care. 100% of patients surveyed would recommend it to a friend. Patients had often been suffering for up to three years before reading the booklet and said that previously they had received very little information.

Patients were also invited to a shared educational session run by an allied healthcare professional, which reinforced the information given and enabled women to ask further questions. Patient feedback:

'I do feel much better informed now and happy that I can try to help myself more than I could before. It is good to know that this is a common problem and I am not alone in dealing with this.'

'I literally cried with relief when I read the UTI booklet.' 'At last something to help me!' 'Thank you for taking my UTI seriously.'

You can find the full case studies on the [Elective Care Community of Practice](#).

Introduction

The national context and challenges facing elective care services in England

The national urology challenge

The Elective Care Development Collaborative

Overview of ideas described in this handbook

Essential actions for successful transformation

1. Rethinking referrals:

a. Standardised referral pathways and structured templates

2. Maximising the role of shared decision-making and self-management support:

a. Self-management education and information

b. Catheter passport

3. Transforming outpatient appointments to better meet patients' needs:

a. Multidisciplinary continence clinic

b. Alternative consultation methods

2. Shared decision making and self-management support

b. Catheter passport



What is the idea?

A catheter passport is a shared care record that informs and educates patients about their catheter and its management. It also enables effective communication with and between the team caring for them.

It supports people to take an active role in the care of their catheter and to access support when necessary. It also includes essential clinical information around the catheterisation itself, such as why the catheter is in place, when it was inserted, management and future plans.

Why implement the idea?

Urinary catheters may promote independence and prevent kidney damage in some patients but they can also delay discharge from hospital and increase the level of care a patient may require. There is also risk of catheter associated urinary tract infection (CAUTI), particularly Gram-negative bloodstream infections (NHS Improvement, 2017). CAUTI can have serious consequences for patients and have estimated costs of £99 million per annum, equating to £1,968 per episode (NHS England 2018).

Catheter passports give **practitioners** easy access to relevant information, ensuring clarity across primary, secondary and community care settings about why the catheter has been fitted and how long it should be in situ. This can improve care and communication between clinicians, reducing the risk of CAUTI and associated acute admissions.

Catheter passports encourage prudent, considered use of catheters and their earliest possible removal. This may lead to a reduction in unnecessary urinary catheter days and may also help to reduce the number of appointments patients have in primary or secondary care (Codd, 2014).

Patients are informed about their condition and empowered to self-manage wherever possible. Patient passports have the potential to support shared decision making and provide a record of the steps patients are taking to manage their condition.

The following standards and guidance may be useful:

[Excellence in Continence Care \(NHS England, 2018\)](#)

[Infection, prevention and control \[QS61\] \(NICE, 2014\)](#)

[Diagnosis of urinary tract infections quick reference tool for primary care \(Public Health England, 2018\)](#)

[Preventing healthcare associated Gram-negative bloodstream infections: an improvement resource \(NHS Improvement, 2017\)](#)

[Guidance for use of the National Catheter Passport \(NHS Scotland, 2013\)](#)

[Catheter care \(Royal College of Nursing, 2012\)](#)

Introduction

The national context and challenges facing elective care services in England

The national urology challenge

The Elective Care Development Collaborative

Overview of ideas described in this handbook

Essential actions for successful transformation

1. Rethinking referrals:

a. Standardised referral pathways and structured templates

2. Maximising the role of shared decision-making and self-management support:

a. Self-management education and information

b. Catheter passport

3. Transforming outpatient appointments to better meet patients' needs:

a. Multidisciplinary continence clinic

b. Alternative consultation methods

2. Shared decision making and self-management support

b. Catheter passport



How to achieve success: implementing self-management education and information

The sections below include learning from sites in Wave 3 of the Elective Care Development Collaborative:

Plan how the catheter passport will be used

- **Review existing patient passports and materials.** Find out what has been already done and shared (e.g. agreed catheter learning packages and protocols). Consider how these might be adapted to meet local needs.
- **Consider any information governance (IG) concerns.** Take expert advice and involve local IG and communications teams throughout.

Design the catheter passport

- **Agree the format and content of the patient catheter passport.** For example, it may be useful to add the patient pathway to the passport for the patient and the health professional(s).
- **Find out as soon as possible about the local publications approval process.** This needs to include timescales, along with any style or logos guidance that must be adhered to. Build these considerations in to the development of the passport.

Catheter Passport

A catheter passport may include:

- What is a urinary catheter?
- When will my catheter need changing?
- How do I look after my catheter on a daily basis?
- Information about urinary tract infections
- How can I reduce the risk of getting an infection?
- What should my urine look like?
- Common catheter related problems
- How to dispose of used catheters and catheter related products
- What about sex?
- When should I ask for help?
- Where to get catheter supplies from
- Sepsis
- Patient details (including details of past UTIs)
- Catheterisation record (to be confirmed at each change)
- Trial without catheter: plans and record

Introduction

The national context and challenges facing elective care services in England

The national urology challenge

The Elective Care Development Collaborative

Overview of ideas described in this handbook

Essential actions for successful transformation

1. Rethinking referrals:

a. Standardised referral pathways and structured templates

2. Maximising the role of shared decision-making and self-management support:

a. Self-management education and information

b. Catheter passport

3. Transforming outpatient appointments to better meet patients' needs:

a. Multidisciplinary continence clinic

b. Alternative consultation methods

2. Shared decision making and self-management support

b. Catheter passport



Implement the catheter passport

- Establish feedback mechanisms and actively seek feedback from patients and professionals to understand how the passport might be improved. Establish processes to make any necessary changes. Consider piloting the passport in a small cohort for an agreed time to allow for review and redesign based on users' feedback.
- Use CCG communication networks, such as newsletters and GP events, to build awareness and uptake among practices. Sharing positive feedback can be powerful.
- Develop training for professionals. This helps to raise awareness and enables local clinical and non-clinical professionals to have further information on how and when to use the passport.

Metrics to consider for measuring success:

- Number of passports distributed.
- Number of patients actively using passports.
- Number of professionals reporting patients presenting with passports.
- Incidence of CAUTI (consider whether GNBSI is present).
- Number of patients reporting changes to their behaviour due to the passport.
- Number of patients completing appropriate treatment plans, e.g. progress made against patient-led goals, reduced complications in patients (such as A&E attendances).

We know it works

A qualitative study exploring how patient-held catheter passports affect patient and staff experience found that effective use of passports can: provide information to patients and staff, improve catheter care, self-management and self-care and help patients adjust to their catheter (Jaeger et al, 2017).

In South London, the Health Innovation Network introduced catheter passports as part of a 'catheter care bundle' to improve catheter care and reduce CAUTI. National Patient Safety Thermometer data shows a decrease in CAUTI rates of just over 30%, with a drop in catheterisation rates of 1.9% against a national rise of 0.2% (Health Innovation Network, 2017).

NHS Scotland have a standard national catheter passport: Urinary Catheter Care Passport (Health Protection Scotland, 2017).

We know it works

As part of the 100 Day Challenge, the team in Somerset the team developed a catheter passport. They distributed approximately 100 passports through their district nursing team. The passport is now also given to all patients who are discharged from Yeovil and Musgrove hospitals, with a catheter. This has contributed to an overall reduction in the number of patients admitted to hospital with catheter associated urinary tract infections from 3.6 per week to 2.2 per week.

Introduction

The national context and challenges facing elective care services in England

The national urology challenge

The Elective Care Development Collaborative

Overview of ideas described in this handbook

Essential actions for successful transformation

1. Rethinking referrals:

a. Standardised referral pathways and structured templates

2. Maximising the role of shared decision-making and self-management support:

a. Self-management education and information

b. Catheter passport

3. Transforming outpatient appointments to better meet patients' needs:

a. Multidisciplinary continence clinic

b. Alternative consultation methods

3. Transforming outpatients

a. Multidisciplinary continence clinic



What is the idea?

A multidisciplinary clinic enables patients with conditions such as stress incontinence to see various clinicians including physiotherapists in one setting and avoids the need for multiple appointments.

Why implement the idea?

Physiotherapy has a vital role to play in continence care. Evidence has shown pelvic floor muscle training can be more effective than pharmaceutical management ([NICE, 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 a reduction in waiting times for urgent and routine appointments.

We know it works

As part of the 100 Day Challenge, the team in **West Suffolk** focused on improving rates of attendance at outpatient clinics and improving compliance with physiotherapy by combining urology and physiotherapy clinics:

- The joint continence clinic enabled patients to see the consultant and physiotherapist at the same time. Follow-up care was then directed as appropriate.
- The average non-attendance (DNA) rate for stress incontinence physiotherapy dropped from 33% to 6%.
- Clinics were initially weekly but were increased to two per week.

You can find the full case studies on the [Elective Care Community of Practice](#).

Introduction

The national context and challenges facing elective care services in England

The national urology challenge

The Elective Care Development Collaborative

Overview of ideas described in this handbook

Essential actions for successful transformation

1. Rethinking referrals:

a. Standardised referral pathways and structured templates

2. Maximising the role of shared decision-making and self-management support:

a. Self-management education and information

b. Catheter passport

3. Transforming outpatient appointments to better meet patients' needs:

a. Multidisciplinary continence clinic

b. Alternative consultation methods

3. Transforming outpatients

a. Multidisciplinary continence clinic



How to achieve success

The sections below include learning from sites in Wave 3 of the Elective Care Development Collaborative:

Design the format and approach of your clinic

- **Find a suitable location for the clinic.** It is important to consider the best location for the clinic to increase attendance. Think about the dynamics of the clinic and how it will work most efficiently. Wherever possible, ensure close co-location of services.
- **Agree the target cohort for the multidisciplinary clinic.** Develop your proposal, involving key stakeholders and consider inclusion and exclusion criteria.
- **Seek input from key stakeholders on the key metrics to demonstrate impact of your intervention.** This provides a useful baseline to measure success against and highlights parts of the pathway with potential for improvement. Encourage live feedback and ensure that changes can be made where necessary.

Metrics to consider for measuring success:

- Referral rates and numbers of appointments per procedure.
- DNA rates.
- Patient feedback on outcomes including quality of life measures.



It is essential that physiotherapists and other members of the multidisciplinary team are involved right from the start of the process of development.



Introduction

The national context and challenges facing elective care services in England

The national urology challenge

The Elective Care Development Collaborative

Overview of ideas described in this handbook

Essential actions for successful transformation

1. Rethinking referrals:

a. Standardised referral pathways and structured templates

2. Maximising the role of shared decision-making and self-management support:

a. Self-management education and information

b. Catheter passport

3. Transforming outpatient appointments to better meet patients' needs:

a. Multidisciplinary continence clinic

b. Alternative consultation methods

3. Transforming outpatients

a. Multidisciplinary continence clinic



Prepare patients for the clinic

- **Ensure that patients are aware of the purpose of their appointment in advance.** Explain how the clinic works and ensure that patients know how long their appointment may take. It may be useful to send letters to patients asking them to call in to book their first appointments and enable a discussion to happen.
- **Consider sending text message reminders to reduce DNAs.** Suggested timescales are one week prior to the appointment and again 24 hours before the appointment.

Optimise the potential for person-centred care

- **Consider the information needs of patients using your service.** Remember to refer to NHS England's guidance on [Shared Decision Making](#). Ensure any documentation needed for patients prior to their appointment is completed in advance.
- **Incorporate patient-led goal setting.** Have a clearly defined and person-centred goal to encourage compliance with physiotherapy.

The following standards and guidance may be useful:

[Physiotherapy works: urinary incontinence \(Chartered Society of Physiotherapy, 2014\)](#)

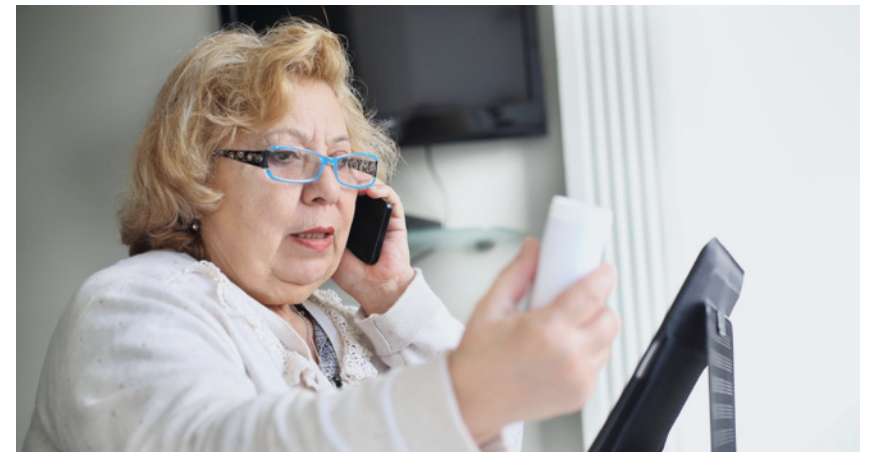
[Outpatient clinics: a good practice guide \(Royal College of Surgeons of England, 2018\)](#)

[Urinary incontinence in women \(NICE, 2015\)](#)

[Systematic review and economic modelling of the effectiveness of non-surgical treatments for women with stress urinary incontinence \(Imamura et al, 2010\)](#)

[Excellence in Continence Care \(NHS England, 2018\)](#)

[Promoting continence with physiotherapy \(Chartered Society of Physiotherapists, 2015\)](#)



Introduction

The national context and challenges facing elective care services in England

The national urology challenge

The Elective Care Development Collaborative

Overview of ideas described in this handbook

Essential actions for successful transformation

1. Rethinking referrals:

a. Standardised referral pathways and structured templates

2. Maximising the role of shared decision-making and self-management support:

a. Self-management education and information

b. Catheter passport

3. Transforming outpatient appointments to better meet patients' needs:

a. Multidisciplinary continence clinic

b. Alternative consultation methods

3. Transforming outpatients

b. Alternative consultation methods



What is the idea?

Alternatives to traditional face-to-face consultations include virtual consultations (over email, Skype or telephone) or group consultations (more than one patient or clinician). Appointments can often be led by nurses or enhanced scope practitioners, saving consultant time and clinic management resources. Patient-initiated follow-up empowers patients to decide themselves whether a follow-up appointment is required.

Why implement the idea?

This is often more convenient for patients, saving time off work and journeys to appointments. It may increase attendance rates and improve **patient experience**. The waiting list for urgent and routine appointments with secondary care clinicians should reduce. The number of outpatient attendances and follow-up appointments should also reduce ([The Royal College of Surgeons of England, 2017](#)).

Patients report an improved experience of care as the interventions may be more convenient for them (e.g. saving time off work).

The waiting list for urgent and routine appointments with secondary care clinicians should reduce. The number of outpatient attendances and follow-up appointments should also reduce ([The Royal College of Surgeons of England, 2017](#)).

We know it works

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 and 95.3% found the telephone assessment preferable to attending the outpatient department. The use of a nurse led telephone follow-up resulted in a saving of £15,105 compared to a face-to-face appointment with a consultant ([Casey et al, 2017](#)).

One in five potential appointments are cancelled or reported as the patient did not attend (DNA). The majority of these are hospital-initiated cancellations ([Royal College of Physicians, 2018](#)).

Optimising alternatives to consultant led, face-to-face appointments can increase capacity and improve access to care, ensuring that the skills of the entire workforce can be utilised.

The following standards and guidance may be useful:

[Outpatients: the future \(Royal College of Physicians, 2018\)](#)

[Demand Management Good Practice Guide \(NHS England, 2016\)](#)

[Outpatient clinics: a guide to good practice \(Royal College of Surgeons of England, 2017\)](#)

[Improving productivity in elective care \(Monitor, 2015\)](#)

Introduction

The national context and challenges facing elective care services in England

The national urology challenge

The Elective Care Development Collaborative

Overview of ideas described in this handbook

Essential actions for successful transformation

1. Rethinking referrals:

a. Standardised referral pathways and structured templates

2. Maximising the role of shared decision-making and self-management support:

a. Self-management education and information

b. Catheter passport

3. Transforming outpatient appointments to better meet patients' needs:

a. Multidisciplinary continence clinic

b. Alternative consultation methods

3. Transforming outpatients

b. Alternative consultation methods



How to achieve success

The sections below include learning from sites in Wave 3 of the Elective Care Development Collaborative:

Identify local options

- **Establish demand and ensure there is workforce capacity to undertake telephone follow-ups.** A multidisciplinary team is required, including a service manager to lead and coordinate the telephone clinics, practitioners (e.g. specialist nurses or consultants) to deliver the clinics, administrative staff to send out appointment letters.
- **Ensure there is explicit time in consultant job plans for alternatives to face-to-face clinics.** Payment mechanisms also need to be agreed.
- **Identify clinical criteria for patient-initiated follow-up and for telephone follow-up.** Co-develop and test your plans with urology specialists across your local area. They can help to secure the 'buy in' of other clinicians. Work with clinical directors and specialist teams to agree these criteria.
- **Identify patient cohorts and review existing clinic lists to select patients appropriate for phone follow-up.** It may be useful to focus on several specific groups (e.g. bladder outflow obstruction patients, haematuria patients). It may be possible to reschedule patients who are already booked in for face-to-face appointments for a telephone review. This can be time consuming but is a way to fill initial clinics.

Implement and evaluate the new ways of working

- **Agree processes and protocols for inviting patients to telephone follow-up.** Ask consultants to book patients for telephone follow-ups straight after intervention or diagnostics, limiting 'doubling up' with face-to-face.
- **Set patients' expectations at the first contact.** Share clear details of the process and explain that follow-up is usually via virtual clinic, with face-to-face as an exception.
- **Agree processes and protocols following the telephone follow-up.** It may be necessary to confirm the results or management plan by letter or email.

Top tips

Even for virtual consultations a quiet room that allows privacy will be required, with access to a secure telephone and a computer network system in order to maintain patient confidentiality.



Introduction

The national context and challenges facing elective care services in England

The national urology challenge

The Elective Care Development Collaborative

Overview of ideas described in this handbook

Essential actions for successful transformation

1. Rethinking referrals:

a. Standardised referral pathways and structured templates

2. Maximising the role of shared decision-making and self-management support:

a. Self-management education and information

b. Catheter passport

3. Transforming outpatient appointments to better meet patients' needs:

a. Multidisciplinary continence clinic

b. Alternative consultation methods

3. Transforming outpatients

b. Alternative consultation methods



- **Agree outcome measures** to evaluate the impact of telephone follow-ups (e.g. feedback from patients, number of face-to-face appointments avoided). Ensure sufficient administrative support for evaluation.



Metrics to consider for measuring success:

- Patient satisfaction measuring the amount of time they have to take off work, number of trips to hospital/community settings.
- Proportion of alternative consultations held compared to traditional face-to-face appointments.
- Patient feedback on method of consultation.



We know it works

As part of the 100 Day Challenge:

In West Suffolk, they implemented a virtual nurse led urology follow-up clinic for bladder outflow surgery patients. Approximately 100 bladder outflow surgery patients are seen annually, of which 85% are discharged at follow-up. Of the 34 patients 'seen' in the new clinic:

- 53% (18) patients were discharged without a face-to-face appointment.
- 38% (13) were referred to a consultant.
- 9% (3) were reviewed by nurses.

Teams in Dudley put in place a weekly nurse led telephone follow-up clinic for TURP (transurethral resection of prostate) patients and also introduced nurse led cystoscopy slots for simple procedures. Of the 21 TURP patients who met the criteria:

- 100% (21) were followed up by telephone with no patients choosing to be seen in clinic.
- 33% (7) did not require any face-to-face follow-up and have been discharged.
- 14 patients were referred for further investigations.
- 100% preferred telephone clinics to outpatient appointments.
- The nurse led cystoscopy clinic increased capacity by 12.5% from 64 to 74 slots, improving consultant availability.

You can find the full case studies on the [Elective Care Community of Practice](#).

Introduction

The national context and challenges facing elective care services in England

The national urology challenge

The Elective Care Development Collaborative

Overview of ideas described in this handbook

Essential actions for successful transformation

1. Rethinking referrals:

a. Standardised referral pathways and structured templates

2. Maximising the role of shared decision-making and self-management support:

a. Self-management education and information

b. Catheter passport

3. Transforming outpatient appointments to better meet patients' needs:

a. Multidisciplinary continence clinic

b. Alternative consultation methods

Taking transformation forward

Learning from the five waves of rapid testing in the Elective Care Development Collaborative has shown that our rapid implementation methodology achieves:

- High levels of clinical engagement and communication across system teams as change is led from the front, with support and permission from above.
- Sustained and embedded improvement with people feeling ownership in the change. Change from the ground up often has more traction and sustainability.

One of the best ways to find out more and to implement transformation of elective care services in your local area is by joining the Elective Care Community of Practice.

What is the Elective Care Community of Practice?

The Community of Practice is an interactive online platform that connects teams, organisations and other stakeholders across the healthcare system to improve communication and knowledge sharing.

It has dedicated sections for all 14 specialties where the Elective Care Transformation Programme has enabled local systems to transform services, along with details of our High Impact Interventions, work to divert referrals from challenged providers to other providers by use of capacity alerts, support for implementing alternative models of outpatient services, and more.

Why join the Elective Care Community of Practice?

On the Community of Practice those at the forefront of elective care transformation can work with others as part of a virtual development collaborative and:

- Access resources such as best practice alternative outpatient models, evidence of what works, and documents to support delivery such as referral templates and job descriptions
- Start and participate in discussions, developing and sharing expertise
- Follow, learn from and offer encouragement to other areas as they take action to improve elective care services.

If you are interested in joining the Community of Practice, please email: ECDC-manager@future.nhs.uk