

Quality and Productivity: Proven Case Study

Improving the quality of care for men with lower urinary tract symptoms: shared decision making

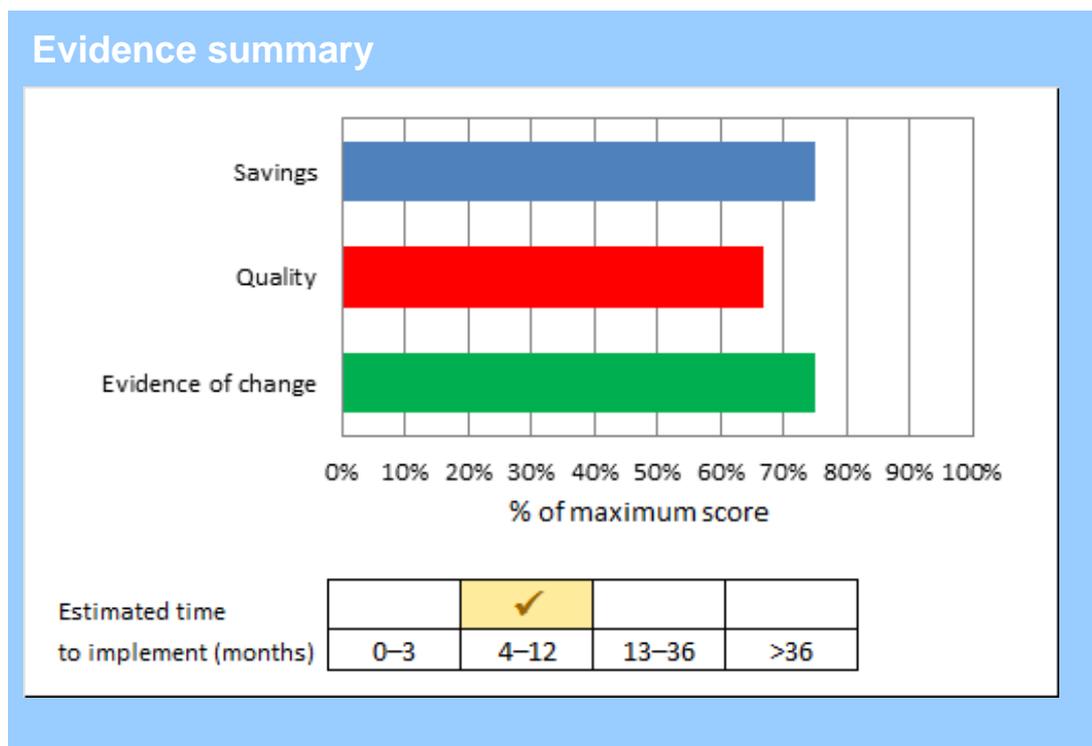
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Sharing QIPP practice: What are 'Proven Quality and Productivity' case studies?

The QIPP collection provides users with practical case studies that address the quality and productivity challenge in health and social care. All examples submitted are evaluated by NICE. This evaluation is based on the degree to which the initiative meets the QIPP criteria: savings, quality, evidence and implementability. The first three criteria are given a score which are then combined to give an overall score. The overall score is used to identify case studies that are designated as 'recommended' on NHS Evidence. The assessment of the degree to which this particular case study meets the criteria is represented in the summary graphic below.

Proven quality and productivity examples are case studies that show evidence of implementation and can demonstrate efficiency savings and improvements in quality.



Details of initiative

Purpose	The primary aim of the initiative was to prevent inappropriate referrals and raise the quality of patient referrals by improving the decisions made by clinicians and their patients with lower urinary tract symptoms (LUTS). The use of patient decision aids (PDAs) and shared decision-making (SDM) would help facilitate the quality of referrals and the better use of resources.
Description (including scope)	<p>The purpose of the initiative was to improve the quality of care for men with lower urinary tract symptoms (LUTS).</p> <p>Clinical peer review was focused on evidence of implementation of NICE guidance on the Management of LUTS in men (NICE, May 2010) at the point of referral from primary care.</p> <p>Detailed feedback to individual clinicians was supported with educational materials with a focus on shared decision-making by educating clinicians and empowering patients.</p> <p>Primary care clinicians receive an increasing quantity of evidence-based advice, guidance, pathway must-dos and don't-dos that all have to be achieved in a working day. It is easy for them to be overwhelmed by information. Crucially the initial decisions, made by the patient and clinician in the consulting room, drive the pathways and costs in the NHS.</p> <p>The 'right decisions at the right time to the right place' gives better outcomes and better use of resources for all. The statement is based on anecdotal evidence that a referral to the wrong speciality results in delay for patients. GPs are then asked to re-refer to the right department. This creates 2 first outpatient appointments and an unspecified but significant time delay. The presumption is that quicker assessment and action leads to better outcomes for patients. Informed patients are also central to the right decisions.</p> <p>The aims were to:</p> <ul style="list-style-type: none">• raise public and clinician awareness of SDM, supported by PDAs• educate clinicians on using PDAs and SDM to deliver high-quality care (the one off cost of the clinical meeting is the price of the venue). Materials are available from websites and have no additional cost• drive decision-making with empowered patients by making PDAs widely available in the community• facilitate behaviour change by:<ul style="list-style-type: none">– providing personal feedback to individual referrers based on an audit of their referral data– using the NICE LUTS guideline to assess the quality of pre-referral care– disseminating educational material based on the NICE LUTS guideline

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- reduce the number of inappropriate referrals
- demonstrate improved quality of referrals that reflect the implementation of the NICE LUTS guideline.

The intention was to test an approach to referral management that focused on the quality of decision-making between clinician and patient. This entailed using peer reviews of referrals to provide feedback to individual clinicians on their referrals. This was supported by education materials developed with consultant colleagues, based on agreed quality markers from the NICE LUTS guideline.

The plan was to:

- test this approach to a single pathway and apply the learning and processes across other clinical areas
- reduce the number of inappropriate referrals
- demonstrate improved quality of referrals that reflect the implementation of the NICE LUTS guideline
- explore ways to engage patients in the community so they can get the information they need to inform decisions for their health.

By achieving these objectives the hope is to show value for money and best use of NHS resources.

Topic

Right care and right care for patients.

Other information

The South Norfolk Healthcare Community Interest Company (CIC) is a not for profit social enterprise formed by 16 of the general practices in south Norfolk to improve local health services.

Reduction in hospital appointments, bed days and journeys produced an annual carbon emission saving of 16,703gCO_{2e} for South Norfolk practices. The annual carbon emissions savings expected per 100,000 population is 12,315gCO_{2e}.

It is not possible to measure whether SDM or PDAs facilitated the largest effect on behaviour change as both are part of the overall intervention.

Savings delivered

Amount of savings delivered

Savings are a result of reduced inappropriate referrals to secondary care. The equivalent annual savings achieved were £28,336 for a population of 130,871 or £21,652 per 100,000 population.

For the population of 130,871 from the 16 participating practices, the annual savings based on 6 months' data showed LUTS referral activity saved 44 inappropriate referrals. The cost for a

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LUTS referral over the 6-month period averaged £644. Costs are based on a detailed analysis of Secondary User Service financial data over a 6-month period.

In the second 3-month referral audit (Jan-March 2012) from the 16 GP surgeries there were 11 fewer referrals for LUTS.

There are a number of 'one-off' implementation costs that reduce the level of savings achievable in year 1:

The main costs were for clinical time to audit, review and discuss the overall approach. Over the 2 years, this development time amounted to around £6,500 for clinicians. The cost of data analysis and management support, including creating the clinician and general practice packs, was approximately £2,100.

At the time of the project the PDAs were free from NHS Direct (now replaced by NHS 111 in England). Since the project concluded, PDAs have been free to download from the NHS Shared Decision Making (SDM) website and are congruent with NICE guidance

<http://sdm.rightcare.nhs.uk>.

There were one-off costs associated with developing the database of contacts in the county council and among the parish councils so patients have the option to access the on line PDA's from the community. Other organisations might already have these, however. There were costs associated with receiving the training in SDM, including watching the SDM video. However, GPs are continuously undertaking professional development, and this subject matter formed part of those on-going costs – it was not above normal.

One year later, the audit was repeated in order to determine whether the effect was temporary. Results showed that there was 1 less LUTS referral in 2013 compared with 2012, along with a slight improvement in the referrals that were considered to be appropriate. This confirmed that the initial results were not just delaying referrals, and that the savings identified in the first audit had not been exaggerated and did not need to be revised.

Type of saving	A mixture of real cash savings and improved productivity was demonstrated. Cash savings are a result of reduced inappropriate referrals from primary care to secondary care.
Any costs required to achieve the savings	Change can be achieved with minimal additional resources. One-off implementation costs were £8,600.
Programme budget	Genito-urinary system problems; LUTS.
Supporting evidence	Savings have been calculated by taking the average cost of LUTS referrals (from Secondary Care User Statistics Data) and the 6-month referral audit data from 16 South Norfolk Healthcare general practices. The actual savings demonstrated post

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implementation of the initiative were equivalent.

Full details of the estimated savings are provided in the South Norfolk Healthcare CIC presentation 'Management of LUTS in men' (July 2012). This document is available on request.

The latest audit (January–March 2013) shows that prostate-specific antigen (PSA) testing is now in use for over 90% of patients which demonstrates sustainability with improving referral data. *International prostate symptom score (I-PSS) use* is now over 40% and appropriate referrals have increased by 54% from the original audit.

Quality outcomes delivered

Impact on quality of care or population health	Clinical quality improved through a reduction in time delays and correct diagnosis and treatment.
Impact on patients, people who use services and/or population safety	Safety increased due to improved assessment in primary care, better application of NICE guidance leading to more appropriate referrals to secondary care services.
Impact on patients, people who use services, carers, public and/or population experience	An improved patient experience was realised because patients are assessed and treated quicker as they are referred to the right department initially. Patients are also actively involved in the treatment decision making process.
Supporting evidence	<p>The value of the educational materials and approach for SDM and PDAs was surveyed with 22 clinicians in mid-2011.</p> <p>The first 2 questionnaires showed:</p> <ul style="list-style-type: none">• a marked improvement in the perceived benefit of both SDM and PDAs• a marked increase in the understanding of both SDM and PDAs• an increase in the likelihood of doctors and patients using SDM and PDAs together. <p>Questionnaire 3 which was not specific to LUTS (but was relevant to the use and understanding of PDA's and SDM) showed:</p> <ul style="list-style-type: none">• 5 out of 8 clinicians used the PDAs• all used it to present patients with various treatment options• all used it to provide information to patients• most used PDAs to find out about patients' values and personal circumstances• all the clinicians using PDAs found they helped engage

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patients in a dialogue.

Patients were also engaged in the initiative. General practice PDA stock levels and statistics from Norfolk Library services show that patients are requesting PDAs and their feedback is very positive. One patient remarked that PDAs were 'one of the most helpful things I have had from the NHS. It is clearly written and places the problem, which was appalling me, in a common sense and understandable context'.

The 3-month audits of referrals showed an overall increase of 39% for appropriate referrals. It also demonstrated a significant improvement in the quality of primary care being delivered.

Quality was measured from the details in referral letters over the 3-month audits.

Quality Markers (based on the NICE LUTS guideline and best practice), agreed with primary care clinicians and urology consultants:

- For Rank 1 (essential to the referral) prostate examination prior to referral improved from below 40% to over 70%
- investigations for urea and electrolytes improved by 43% and urinalysis improved by 36%
- use of PSA testing improved by 2%
- 54% increase in the use of A-blockers
- 23% increase in the use of combined A-blocker and 5-alpha reductase.

To improve practice further the service now evaluates urea and electrolytes if there are any concerns about renal impairment, for example, a palpable bladder.

The Rank 2 (highly desirable – give the consultant a happy day) Quality Markers improved by 7% and 17%.

Evidence of effectiveness

Evidence base for case study

Evidence includes the development of a published decision aid for patients with benign prostatic hyperplasia by the NHS Urology Informed Decision Making Project (Archer and Finn, 2011). This pilot study has been evaluated in 11 hospitals in England and is underpinned by international published research on PDAs by Elwyn and Edwards (2009), The Picker Institute (Care Quality Commission), O'Connor and Sun (2005), Sun (2004) and Gattelari and Ward (2004), National Steering Group for Decision Support Aids in Urology (2005), Wirrmann and Askham (2006). These studies provide the evidence for using PDA's which Archer and Finn (2011) specifically developed to use with LUTS patients.

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Evidence of deliverables from implementation	The first audit was performed in January–March 2011, followed by education, training and development. The second audit took place in January–March 2012 and has been repeated in January–March 2013.
Where implemented	Within 16 general practices in South Norfolk.
Degree to which the actual benefits matched assumptions	Assumptions are met and the re audit in 2013 has shown the continuing benefit of the work.
If initiative has been replicated how frequently/widely has it been replicated	The submitter is not aware that anyone has used the same approach specifically.
Supporting evidence	The plan is to apply the learning from this study to other clinical areas. The materials and experience can be shared with interested colleagues in the NHS.

Details of implementation

Implementation details	<p>General practices, clinicians and patients attended educational events; general practices received education packs, patient information cards, waiting rooms posters and PDAs. Patients and clinicians were able to access materials from the website (www.snhcic.org.uk).</p> <p>General practice clinicians and urology consultants jointly audited 320 LUTS and prostate problem referrals and associated hospital outcome letters. Quality markers were developed based on the NICE LUTS guideline. LUTS referrals over a 3-month period from January to March 2011 were audited using the quality markers. Analysis of the referrals identified doctors' educational needs and formed the basis for education and training.</p> <p>The focus was on the decisions made in the consulting room. The quality markers evaluate the quality of the work and assessment made by the clinician. This was the key intervention.</p> <p>Every clinician was aware that their decisions were evaluated.</p> <p>Comments from clinicians show they are thinking more closely about their decision-making process, their</p>
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management plan as well as the input of their colleagues.

Norfolk County Council launched PDAs within local libraries, advertising the initiative through their online newsletter, posters and plasma screens. Library staff helped patients to access the PDAs.

The launch was covered by the local press.

Twenty-eight parish councils raised patient awareness, signposting patients to their general practice and library initiatives through their newsletters.

The Norfolk and Waveney Prostate Cancer Support Group distributed PDAs and raised awareness through its membership.

Clinicians were provided with bi-monthly feedback on their referrals, against the agreed quality markers, to inform and reinforce behaviour change.

One year later (January–March 2012) all LUTS referrals from the participating general practices were audited.

The South Norfolk Healthcare CIC produced a presentation in July 2012, highlighting its work 'Management of LUTS in men'.

Time taken to implement	4 months to 1 year.
Ease of implementation	Affects clinicians based within primary care and consultant urologists based in secondary/tertiary care NHS organisations.
Level of support and commitment	The submitter stated that the initiative achieved good buy-in, because although working in partnership with GPs and consultants was very effective, it was difficult to organise because of busy schedules.
Barriers to implementation	<p>Agreeing times for clinicians to work on the initiative was fundamental to success because it was found that implementing the NICE LUTS guideline and improving healthcare decision-making are more effective if clinicians are given personalised feedback. Feedback is better received if the quality markers used are based on the LUTS guidance from NICE and have local consultant support.</p> <p>Implementing PDAs within general practice required buy-in from clinicians and practice managers – it was found that providing practice managers with all necessary communications (including staff and patient information) helped to smooth the implementation process.</p>

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Risks The key potential risk relates to data handling for the clinical audit. This was managed through the policies and protocols for data handling at South Norfolk Healthcare CIC. Level 2 compliance was achieved for the Information Governance tool kit and a revised data management process specific to this project has been implemented. It was also clear that there was a risk if good engagement with local GPs could not be obtained. This could be mitigated by consistent communication and by obtaining endorsement from local consultants.

Supporting evidence The NHS number was used to identify patients and provide feedback to individual clinicians regarding their referrals. The NHS number was also used as the key identifier to gather and review all referral data, including hospital letters and Secondary User Service data.

Further evidence

Dependencies The success of the project depended on a significant amount of interworking with other organisations and stakeholders (each practice and their clinicians, consultant colleagues, library staff, local parishes and the patients with LUTS in South Norfolk). NHS Direct was used to provide the hard copy PDAs.

These relationships were managed through regular communication.

Contacts and resources

Contacts and resources If you require any further information please email: gipp@nice.org.uk and we will forward your enquiry and contact details to the provider of this case study. Please quote QIPP reference 12/0013 in your email.

Archer MD, Finn J (2011) Helping men make informed decisions about treatment for LUTS caused by BPH. Trends in Urology January/February 2011

Elwyn G, Edwards A (2009) Shared decision making in health care: achieving evidence-based patient choice, 2nd edition. Oxford: Oxford University Press

Gattelari M, Ward JE (2004) Will men attribute fault to their GP for adverse effects arising from controversial screening tests? An Australian study using scenarios about PSA screening. Journal of Medical Screening 11: 165–9

LUTS_NICE_Initiative SNH (5 July 2012) Slideshow. Internal report produced by South Norfolk Healthcare CIC (available on

the NICE shared learning website)

National patient surveys undertaken by the Picker Institute Europe on behalf of the Care Quality Commission (www.nhssurveys.org)

National Steering Group for Decision Support Aids in Urology (2005) Implementing patient decision aids in urology – final report, October (www.pickereurope.org)

O'Connor A, Sun Q (2005) Predicting downstream effects of high decisional conflict. 3rd International Shared Decision Making Conference, Ottawa, Ontario, Canada, June 14–16

Sun Q (2004) Predicting downstream effects of high decisional conflict: meta-analysis of the Decisional Conflict Scale. Master of Science in Systems Science, School of Management, University of Ottawa

Wirmann E, Askham J, Picker Institute Europe (2006) Implementing patient decision aids in urology, September (www.pickereurope.org)

Other documents

NICE has published evidence-based guidance for healthcare professionals. This QIPP case study goes beyond the scope of these guidelines. Links to the guidance have been included here for information and to support you in the development of evidence-based services:

National Institute for Health and Clinical Excellence (2010) [Lower urinary tract symptoms: the management of lower urinary tract symptoms in men](#). NICE clinical guideline 97

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