SPECIFICATION OF SERVICES

Urology

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<th>Commissioner lead:</th>
<th>Jane Cobby</th>
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## Document Control

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<td>Commissioning Executive</td>
<td>Louise Watson</td>
<td>Director of Primary Care Development</td>
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### Distribution

- Practice Based Commissioning Leads
- Primary Care Development (inc. Meds. Management)
- Urology Strategic Working Group & other key clinicians
- PCOH Patient Forum
- Posted on: Supply2health.nhs.uk
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Part A: Setting the scene
This section contains an overview of NHS West Sussex and a brief description of the high-level goals of the service linked to the Commissioning Framework, Operating Plan (OP) and the Strategic Commissioning Plan (SCP).

1 INTRODUCTION

1.1 Overview of NHS West Sussex

NHS West Sussex covers a population of 776,300 (2007 MYE) within which there are 95 GP practices making up eight Practice Based Commissioning (PBC) groups.

More details, such as the local demographics are available at www.westsussex.nhs.uk/about-us/commissioning

1.2 Strategic goals of the service

NHS West Sussex and the Practice Based Commissioning (PBC) groups, “the commissioners” are committed to ensuring equity of patient access to new high quality and integrated Local Specialist Urology Services across West Sussex.

The key aim of this specification is therefore to procure or buy Local Specialist Urology Services (LSUS) that will deliver care into the heart of local communities, which means outside of the acute hospital setting for many patients. These services will have at their core Consultant Urologists who will be responsible for ensuring that continuity of care and consistent quality of care is delivered by all members of the local specialist urology team.

The service will take a ‘hub’ and ‘spoke’ approach and comprise specialist services for a routine urology case-mix (for both ‘new’ and ‘follow up’ patients) provided in community settings where it is safe and clinically appropriate to do so.

This document describes the core principles and the specialty specific standards required to deliver the West Sussex model for integrated Urology Care Closer to Home.

The specification represents an invitation for innovation both in term of achieving pathway efficiencies and financial efficiencies with services provided from a range of locations. The commissioners are, therefore, not attempting to specify the pathways of care to be delivered in all settings. However attention is drawn within the document appendices to the specific standards that have been developed by the Urology Strategic Working group for the following pathways:

- Shared care arrangements for the follow up of prostate cancer patients in primary care
- Erectile Dysfunction

This document links to the following strategic goals as identified in the Strategic Commissioning Plan:

- Goal 2: To improve the health of patients with long term conditions;
- Goal 5: To develop community based services, specifically for the elderly. NB The development of community based urology services should improve access for all members of the local population;
- Goal 8: To ensure access to specialist services;
- Goal 9: To reduce health inequalities in deprived areas.
- Goal 10: To improve the quality of life, life expectancy and reduce the gap between areas.

NB This document should be read in conjunction with the Generic Specification of Service (attachment 1) and the Urology Commissioning Framework (Attachment 2).
Part B: Background to the requirement
The section sets in context the requirements of the service, taking into account the service picture at a national level, local needs and any political, regulatory or technological influences that are shaping the direction service development in this area.

2 SERVICE BACKGROUND

2.1 National service context

There have been a range of publications considering the opportunities to redesign some urology pathways and services and providing more integrated services in community settings, closer to home.

- ‘Our Health, our care, our say – a new direction for community services’ (DH, 2006)
- ‘Shifting Care Closer to Home Demonstration Sites – report of the specialty sub-groups’ (DH: 2007)
- ‘Providing care for patients with urological conditions: guidance and resources for commissioners’ (Primary Care Contracting, 2008)

2.2 Local service context

Within West Sussex, the Urology Strategic Working Group has developed a Commissioning Framework that describes the overarching standards and outcomes to be delivered by LSUS for the population of West Sussex. This has been subject to consultation through patient engagement workshops.

There is significant patient level support for the development of Local Specialist Urology Services.

Patient engagement workshops have articulated to commissioners that ‘there is a need for improvements in communication and education, as well as systems that offer good accessibility and consistency of care’. Good communication is essential, both among clinicians and with patients.

Patients' comments have included:

“The patient needs to understand the different stages of the process. The pathway needs to detail staging posts where the patient can review that they understand where they are on the pathway and that they have the relevant information.”

“A nurse specialist role as part of the community based urology multi-disciplinary team (MDT), who can co-ordinate patient care and be available to offer practical advice as well as emotional support where needed”. “Such a resource would be invaluable and much appreciated, particularly for patients with prostate cancer”.

Underpinning the delivery of the standards and outcomes described in the commissioning framework and this specification, is the requirement to deliver a maximum 18-week referral to treatment patient pathway as well as the need to deliver against the pledges outlined in the South East Coast SHA (Strategic Health Authority) Operating Plan for 2009-10. These include:

- **Pledge 1** - More diagnostic tests requested in Primary Care will be available outside a traditional hospital setting: for example, on the high street, and in health centres and GP surgeries.

- **Pledge 2** - The time from referral for an everyday diagnostic test to the result being available will be 72 hours for urgent tests and two weeks routinely for all others.

- **Pledge 3** - Waiting times for hospital treatment will be shorter, falling to an average of less than 9 weeks by 2009.
2.3 Key aims of the Commissioners in the delivery of the service

The key aims of the commissioners include:

- Develop a new integrated model of care comprising LSUS that have Consultant Urologists and their teams working in these local settings. These new services must interface seamlessly with referring GPs and with a range of hospital based services to ensure direct and unencumbered patient pathways in the event that the patient is referred onwards.
- Promote a vision of community based and community led services that are developed through joint working between general practice and the LSUS and with in-reach to specialist care in acute settings.
- The LSUS will manage at least 50% of urology care in the heart of the local health economies across West Sussex. This will be achieved by March 2011.

This new integrated model of care should:

- Facilitate and encourage better management of urological conditions by GPs leading to a higher threshold of referral from GP to a specialist service.
- Be delivered on the common understanding that the patient will remain under the care of a named consultant urologist until discharged from specialist care. This is to ensure the continuity and quality of care delivered by all members of the local specialist urology team.
- Delivered along a common specification of service.

In addition, commissioners and patients will need to be reassured that LSUS providers have direct and unencumbered pathways of care to sub-specialities, inter-dependent specialties, and across a range of acute providers.

This document represents the minimum service specification required for all patients registered permanently or temporarily within the county of West Sussex.

The commissioning intentions with respect to the continence pathways, is to commission community based continence services alongside the LSUS, and this will be the subject of a separate specification. Delivery of the community based continence service will require close integration with the LSUS to ensure consultant support to the service.

Part C: Summary of requirements
This section describes the requirements for the Services that the Provider shall deliver.

3 SERVICE REQUIREMENTS AND SCOPE

3.1 Care pathways

All referrals, whether from a GP or other health care professional, will be treated as a GP referral for the purposes of delivering a maximum 18 week wait.

The commissioners will require the LSUS providers to submit the referral criteria that will determine which patients can be referred to the service, together with any exclusion criteria, and it will be the responsibility of the provider to communicate these to their referring GPs. The referral criteria should be based on the principle that the local service provider will not accept referrals for treatment that should be provided under a standard GMS or PMS contract. Referral guidelines should be consistent with guidelines already in place in West Sussex, where these exist.

LSUS must be able to demonstrate close links and direct pathways of care with a range of community based services, e.g., Community Continence Services, in order to ensure that the patient is treated in the right service, right place, first time. In addition providers must interface seamlessly with referring GPs, local voluntary sector support groups and with a range of hospital based services to ensure that
choice is offered and that direct and unencumbered patient pathways are in place in the event that the patient is referred onwards.

For patients referred on for elective procedures the local provider fully manages the sequence of care, including diagnostic work up and direct listing for procedures as appropriate. Where multi-disciplinary clinics exist, the local service provider should aim to complete the pre-assessment work up and informed consent in the community setting where this is possible and clinically appropriate to do.

LSUS providers will ensure that all patients referred onto secondary care meet the criteria for surgery/treatment according to the NHS West Sussex 'Commissioning for Clinical Effectiveness' guidance and the referral guidelines that underpin the service.

3.2 Functional requirements and outputs

The functional requirements are outlined on Page 5-7 of the generic specification at (Attachment 1).

However these have been developed further through discussion with the Urology Strategic Working Group and are shown below.

**General practice and PBC commissioners:**

Roles and responsibilities for general practice and PBC include:

- Increasing the knowledge and skills within general practice to ensure that patients with urological conditions are assured of a competent and consistent level of assessment, examination and care;
- Participation in shared care protocols to enable monitoring of patients with stable, well controlled disease to take place safely and effectively in primary care;
- Ensuring that all GPs are aware of services available locally and how to access them;
- Adhering to published referral guidelines available through Choose and Book or from the local specialist teams;
- Signposting and/or referring patients to the range of health services available to them, e.g. Physiotherapy, smoking cessation, weight management services as appropriate;
- Acting as a conduit to assist the patient to access the range of information, advice and education services available locally or nationally to facilitate supported self care;
- In the event of onward referral completing the required work up of the patient in primary care;
- Attaching the referral letter on Choose and Book within 2-3 days of the decision to refer to enable the specialist teams to triage the referral effectively and to ensure the patient is directed to the right person, right place, first time;

**Local Specialist Urology Services:** The key features of clinical care should be based on the premise that these services are delivered locally (*please see PBC commissioning aspirations at Appendix E*) and should include:

- The care of the patient must be in line with national guidance including NICE guidance and that published by the British Association of Urology Surgeons on the management of urological conditions;
- The patient will remain under the care of a named consultant urologist until discharged from specialist care. This is to ensure the continuity and quality of care delivered by all members of the local specialist urology team;
- Post diagnosis, and at all stages of the patient pathway, patients are offered appropriate patient information
- Patients should have access to a range of clinicians working within the local specialist team, who are co-located to ensure close working relationships and co-ordinated care for the patient with care provided wherever possible in a one stop clinic
- All members of the LSUS engage with, and support, patients and carers at all stages of the patient pathway, including telephone advice and support as well as signposting to a diverse range of relevant support services.
- Provision of telephone follow up where clinically appropriate.
Ongoing care: The key features of ongoing clinical care for all patients seen within the LSUS include:

- Long term follow up care should be delivered as close to the patient’s home as possible, ideally at their GP practice;
- The development of shared care protocols that facilitate joint working between general practice and specialist clinicians;
- People are confident of equity of access to consistent levels of care outside of hospital settings and that where clinically indicated, they can continue to access consultants and their teams;
- People are confident that they will be involved in the development of individualised patient care plans and of a pathway of care that clearly identifies how their follow up care will be managed;
- A much greater emphasis on supported self care for patients and their carers throughout the patient pathway with providers developing a greater range of education, advice and support services that are well publicised in a variety of formats;
- Patients are confident of care that signposts them early in the pathway, and at regular intervals, to a range of local and national advice and support services.
- Patient access to telephone follow up where clinically appropriate;

3.3 Required service outcomes

The key outcomes to be commissioned through the specification have been developed through a variety of means including:

- National requirements, e.g. NICE guidance
- National guidelines
- The Urology Strategic Working Group
- Feedback from patients, public and third sector organisations including Prostate Cancer Charities

The outcomes:

- GPs will have access to advice and guidance services through the LSUS to support them in the diagnosis and the ongoing management of the patient in general practice.
- Patients will have equal access to LSUS that offer consistent levels of service regardless of where they live in West Sussex and regardless of gender, age, ethnicity, disability, sexual orientation, religion or beliefs.
- Referrals will be triaged within the LSUS to ensure that the patient is directed to the right person, right place or service, first time.
- Managing inappropriate referrals through education and support.
- Patients will have prompt access to specialist opinion, advice and treatment.
- Care will be delivered where possible in a one stop shop, by providing care that minimises the number of appointment visits for patients. This can be achieved by locating staff together and by amalgamating appointments so that patients can be assessed, undergo diagnostic tests, receive the results and the diagnosis and start treatment.
- Patients and clinicians will have prompt access to routine diagnostic tests and to the results.
- Supported self care will be delivered through much greater access to patient and carer education, advice and support services throughout West Sussex.
- Improved health and quality of life for patients.
- Improved patient experience.
- High referrer satisfaction.

3.4 Mandatory activity for the service

The commissioners expect providers to develop new and innovative ways of delivering urology care closer to the patient’s home by using a greater range of staff working in extended roles and by developing shared care arrangements with general practice.

For patients and their carers living in more rural areas and in towns without acute hospitals, then a new range of services must be developed with clinics provided in community hospitals and general practice.
The LSUS will manage at least 50% of urology care in the heart of the local health economies across West Sussex. This will be achieved by March 2011 and reflects the lead in time to recruit and train additional staff into role.

3.5 Options for future development

With 50% of care provided in local settings, this will mean a significant shift in care traditionally provided in the outpatient departments of the acute hospitals. However, it could also include shifting elements of care previously provided as day case.

There is an opportunity to develop a more integrated service with general practice with named GPs and practice nurses forming part of the LSUS and providing the initial assessment and care of the urology patient, underpinned by an inter-practice referral system. Regardless of the mix of clinicians, all must be part of a defined clinical governance framework.

3.6 Potential for variation

The PBC consortia have completed a gap analysis against the core standards in the urology commissioning framework. As a result of this exercise, PBC aspirations to address the gaps are attached in Appendix E.

Potential providers of service are therefore encouraged to align their plans to these aspirations. Further clarification can be sought from the Planned Care Outside Hospital programme team who are prepared to maintain open and co-operative dialogue with all potential providers of service.

The commissioners are particularly interested to receive proposals from providers who are prepared to deliver innovative services that achieve the desired pathway and financial efficiencies.

In addition, the commissioners are interested in investigating whether ‘two week rule’ referrals could move through the LSUS. This would be predicated on the principle that cancer patients are identified quickly and are ‘fast-tracked’ directly to be treated and managed under the Local Specialist Multi-Disciplinary Team (LSMDT).

3.7 Required infrastructure

The provider will ensure all equipment necessary to run the service is provided and maintained according to good clinical practice and meets NHS standards.

Successful delivery of local specialist urology services is dependent on clinician access to the following:

- Access to necessary diagnostic equipment, such as ultrasound, uro-dynamic studies etc
- Access enabled to Pathology systems for test results with access across different acute trusts/providers.
- Access to back up paper records in the event of I.T. failure.
- Clinics provided outside of normal working hours to be facilitated by access to the appropriate support services, e.g. Radiology and pathology.

The Planned Care Outside Hospital programme has a separate diagnostics work stream which is tasked with procuring a range of community diagnostics that includes MRI, X-Ray, ultrasound and clinician access to a range of acute Trust Pathology systems. The aim is to bring these work streams together to ensure that clinicians working outside of hospital settings have real time access to tests and results.
3.8 Constraints

These include:

- The need for community based diagnostics to come on line at, or as near to, the go live of the LSUS to support clinicians working in community settings to be able to access in real time the patient's images/films and test results.
- The provision of these diagnostics may be constrained by long lead times for COIN installations, or other connection or hook up issues for the mobile vans.
Part D: Required standards and performance
The section contains the specific outcome results and output targets that must be achieved and how they will be measured.

4 PERFORMANCE MANAGEMENT AND OUTCOMES

4.1 Key performance indicators

The commissioners wish to support the delivery of at least 50% of the urology case-mix in local settings by 2010/11 and will be monitoring referral activity across the different models of care.

New to follow up ratio. The LSUS should aim to keep the ratio of new to follow up appointments below the upper quartile national ratio. (Best decile 1:2)

The new to follow up ratio will remain under review while commissioners shadow monitor the contract in the first instance, while determining the impact of shifting routine outpatient care in this specialty is identified.

Outcomes to be achieved:
In order to provide clarity, outcomes to be achieved is divided into the following:

- Process outcomes
- Patient experience outcomes
- Service effectiveness outcomes

Process outcomes:
These measures will be monitored by the commissioners.

Advice and guidance:
- Urgent advice and guidance for GPs within a maximum of two working days of receipt of request;
- Routine advice and guidance requests within a maximum of five working days of receipt of the request.

Access to specialist opinion:
Referrals sent directly to local specialist urology services (excluding patients referred under the 2-week rule)
The commissioners will expect a minimum of 50% of urology referrals to be managed in the LSUS.

NB Commissioners wish to commission pathways of care that are 18 week compliant. Therefore, performance will be measured on the basis of a maximum handling time of six weeks.

Patient experience outcomes:
The commissioners would expect LSUS to develop and implement patient experience surveys on an annual basis. These surveys would include:

- An evaluation report detailing the results of the survey, the key themes that have emerged and an action plan to address concerns or issues raised by patients and service users.
- Distribution of the report to the commissioners and patients.
- Evidence of active and continual patient involvement in the review and redesign of service provision.

Service effectiveness outcomes:

- PROMs (Patient Reported Outcome Measures). The commissioners would expect the LSUS to develop and implement appropriate PROMs and to have systems in place to continuously monitor and act on information provided by patients.
- Supported self care. The commissioners would expect LSUS to develop and implement a range of patient support and patient education initiatives that seek to maintain the health of patients and facilitate self care and self management of their condition.
5 SERVICE STANDARDS

5.1 Clinical governance

A “system of clinical governance” means a framework through which the Contractor endeavours continuously to improve the quality of its services and safeguard high standards of care by creating an environment in which clinical excellence can flourish.’

The provider will be required to evidence an effective system of clinical governance, and put in place appropriate and effective arrangements for quality assurance, continuous quality improvement and risk management.

The commissioners would expect Consultant Urologists to be the clinical lead within the individual LSUS and to oversee the development and implementation of a robust clinical governance framework as referenced in Page 10-12 of the generic specification (Attachment 1).

5.2 Workforce competencies

Clinicians working in these community settings could include any combination of GPSI, clinical assistants, nurse specialists, and allied health professionals within the multi-disciplinary team.

The exact staffing configuration in the new LSUS will be influenced by existing services, staff and skills. It will also be significantly influenced by the commissioning aspirations of the PBC localities which are appended and through ongoing discussion with PBC leads and their nominated representatives.

The commissioners require services based on the co-located one stop shop model to facilitate better, faster access to care for patients and the achievement of the 9-weeks RTT target.

Please refer to generic specification Page 10-12 (Attachment 1).

5.3 Workforce governance

The LSUS provider must be able to evidence that all proposed workforce polices, processes and practices comply with all relevant employment legislation and codes of practice applicable in the UK. In addition, providers will be expected to evidence that they comply with the provisions of the following:

- Safer Recruitment-A Guide for NHS Employers (April 2006);
- Standards for Better Health;
- The Code of Practice for the International Recruitment of Healthcare Professionals (December 2004)-only applicable where international recruitment is planned.

5.4 National Institute for Health and Clinical Excellence (NICE)

Providers must comply with all NICE guidance pertaining to the management of patients who present for treatment within the LSUS.

5.5 Legal obligations

Providers must comply with all national legislation or regulations referenced in this specification, the generic specification or the attachments.
5.6 Quality assurance and monitoring systems

It is an absolute requirement that local service providers implement robust audit arrangements and providers will be asked to submit an annual audit calendar. The commissioners would expect to receive an evaluation report on the audit results at regular pre-defined intervals as defined within the Service Level Agreement.

5.7 NHS West Sussex responsibilities to uphold

The DH document ‘Health Reform in England: update and commissioning framework annex (P. 31), clearly outlines PCT responsibilities to facilitate PBC and transformational change in the commissioning of 18 week RTT pathways of care.

This includes a requirement to ‘enable the development of new services’ and will include such issues as adding new providers to the Directory of Services on Choose and Book.

NHS West Sussex will be responsible for supporting providers during the implementation phase and where applicable facilitating the introduction of new services in new locations.

6 SERVICE REPORTING REQUIREMENTS

6.1 Management Information requirements
Please refer to generic specification P12-13.

6.2 Service monitoring and review
Reporting intervals: The provider will supply the commissioners with reports on a monthly basis and at further intervals as required by the commissioners and established within the SLA.

Reporting format: The provider will supply the commissioners with reports in a format specified within the contract agreement.

Reporting responsibility: The contract agreement will detail the named person responsible within the provider for provision of the reports and will also detail the named personnel who are to receive the information.

Frequency of contract review meetings
As a minimum the commissioners would expect quarterly meetings with the local service provider to review the outcomes and the KPIs for the service.
Part E: Pricing Methods
This section defines the ‘contract currency’ or desired Pricing Methods that shall apply to the Services commissioned.

### 7 COMMERCIAL MODEL

#### 7.1 Pricing Method and ‘Contract Currency’

The commissioners wish to procure local services closer to people’s homes and are considering a number of procurement routes including AWP (Any Willing Provider).

Services will be procured through a community tariff set below standard tariff. However the commissioners will wish to work closely with providers to move to a position of developing tariffs for outcome based pathways of care.
Appendices

**Appendix A** – Glossary of terms

**Appendix B** – References (see references for PSA)

**Appendix C** – Shared Care Arrangements for the Follow-up of Prostate Cancer in Primary Care

*(West Sussex Aid to Discharge to GP PSA Follow Up and Standard Discharge Template attached)*

**Appendix D** – Erectile Dysfunction pathway and clinical competencies *(pathway attached)*

**Appendix E** – Practice Based Commissioning Aspirations

**Attachment 1** – Generic Specification of Service

![Draft Generic Spec 0409 (5)](image)

**Attachment 2** – Urology Commissioning Framework

![Urology Commissioning Frame](image)
## Appendix A: Glossary of terms
The following terms shall have the following meanings:

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<th>Term</th>
<th>Meaning</th>
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<tr>
<td>AHP</td>
<td>means Allied Health Professional</td>
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<tr>
<td>AWP</td>
<td>means Any Willing Provider</td>
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<tr>
<td>BNF</td>
<td>British National Formulary</td>
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<td></td>
<td>The BNF provides UK healthcare professionals with authoritative and practical information on</td>
</tr>
<tr>
<td></td>
<td>the selection and clinical use of medicines</td>
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<tr>
<td>COIN</td>
<td>means Community of Interest Network, the COIN enables healthcare information to be accessed and</td>
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<td></td>
<td>shared in real time.</td>
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<tr>
<td>DH</td>
<td>means Department of Health</td>
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<tr>
<td>EPP</td>
<td>means Expert Patient Programme</td>
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<tr>
<td>GMS Contract</td>
<td>means Contract that creates greater flexibility for GPs and represents a significant level of</td>
</tr>
<tr>
<td></td>
<td>investment in primary care.</td>
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<tr>
<td>GPSIs</td>
<td>means GPs with a special interest</td>
</tr>
<tr>
<td>ICIS</td>
<td>means ICIS is an impartial information 'bank' helping people of all ages in West Sussex find</td>
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<td></td>
<td>support and care, and developing and managing information resources for health and social care</td>
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<tr>
<td></td>
<td>providers.</td>
</tr>
<tr>
<td>IT</td>
<td>means Information Technology</td>
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<tr>
<td>LES</td>
<td>means Local Enhanced Service</td>
</tr>
<tr>
<td>LSUS</td>
<td>means Local Specialist Urology Services</td>
</tr>
<tr>
<td>MDT</td>
<td>means Multi-disciplinary Team</td>
</tr>
<tr>
<td>NICE</td>
<td>means National Institute for Health and Clinical Excellence</td>
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<tr>
<td>PbR</td>
<td>means Payment by Results, transparent rules based system that sets fixed prices (a tariff) for</td>
</tr>
<tr>
<td></td>
<td>clinical procedures and activity in the NHS, enabling all trusts to be paid the same for</td>
</tr>
<tr>
<td></td>
<td>equivalent work.</td>
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<tr>
<td>OP</td>
<td>means Operating plan</td>
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<tr>
<td>PACS</td>
<td>means Picture Archiving and Communication System</td>
</tr>
<tr>
<td>PBC</td>
<td>means Practice Based Commissioning</td>
</tr>
<tr>
<td>PCT</td>
<td>means Primary Care Trust</td>
</tr>
<tr>
<td>PMS Contract</td>
<td>means Personal Medical Services Contract, one of the types of contracts primary care trusts</td>
</tr>
<tr>
<td></td>
<td>can have with primary care providers. This contract is locally negotiated with practices.</td>
</tr>
<tr>
<td>Primary Care</td>
<td>means health services that play a central role in the local community: GPs, pharmacists,</td>
</tr>
<tr>
<td></td>
<td>dentists and midwives.</td>
</tr>
<tr>
<td>Secondary Care</td>
<td>means services provided by medical specialists who generally do not have first contact with</td>
</tr>
<tr>
<td></td>
<td>patients, eg urologists.</td>
</tr>
<tr>
<td>SCP</td>
<td>means Strategic Commissioning Plan</td>
</tr>
<tr>
<td>SEC SHA</td>
<td>means South East Coast Strategic Health Authority</td>
</tr>
<tr>
<td>SHA</td>
<td>means Strategic Health Authority</td>
</tr>
<tr>
<td>SLA</td>
<td>means Service Level Agreement</td>
</tr>
<tr>
<td>Urology</td>
<td>means the surgical specialty that focuses on the urinary tracts of males and females, and on the</td>
</tr>
<tr>
<td></td>
<td>reproductive system of males</td>
</tr>
</tbody>
</table>
Appendix B: References

Department of Health ‘Health Reform in England: update and commissioning framework annex (P. 31)
Department of Health (2006) ‘Our health, our care, our say – a new direction for community services

Department of Health (2007) ‘Shifting Care Closer to Home Demonstration Sites – report of the specialty sub-groups’


NHS West Sussex (2007) Commissioning for Clinical Effectiveness Guidance

NHS West Sussex (2009) West Sussex Strategic Commissioning Plan
Appendix C: Shared Care Arrangements for the Follow-up of Prostate Cancer in Primary Care

Shared care implies a partnership between urologists, GPs and patients.

The ultimate goal of shared care for prostatic disorders is to enhance patient care both by improving understanding of the diseases and by fostering closer links between GPs and urologists. Therefore, shared care should increase rather than decrease the early diagnosis of prostate cancer and therefore provide better prospects for cure rather than palliation.

The commissioners have now developed a common specification for prostate cancer follow up (incl. PSA monitoring) to deliver safe and effective patient care, which is integrated across primary and secondary care and delivered under ‘shared care arrangements’.

All patients being cared for under shared care arrangements will be part of a clinical governance framework, supervised by an appropriately appointed cancer multi-disciplinary team in secondary care, which ensures patient safety through a co-ordinated approach to audit and review.

Follow up care of men with stable prostate cancer (in whom active intervention is not currently planned) will be provided in general practice. All identified patients will be monitored across an integrated pathway of care, supported by improved education and training and underpinned by a robust structure for quality assurance.

Funding mechanisms will be in place to support the delivery of shared care arrangements in the form of a Local Enhanced Service in primary care and a Service Level Agreement with the acute urology providers in accordance with this specification of service.

Urology care provided under a Consultant-led Multi-disciplinary team (MDT) (provided in hospital or community based clinics):

Commissioned Outcomes:

- All West Sussex patients with diagnosed or suspected prostate cancer will be considered by acute urology providers/MDT provider for discharge to primary care for PSA monitoring and follow up, in accordance with the ‘West Sussex Aid for Discharge to GP PSA Follow Up’ (see annex 1).
- All West Sussex acute urology providers/MDT provider will provide standard discharge information in the form of a detailed management plan to GPs for patients who require PSA follow up as part of agreed shared care arrangements. (A standard discharge template is included at annex 2)
- All West Sussex acute urology providers/MDT provider will be required to set up and maintain a database of patients being cared for under shared care arrangements and will receive and log ‘confirmation of acceptance’ responses from primary care.
- All West Sussex acute urology providers/MDT provider will ensure a named consultant urologist/CCT holder takes responsibility for overseeing the process to ensure quality of care.
- Patients and their carers will be involved in decisions about the planned protocol of their care, and will be provided with appropriate documentation explaining the new pathway of care.
- All West Sussex acute urology providers/MDT provider will ensure ongoing and timely advice and guidance is available to GPs via a single point of access to their respective departments. Requests for advice will be co-ordinated by a member of the consultant-led MDT, responding within five working days.
- A named Urologist/CCT holder within each acute urology provider in West Sussex, will be responsible for co-ordinating annual audit and review of specified patient cohorts. This will be achieved through close working with Urology Liaison GPs identified for each GP practice within the locality/localities being served.
- A named Urologist/CCT holder within each acute urology provider in West Sussex will have responsibility for presenting outcomes and recommendations from annual audit process to local Urology Clinical Governance meetings, and to consider plans to deliver to training needs identified. [NB Training and education to address gaps in knowledge will be considered and commissioned directly by PBC consortia?]
Outcomes from audit and recommendations for action arising from local Urology Clinical Governance Meetings will be formally reported to the PCT Clinical Governance Committee (annually).

Please see the following attached documents:

Annex 1

*West Sussex Aid to Discharge to GP PSA Follow Up (incl. references)*

Annex 2

*Standard Discharge Template for Prostate Cancer Follow Up*
Appendix D: Erectile Dysfunction

The commissioners require local management of patients suffering from erectile dysfunction in line with recent evidence, modern research and clinical opinion, while adhering to the correct interpretation of the current Department of Health guidelines.

The majority of clinical care (approximately 90%) for patients suffering from erectile dysfunction should be provided in primary care as part of core GMS/PMS.

The commissioners require integrated primary and community based services to be available which allow for specialist assessment of patients, in accordance with the British Society for Sexual Medicines (BSSM) Guidelines on the Management of Erectile Dysfunction.

Patients referred for specialist advice will have received appropriate work-up in primary care which includes full consideration of underlying cardiovascular disease or poorly controlled diabetes.

The second line treatment options will be considered in accordance with the following criteria:

- A trial of at least two PDE5 inhibitors has failed to resolve the problem
- If PDE5 inhibitor is contra-indicated due to patient’s current medication
- The patient is willing to try other options, e.g., intracorporal injections or vacuum therapy

The clinical competencies as defined by the Urology Strategic Working Group are as follows:

- Competency in the anatomy and physiology of the penis, testes and prostate, and pathology of erectile dysfunction and its management including drug therapy, side effects and interactions, surgical options etc
- Competency in history taking, examination of abdomen, genitalia and DRE
- Ability to correctly interpret investigations and discuss findings with the patient
- Knowledge of treatment options, Schedule II and its implications to treatment funding and self-help measures.
- Competency in demonstrating and administering intraurethral alprostadil, intracavernosal alprostadil and vacuum devices.
- Ensure ongoing professional development through attendance at relevant educational events.

The key features of clinical care in the LSUS include:

- Specialist advice and guidance to referrers by clinicians with the appropriate clinical competencies (including cardio-vascular medications and side effects)
- Specialist assessment, examination and diagnosis to patients in a patient responsive service within an appropriately accredited community based setting
- Prescribing of second line treatments in accordance with Schedule II guidance
- Education and support to patients/partners in appropriate use of second line treatments etc
- Onward referral to a urologist for surgical intervention if required
- Onward referral to psychosexual counselling as appropriate

Men who fulfil the “severe distress” criteria and require specialist supervision for their prescriptions will continue to be dealt with under the clinical supervision of the LSUS.

Providers should follow current BNF guidelines with regard to prescribing to men who fulfil the “severe distress” criteria. Medically qualified and non-medical prescribers must ensure that they are operating within an appropriate framework of accountability and governance.

Providers must ensure appropriate access for severe distress patients to acute and repeat prescriptions using secondary care prescription form, commonly known as FP10(HP) and endorse them ‘SLS’ when treatment is dispensed in the community.

The pathway for specialist advice is shown below:
Appendix E: Practice Based Commissioning Aspirations

PBC consortia gap analyses against the standards in the commissioning framework and their commissioning aspiration against the gaps identified.

North East Area

Gap analysis Urology Outline Male LUTS pathway NE April 09 - Final.xls commissioning intentions modified (north east).

South East Area

Outline commissioning intentions template

West Area

Gap analysis Urology West April 09.xls
NHS West Sussex

Specification of Service

For

Local Specialist Urology Services (LSUS)

Appendices
Available on Request

Appendix

Attachment 1  Generic Specification of Service
Attachment 2  Urology Commissioning Framework
C - Annex 1  West Sussex Aid to Discharge GP PSA Follow Up
C - Annex 2  Standard Discharge Template for Prostate Cancer Follow Up
D  Erectile Dysfunction Pathway
E  Practice Based Commissioning Aspirations

For a full copy of the appendices please contact:

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Tel: 01903 708363