

18 weeks commissioning pathways

Blood in urine (haematuria)

Supplementary information to be read in conjunction with the pathway

Reference	Supplementary Information
Blood in urine	Discolouration of urine, can be painful or painless
1.1 Symptom Description	<p>Definition of positivity</p> <ol style="list-style-type: none"> 1 Urine dipstick of a fresh voided urine sample is considered a sensitive means of detecting the presence of haematuria 2 Routine microscopy for confirmation of haematuria is not necessary 3 Significant haematuria is considered to be 1+ or greater. Trace haematuria should be considered negative 4 There is no distinction between non- haemolysed & haemolysed positive haematuria. 1+ for either is of equal significance <p>Renal Association and BAUS consensus statement (to reach final agreement in 2008)</p> <p>Screening reference : National Screening Committee. Population screening for bladder cancer and glomerulonephritis. London: National Screening Committee, UK: 2002</p>
1.2 Metric Incidence & Prevalence	<p>Risk of urinary tract malignancy with macroscopic haematuria (visible haematuria) 24%. The risk of urinary tract malignancy with microscopic haematuria (invisible haematuria) ON MICROSCOPY is 9% (J Urol 2000; 163: 524)</p> <p>The prevalence of asymptomatic microscopic haematuria in the population varies between less than 1% and 20% depending on the age and gender profile of the population. Overall prevalence in adult population around 5%.</p> <p>In a large population study of testing for asymptomatic microscopic haematuria in men aged over 35 and women aged over 55 the positive predictive value for bladder cancer of a positive urine dip test for haematuria was less than 0.2%. Similar rates of urological cancer were found in those who tested positive and those who tested negative to microscopic haematuria. Many patients who start with haematuria as a diagnosis will exit onto another pathway at the point where the underlying pathology is confirmed</p>
1.3 Self Assessment & Self Care (Supported/Unsupported)	<p>WORKFORCE FUNCTIONS</p> <ul style="list-style-type: none"> - Support individuals to undertake and monitor their own healthcare - Provide expert advice - Obtain information from individuals to support assessment of their health status and needs (History Taking)
1.6 Triage thresholds & decision aids	<p>WORKFORCE FUNCTIONS</p> <ul style="list-style-type: none"> - Receive and direct requests for health care assistance using protocols and guidelines - Prioritise treatment and care for individuals according to their health status and needs - Refer individuals to specialist services for treatment and care - Advise and support others pending the attendance of a healthcare practitioner
1.7 Red Flags	<p>In addition to any single episode of visible (microscopic) haematuria there may be pts entering or re-entering the pathway who have consulted with a professional e.g. pharmacist and the following red flags apply:</p> <ul style="list-style-type: none"> - Any single episode of symptomatic invisible haematuria (in the absence of UTI or other transient cause) - Persistent asymptomatic invisible haematuria (defined as 2 out of 3 dipsticks positive)

2.0 Primary Assessment	<p>COMMISSIONING AND CONTRACTING See the Contractual Levers for 18 week Pathways for more detailed directions and guidance that underpin primary care contracting.- Before starting commissioning consider existing primary care medical contracts. Are you already paying for this work? Is it more appropriate to commission this stage of the pathway from primary care contractors?- Have your Practice Based Commissioning (PBC) groups considered this pathway for any service redesign? http://www.primarycarecontracting.nhs.uk/99.php - Have you considered the contractual options to commission the pathway at primary care level? http://www.primarycarecontracting.nhs.uk/238.php</p> <p>Is the current primary care contract fully utilised? Is there capacity to commission additional activity under additional or enhanced service arrangements?(Links to Contract Monitoring template, definitions of essential, advanced and directly enhanced services) http://www.primarycarecontracting.nhs.uk/uploads/ngms/gms_framework__4_.pdfhttp://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsLegislation/DH_077184</p>
2.0 Primary Assessment	<p>WORKFORCE FUNCTIONS</p> <ul style="list-style-type: none"> - Obtain information from individuals to support assessment of their health status and needs (History Taking) - Undertake routine clinical measurements - Determine an individuals state of physical health and fitness - Assess an individual with a suspected health condition <p>2.1</p> <ul style="list-style-type: none"> - Agree the nature and purpose of assessment and investigation into an individuals health status - Plan assessment and investigation into an individuals health status - Plan inter-disciplinary assessment and investigation into an individuals health status - Select assessment and investigative techniques/procedures for use - Request investigations to provide information on an individuals health status and needs - Agree courses of action following assessment
2.0 Primary Assessment	<p>History : also consider - urinary tract symptoms, trauma, family history of renal disease, medication, renal disease</p>
2.2 Diagnostics (Dx)	<p>WORKFORCE FUNCTIONS</p> <p>2.2.2</p> <ul style="list-style-type: none"> - Request investigations to provide information on an individuals health status and needs - Obtain specimens - Interpret and report on the findings of investigations <p>2.2.3</p> <ul style="list-style-type: none"> - Request investigations to provide information on an individuals health status and needs - Obtain images of organs and tissues using plain film radiography - Process images - Obtain images of organs and tissues using ultrasound <p>Implied functions associated with laboratory tests</p> <ul style="list-style-type: none"> - Package biomedical specimens, samples and donations - Transfer biomedical specimens, samples and donations - Receive and check specimens to ensure suitability for analysis - Prepare specimens for analysis - Store specimens, samples, and components - Investigate specimens and samples using diagnostic procedures - Dispose of biomedical specimens and samples - Interpret and report on the findings of investigations <p>2.3</p> <ul style="list-style-type: none"> - Undertake a risk assessment in relation to a defined health need - Assess an individuals needs arising from their health status - Assess an individuals suitability to undergo planned actions - Assess the need for and provision of environmental and social support - Determine a diagnosis and prognosis for an individual - Refer individuals to specialist services for treatment and care
2.2 Diagnostics (Dx)	<p>2.2.2 Plasma creatinine / eGFR Dipstick for proteinuria - if > 1+ send urine for protein : creatinine ratio (PCR) or albumin : creatinine ratio (ACR) on a random sample Nb 24 hr collections for urine protein excretion are no longer required</p>

2.2.3 Abdominal x-ray and Ultrasound scan (urinary tract): Ideally these should be performed as part of a one stop haematuria clinic referral (including urologist review and flexible cystoscopy).
If not available, direct refer for any unexplained (visible) macroscopic haematuria (no UTI), any microscopic haematuria >40years, persistent microscopic haematuria <40 years (defined as 2/3 positive) without proteinuria or raised serum creatinine, or any patient with recurrent/persistent UTI with haematuria.

Nephrology referral :

For patients who have had a urological cause excluded, or have not met the referral criteria for a urological assessment, a nephrology referral should be considered. The need for a nephrology referral in this situation depends on factors other than simply the presence of haematuria. NICE chronic kidney disease guidelines for such referral criteria will be published in September 2008. Until then, nephrology referral is recommended if there is concurrent:

- evidence of declining GFR (by 10ml/min at any stage within the previous 5 years)
 - stage 4 or 5 CKD (eGFR <30ml/min)
 - significant proteinuria (ACR > or = to 30mg/mmol or PCR > or = to 50mg/mmol)
- isolated haematuria (i.e. in the absence of significant proteinuria) with hypertension in those aged <40.
visible haematuria coinciding with intercurrent (usually upper respiratory tract) infection

In the event the above criteria are not met, haematuria itself (visible or invisible) does not require nephrology referral. Such patients should however continue to be monitored in primary care (see below).

2.2 Diagnostics (Dx)

COMMISSIONING AND CONTRACTING

Commissioning a World Class Imaging Service tool has been developed to support commissioners of imaging services. It aims to bring together a number of valuable resources about diagnostic imaging in one easy and convenient reference tool. For more information see the web page.

Generic Patient Reported Outcome Measures exist for this pathway (EQ5D). Currently clinical consensus has not been reached for a condition specific measure.

2.4 Treatments (Tx)

WORKFORCE FUNCTIONS

2.4.1

- Provide information and advice to individuals/carers on managing health care needs

2.4.4

- Provide expert advice
- Manage an individuals medication to achieve optimum outcomes
- Administer medication to individuals
- Support individuals to self medicate

2.4.5

- Assess an individuals suitability to undergo planned actions

2.5 Rehabilitation & Review

WORKFORCE FUNCTIONS

- Assess an individuals needs arising from their health status
- Arrange access to resources needed to support planned health care/lifestyle programmes
- Evaluate treatment plans with individuals and those involved in their care

2.5 Rehabilitation & Review

Monitoring of patients with haematuria (visible or invisible) of undetermined aetiology

- 1 The development of Lower Urinary Tract Symptoms (LUTS)
- 2 The development of visible haematuria
- 3 Significant or increasing proteinuria
- 4 Progressive renal impairment (falling eGFR)
- 5 Hypertension

2.6 Referral thresholds, QOL meas., decision aids, remote advice

TECHNOLOGY

Oldham Community PAS system for recording 18 week journeys through ICATs or other intermediate services.

2.6 Referral thresholds,

COMMISSIONING AND CONTRACTING

QOL meas., decision aids, remote advice Can the quality of primary care be improved to help referrals?
http://www.primarycarecontracting.nhs.uk/uploads/medical/pcc_provider_guide__nov_06_final.pdf and http://www.primarycarecontracting.nhs.uk/uploads/ngms/gms_framework__4_.pdf

2.6 Referral thresholds, QOL meas., decision aids, remote advice CKD pathway referral

2.7 Red Flags

In addition to any single episode of visible haematuria there may be pts entering or re-entering the pathway to whom the following red flags apply:

- Any single episode of symptomatic invisible haematuria (in the absence of UTI or other transient cause)
- Persistent asymptomatic invisible haematuria (defined as 2 out of 3 dipsticks positive)

Nephrology referral :

For patients who have had a urological cause excluded, or have not met the referral criteria for a urological assessment, a nephrology referral should be considered. The need for a nephrology referral in this situation depends on factors other than simply the presence of haematuria. NICE chronic kidney disease guidelines for such referral criteria will be published in September 2008. Until then, nephrology referral is recommended if there is concurrent:

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- significant proteinuria (ACR > or= to 30mg/mmol or PCR > or = to 50mg/mmol)
- isolated haematuria (i.e. in the absence of significant proteinuria) with hypertension in those aged <40.
- visible haematuria coinciding with intercurrent (usually upper respiratory tract) infection

In the event the above criteria are not met, haematuria itself (visible or invisible) does not require nephrology referral. Such patients should however continue to be monitored in primary care (see below)

3.0 Specialist Assessment WORKFORCE FUNCTIONS

- Obtain information from individuals to support assessment of their health status and needs (History Taking)
- Undertake routine clinical measurements
- Determine an individuals state of physical health and fitness
- Assess an individual with a suspected health condition

3.1

- Agree the nature and purpose of assessment and investigation into an individuals health status
- Plan assessment and investigation into an individuals health status
- Plan inter-disciplinary assessment and investigation into an individuals health status
- Select assessment and investigative techniques/procedures for use
- Request investigations to provide information on an individuals health status and needs
- Agree courses of action following assessment

3.0 Specialist Assessment (eg. Interface services (eg. ICATS) with consultant involvement) or consultant led outpatient services)

Assessment, examination, diagnostics and treatment, should be carried out within a one-stop urology service model.

Nephrology patients will be treated in accordance with the CKD pathway

3.2 Diagnostics (Dx)

3.2.3 CTU (CT Urography) is the best test for detecting renal calculi, renal masses and upper tract urothelial tumour. However, this is at the expense of higher radiation dose and should be considered when other tests (US & AXR and retrograde studies) are negative for high risk patients and older patients (age >45) (MBUR6).
 IVU: An alternative to CTU. Its role is now debatable as it is less sensitive than CTU for detection of upper tract urothelial tumour (MBUR6)

3.2.4 Cytology - has low specificity and low sensitivity and is of little value in the Dx of haematuria. It should be reserved for use in the haematuria clinic, according to local protocols
 Urine biomarkers (NMP 22 etc) - there is no evidence currently that such tests are sensitive or specific enough for routine clinical use outside specialised departments

3.2 Diagnostics (Dx)

WORKFORCE FUNCTIONS

3.2.2

- Obtain specimens invasively
- Request investigations to provide information on an individuals health status and needs
- Maintain health care equipment and devices
- Perform a specialist clinical measurement investigation
- Interpret and report on the findings of investigations

3.2.3

- Request investigations to provide information on an individuals health status and needs
- Obtain images of organs and tissues using ultrasound

3.2.4

- Request investigations to provide information on an individuals health status and needs
- Obtain images of organs and tissues using light sensitive film and digital imaging equipment

3.2.5

- Request investigations to provide information on an individuals health status and needs
- Perform a specialist clinical measurement investigation
- Record and report the results of laboratory investigations

3.3

- Undertake a risk assessment in relation to a defined health need
- Assess an individuals needs arising from their health status
- Assess an individuals suitability to undergo planned actions
- Assess the need for and provision of environmental and social support
- Determine a diagnosis and prognosis for an individual
- Refer individuals to specialist services for treatment and care

3.2 Diagnostics (Dx)

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3.4 Definitive Treatments (Tx)

WORKFORCE FUNCTIONS

3.4.1

- Provide information and advice to individuals/carers on managing health care needs

3.4.2

- Discharge individuals
- Support individuals to access and use services and facilities

3.5 Rehabilitation, Review & QOL measurement

WORKFORCE FUNCTIONS

- Assess an individuals needs arising from their health status
- Arrange access to resources needed to support planned health care/lifestyle programmes
- Evaluate treatment plans with individuals and those involved in their care