2013 / 2014

PRIVATE HEALTHCARE EDITION

The Parliamentary Review

A YEAR IN PERSPECTIVE

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The Rt Hon David Cameron MP

Professor Sir Mike Richards

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Foreword

The Rt Hon David Cameron MP Prime Minister

Four years ago our economy was in the danger zone. We now have one of the fastest growing economies in the developed world, and a better and brighter future for Britain is within reach. This hasn't happened by accident – it is thanks to the ongoing sacrifices and determination of the British people, and because of the long-term economic plan the government is working through.

The deficit is down by more than a third, safeguarding the economy for the long term and keeping mortgage rates low. 25 million hard-working people have had their taxes cut, helping families be more financially secure. There are 1.8 million more people in work – that's 1.8 million more people with the sense of security and dignity that comes with a job. Immigration is down and benefits have been capped, ensuring our economy delivers for people who want to work hard and play by the rules. And 800,000 more children are now taught in good or outstanding schools, as we give the next generation a decent education, with the skills necessary to succeed in the global race.

44,000 people have received the life-saving cancer treatment they deserve, thanks to our Cancer Drugs Fund. Our Help to Buy schemes are enabling people to access an affordable mortgage and buy their own home, with nearly 40,000 people already on the property ladder as a result. And with crime down to its lowest level since records began, people up and down the country can feel safer in their own homes and communities.

Those jobs that used to be sent overseas – they're returning to these shores. The production lines that ground to a halt – they're cranking into action. Businesses from all over the world are asking how they can invest in our country.

But it's not just what we are doing that matters, it's why. Our ambitions are not only measured in percentage points on a graph but in the families who have the hope of a better, more secure future; the father who gets back into work after years unemployed; the moment when someone gets the keys to their first home, starts their first business, or receives their first pay cheque.

Our recovery is real, but it has not been easy – as the articles in this year's *The Parliamentary Review* demonstrate, it is thanks to the ongoing resolve of the British people that our country is starting to recover after such tough economic times. That is why it is so important that we stick to the plan.

We must continue to take the difficult decisions to help us build a better Britain; one that rewards those who have put in, who contribute and who play by the rules. This way we can deliver a brighter future for our country – with Britain standing tall in the world again and its people more secure at home.

> "We now have one of the fastest growing economies in the developed world, and a better and brighter future for Britain is within reach"

Foreword

Professor Sir Mike Richards

Chief Inspector of Hospitals

The role of the Care Quality Commission (CQC) is to inspect, monitor and regulate all health and adult social care providers in England. These cover more than 40,000 locations and include NHS hospitals, mental health services, community health services, ambulance services, primary medical (GP) services, dental services and care homes – both in the NHS and in the independent sector. The CQC is not an improvement agency, but we do believe we are an agent for improvement.

Over the past 18 months, the CQC has been undergoing a major transformation. Three chief inspectors have been appointed, and between us we cover all sectors. We have introduced entirely new approaches to inspection, involving clinical experts and experts by experience (patients and carers) working alongside CQC staff. In all the services we inspect, we ask five questions: is it safe? Is it effective? Is it caring? Is it responsive to people's needs? And is it well led? We will then rate each of these services on a four-point scale – outstanding, good, requires improvement and inadequate. Our judgments are based on a combination of the information that we collate before undertaking an inspection and what we see and hear while we are on site.

The new programme is furthest advanced for acute hospitals, where we have now inspected almost half of the 160 acute NHS trusts. While we are still on a learning curve, we have clear independent evidence that our new approach is more robust and credible than that used by the CQC in the past.

We have found wide and unacceptable variation in the quality of care provided in the NHS. There is variation between trusts, with one already having been rated as outstanding and several as inadequate. There is also variation between services within trusts – sometimes it is just a single ward where we find poor-quality care. We provide immediate feedback to the trust chief executive, and we take enforcement action where necessary.

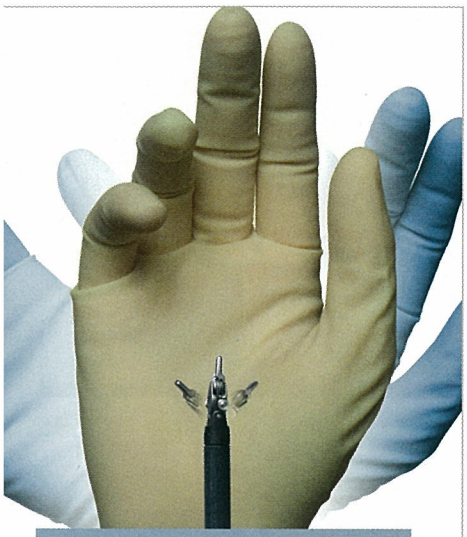
We are now extending the new approach, with appropriate modifications, to independent-sector providers. During autumn 2014, we are piloting the programme in six independent hospitals of varying size. Ultimately, our objective is to rate independent-sector providers in the same way as we do NHS providers, as we believe this will be valuable for patients who wish to make informed choices.

Ensuring consistency across all our inspections is crucial. Recruiting and training high-quality teams, setting out clearly what we see as the characteristics of good and outstanding care, and reviewing all reports carefully at a national level will help to minimise any inconsistencies.

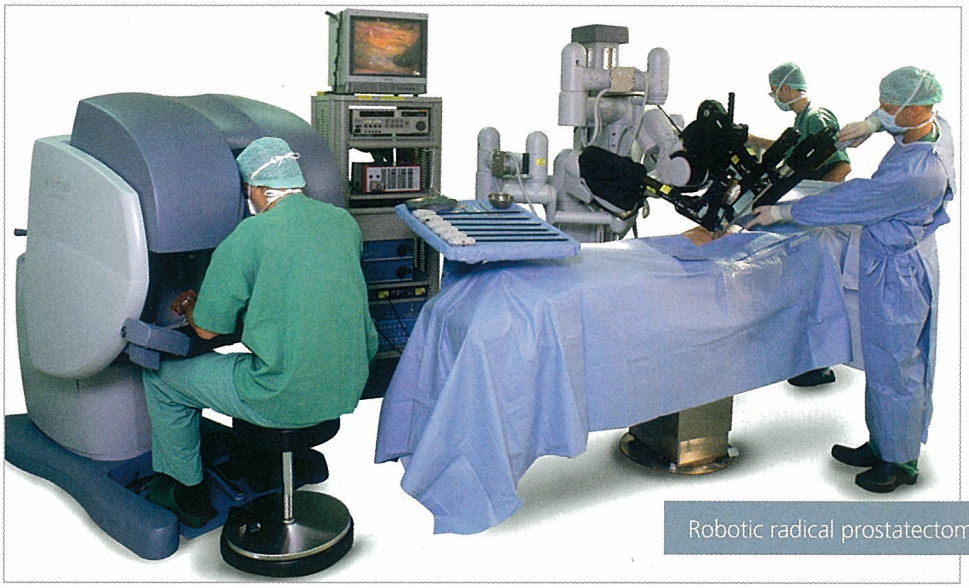
We are currently consulting on the way we regulate independent health services. We are keen to hear your views – full details of current consultations and how to contact us are on our website.

"While we are still on a learning curve, we have clear independent evidence that our new approach is more robust and credible than that used by the CQC in the past"

The Cambridge Urology Partnership



The robotic instrument – its size and range of movement shown against the hand



Robotic radical prostatectomy

The Cambridge Urology Partnership (CUP) is a group of specialists from the areas of urology and oncology with a national and international reputation for using their clinical expertise and research interests to provide state-of-the-art treatment and management. Its model of multidisciplinary private patient care ensures the highest quality of evidence-based care and patient safety.

CUP has achieved its reputation primarily through learning the lessons of treating illnesses in high volume within the NHS and applying this knowledge to private practice. For example:

- it is overhauling prostate cancer diagnosis by researching new technologies that can be used to target abnormalities
- it works as a group, as a team of specialists having organ- or disease-specific areas of expertise
- it takes a holistic approach that includes bladder-outlet surgery and the assessment of patients with urinary-tract stone disease by applying a management pathway that is unique to CUP
- it addresses pelvic pain and constructs treatment pathways using a multidisciplinary therapeutic approach.

The urologists at CUP have all worked at the Cambridge teaching hospital, Addenbrooke's, now known as Cambridge University Hospitals NHS Trust. The urology department there developed a model of care involving specialist teams whose focus was either organ specific or cancer specific, such as urinary-tract stone

ABOUT THE CAMBRIDGE UROLOGY PARTNERSHIP

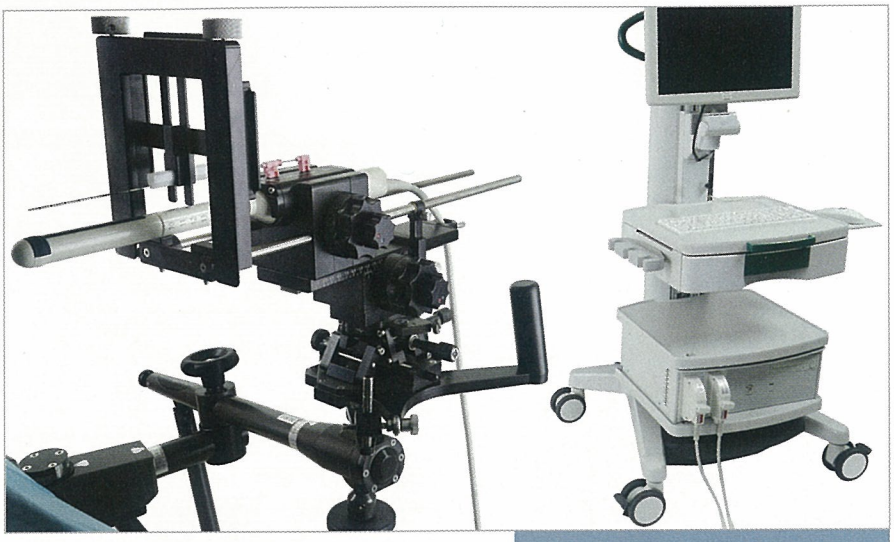
Cambridge Urology Partnership was founded in 2008 with the aim of providing patients with compassionate and timely subspecialist care for a wide range of urological conditions. Over the last six years it has grown into one of the largest private urological and uro-oncological groups in the UK, offering patients the latest, most evidence-based and technologically advanced treatments. Its team is recognised nationally and internationally as being experts in their fields, and because of this they treat patients not just from East Anglia but from right across the UK and overseas.

disease, benign prostatic enlargement or reconstructive urethral surgery. The benefits of this model are that specialists can work within a group, sharing their results and improving treatment methods, and thereby provide safe and high-quality care. The achievements of these groups were harnessed by the specialists working within them, who were keen to pursue a means of delivering the same quality of care in the private sector.

Prostate cancer

Prostate cancer diagnosis is undergoing a major overhaul, with the development of high-quality imaging technology in the form of multiparametric MRI. Andrew Doble and Christof Kastner, two of the CUP partners, have carried out extensive research in this area over the last five years, and in the last three years have used MRI fusion technology to enable a precise targeting of abnormalities seen on the MRI image in the clinic, using either biopsy under general anaesthetic (transperineal) or ultrasound-guided biopsy under local anaesthetic (transrectal). The MRI fusion technique provides the most comprehensive and accurate means of assessing the prostate, and enables the cancer to be diagnosed accurately and stratified adequately. Treatment plans can thereby be personalised to the individual more appropriately. This precise diagnostic approach is unique to CUP in the UK.

The transperineal approach for biopsy provides the urologist with precise information on the nature of the tumour, and therefore treatment can be calculated much better against the risk. Patients with low-risk prostate cancer are best served by monitoring. This active-surveillance approach enables the detection of cancers that progress, and thereby harm the patient, but avoids overtreatment of small, low-risk cancers, thereby preserving the patient's quality of life by avoiding complications.



MRI fusion prostate biopsy allows accurate and targeted placement of the biopsy needle

The incidence of prostate cancer is increasing, in part through more cases being picked up via the more widespread use of the screening blood test for PSA, which is present in elevated levels in the bloodstream in prostate cancer. However, although the number of new cases of prostate cancer identified has increased, there has been little impact on the death rate from this disease, suggesting that there has simply been a greater diagnosis of cases where there is a low risk of the disease causing the patient harm. Patients with intermediate or high-risk disease can be selected for active treatment such as robot-assisted radical prostatectomy (removal of the whole prostate), external beam radiotherapy and the insertion of radioactive seeds (brachytherapy).

CUP has two urologists with the expertise to perform transperineal fusion biopsy, two robotic laparoscopic surgeons, three partners who perform brachytherapy and two partners who specialise in the oncological treatment of prostate cancer, including radiation and drug therapy. The partnership has, therefore, been able to construct a team that is unique in its ability to provide all levels of care in the diagnosis and management of prostate cancer. In addition, the group includes a nurse specialist who can provide the counselling and support that is essential for patients throughout their journey, as well as manage treatment complications such as erectile dysfunction.

» THE CUP SPECIALISTS

Tev Aho – male lower urinary tract symptoms (LUTS), HoLEP and kidney cancer

James Armitage – endourology, male LUTS and HoLEP

Richard Benson – clinical oncology

Andrew Doble – prostate disease, including chronic prostatitis and urethroplasty

Christof Kastner – prostate disease and HoLEP

John Kelly – prostate and bladder cancer, and robot-assisted laparoscopic surgery

Michelle Leighfield – nurse specialist

Simon Russell – clinical oncology

Nimish Shah – robot-assisted laparoscopic prostatectomy and endourology

Oliver Wiseman – kidney stone disease and male infertility

» GLOSSARY OF TERMS

HoLEP (holmium laser enucleation of the prostate) – the central portion of the prostate that is obstructing outflow of urine from the bladder is removed using a laser device that reduces bleeding and enables complete removal of the central portion.

Multiparametric MRI (magnetic resonance imaging) – imaging based on magnetic energy that provides high-resolution anatomical information.

PCNL (percutaneous nephrolithotomy) – telescopes are inserted into the kidney via the flank under general anaesthetic. Stones are fragmented into pieces using ultrasound and sucked out of the kidney.

PSA (prostate-specific antigen) – an enzyme present in the blood of men that is made in the prostate. The PSA level in the bloodstream may be elevated in prostate cancer, so a blood test can help identify patients who may have this condition.

Robot-assisted radical prostatectomy – removal of the whole prostate in men with prostate cancer, using telescopes inserted into the abdomen for visualisation and a robot to improve access to the prostate and facilitate fine movements.

Shockwave lithotripsy – pressure waves are directed from outside the body and focused onto kidney and ureteric stones, causing them to break up into smaller particles that will pass spontaneously in the urine.

Transperineal prostatic biopsy – under general anaesthetic, sampling needles are placed into the prostate via the skin between the testicles and the anus.

Transrectal prostatic biopsy – under local anaesthetic, sampling needles are placed into the prostate via an ultrasound probe inserted in the rectum.

Benign prostate disease

CUP also has surgeons with wide experience in bladder-outlet surgery for the correction of the urinary symptoms of bladder-outlet obstruction caused by prostate enlargement. The specialist surgeons in HoLEP surgery, a procedure in which the central portion of the prostate that is obstructing urine flow is removed, can provide treatment for all patients with bladder-outflow obstruction. This procedure can be done irrespective of the size of the prostate gland but is particularly efficacious where the gland is of large volume, where HoLEP gives patients the most complete and effective surgical outcome. One partner at CUP, Tev Aho, was instrumental in the development of this technique in the UK, and together with Christof Kastner and James Armitage now provides one of the highest volume HoLEP centres in the UK. This approach reflects the group's interest in translating research into better patient care.

Stone disease

Stone disease is a common urological problem that is treated using state-of-the-art technology. Targeted laser energy and focused pressure waves (shockwave lithotripsy) are used to break the stones into fragments small enough to pass in urine. At CUP, with a view to preventing recurrence of stones, the team has introduced comprehensive testing, which includes blood, urine and dietary assessment, allowing bespoke advice to be given to patients to reduce their future risk of stones. This part of patient care is unique to CUP, and CUP was the first private group to offer their patients the StoneScreen service in the UK.

In a further example of CUP taking up advances in technology and translating them into improved care and benefits for CUP patients, Oliver Wiseman, a partner at CUP, was one of the first UK surgeons to perform ultra-mini PCNL. In this technique fine telescopes are inserted into the kidney via the flank, and the stones are fragmented using a laser. This technique has the advantages that it leads to a much smaller scar and to a shorter hospital stay.

Chronic pelvic pain syndrome/ chronic prostatitis

Chronic pelvic pain syndrome/chronic prostatitis is a problem that will affect up to 30% of men in their lifetime. It is a difficult condition to address and treat because of the uncertainty surrounding its causes. CUP has expertise to address this problem. A comprehensive assessment is carried out using a multidisciplinary approach, involving psychologists, pelvic floor physiotherapists and counselling, and the results are used to construct a specific multimodal therapeutic approach to help alleviate the patient's symptoms. The CUP partner involved, Andrew Doble, has contributed to the construction of international and national guidelines and national research.

Educating the patients and the professionals

CUP is keenly aware of the need to provide patients with accessible and clear information about the treatments it provides. To this end it has produced treatment-specific information sheets that can be accessed via the CUP website. It is a goal of paramount importance to CUP that it helps its patients become educated about their disease and treatments.

Through its multidisciplinary management model and its wealth and range of experience, CUP is able to provide holistic, personalised care, yet still carry out active research and development of state-of-the-art pathways for disease investigation and treatment.