Urology outpatient transformation

A practical guide to delivery

January 2022

GIRFT is part of an aligned set of programmes within NHS England and NHS Improvement

Executive Summary

Who should read this guide?

This document has been developed by the GIRFT outpatient transformation team to support all those with a role in delivering outpatient transformation in urology, including:

- Urology clinical leads and multi-disciplinary teams involved in the development of urological services
- Operations managers, transformation leads and service improvement teams
- Commissioners involved with urology and service transformation

What is the guide's aim?

The guide describes the ways in which outpatient care is developing, in the face of escalating demand and the introduction of new technologies. The reader will be able to evaluate their own service against this description of a fully-developed outpatient service by gaining an understanding of the key outpatient transformation initiatives. Finally, it provides detailed practical advice that will help people embark on quality improvement through outpatient transformation.

What the guide contains:

Foreword

The 2018 GIRFT national specialty report on urology demonstrated a wide variation in practice across the NHS and highlighted the need for improvement in urological practice in a range of areas. Improvement in the management of common urological conditions and appropriate investigation are likely to have the greatest impact for our patients. Key to this is the consultation process, traditionally done face to face, and is best thought of as a two way social interaction, where in the clinician elicits information from the patient, offers a diagnosis or opinion and may offer investigation and /or treatment.

The rapid uptake of remote consultations and telemedicine during the Covid-19 pandemic has challenged the traditional paradigm of face to face consultations and have opened new opportunities to providing healthcare that is both beneficial for clinicians and our patients.

The world is currently facing two unparalleled threats, global warming and the ongoing COVID-19 pandemic. The Recent United Nations COP26 reinforced for us all that climate change is the greatest challenge facing humanity and that is very clear that global emissions must be cut significantly. The COVID-19 pandemic has exposed many inefficiencies in the way health care has traditionally been delivered. Allied with workforce shortages and an aging population, the challenges facing us all are significant.

Urology, with a large emphasis on outpatient diagnostics and care is well placed to meet these challenges. Providing a patient focussed approach to consultations and requirements for investigations, using new technology, not only supports greater flexibility for patients and clinicians, but also helps facilitate delivery of the net zero ambition of the NHS, by reducing patient journeys to health care facilities. This gives us all the opportunity to do ‘our bit’ to help resolve the major impact on all our lives of global warming.

Policy makers view remote consultations as a way of delivering health care efficiently in the context of rising rates of chronic illness and a growing demand for services. Establishing such services in a busy and financially stretched NHS will be complex and require significant resources. Remote consultations are likely to work best when both patients and clinicians trust the ‘system’. For practical and safety reasons, remote consultations are unlikely to be appropriate for every patient or every consultation.

This document aims to provide the vision, reasons and the tools for clinicians and mangers in urology for improving the provision of urology services. Our thanks go to all those health professionals involved in this document, from inception to completion. This is the start of a long, difficult and complex road to adapting healthcare to meet the emerging challenges of delivering high quality healthcare.

Andrew Dickinson, *Chair of GIRFT Academy outpatient transformation group and consultant urologist at University Hospitals Plymouth NHS Trust*

Kieran O’Flynn, *GIRFT co-lead for Urology and consultant urologist at the Northern Care Alliance NHS Foundation Trust*

John McGrath, *GIRFT co-lead for Urology and consultant urologist at the Royal Devon and Exeter Foundation Trust*

Simon Harrison, *GIRFT co-lead for Urology and retired consultant urologist*

Professor Tim Briggs CBE, *GIRFT Programme Chair and National Director of Clinical Improvement for the NHS.*

GIRFT and a greener NHS

Climate change is one of the greatest health threats and opportunities of the 21st Century. The NHS is acting now to mitigate and adapt to this threat in order to protect the health of current and future generations. Doing so will not only protect the environment but will also bring many health, social and financial benefits. As the largest employer in the UK, contributing 4.6% of national emissions, the NHS is both part of the challenge and the solution.

In direct response to this the NHS has committed to delivering the world's first net zero health service. This was marked by the ambitious and landmark report: Delivering a Net Zero NHS published in October 2020. This provides a national-level roadmap for reaching net zero carbon emissions by 2040 for the emissions the NHS controls directly, and 2045 for those it can influence. One year on and the NHS in England is on track to reduce its carbon emissions in line with its net zero plans.

Through its endeavour to improve the quality of care within the NHS by reducing unwarranted variation Getting It Right First Time (GIRFT) can play an important role in reducing the carbon emissions associated with care delivery. Through its in-depth reviews, benchmarking and rich-data collection there is the opportunity to identify changes that will help reduce the NHS carbon footprint and therefore improve patient care now and in the future.

The GIRFT Academy as part of its remit to provide easily accessible materials to support best practice delivery across specialties, has the opportunity to consider and reduce the carbon footprint of the care we deliver. Examples of this include review and recommendations on practices which reduce unnecessary appointments and travel, drive good prescribing and promote the use of digital technology to streamline care and facilitate self-management.

About GIRFT and the GIRFT Academy

Getting It Right First Time (GIRFT) is an NHS programme designed to improve the quality of care within the NHS by reducing unwarranted variation. By tackling variation in the way services are delivered across the NHS, and by sharing best practice between trusts, GIRFT identifies changes that will help improve care and patient outcomes, as well as delivering efficiencies such as the reduction of unnecessary procedures and cost savings.

The GIRFT Academy has been established to provide easily accessible materials to support best practice delivery across specialties and adoption of innovations in care.

Importantly, GIRFT Academy is led by frontline clinicians who are expert in the areas they are working on. This means advice is developed by teams with a deep understanding of their discipline, generated by the management of services on a daily basis.

The GIRFT programme is one element of the government's response to the recommendations of Lord Carter's report on operational productivity and performance in NHS acute trusts in England, published in 2016. The Carter Report highlighted the GIRFT programme within its theme on quality and efficiency, outlining the orthopaedic GIRFT pilots which identified the scale of benefit to tackling unwarranted variation.

For more information on the GIRFT programme, visit our website at:

www.gettingitrightfirsttime.co.uk

GIRFT Academy has also published urology delivery guides on acute stones, bladder outlet obstruction and bladder cancer. These are available at: www.gettingitrightfirsttime.co.uk/urology

1. Introduction

The NHS Long Term Plan sets out a desire for outpatient services in the NHS to be fundamentally redesigned. The need to look afresh at how secondary care outpatient services operate is made more pressing as outpatient visits have almost doubled during the last decade from 54 to 94 million, at a cost of £8 billion a year.

Overall, 32% of outpatient appointments are first appointments and 68% are follow up appointments. Technological advances, and an increase in patients' digital connectivity, present new opportunities for outpatient interaction. The Long Term Plan articulates an ambition for the NHS to reconfigure services to enable patients to avoid up to a third of outpatient visits by 2024, removing the need for up to 30 million outpatient visits a year.

Work to deliver outpatient transformation is already underway across multiple specialties, with COVID-19 serving as a catalyst to speed up change. For example, between April and October 2020, video appointments increased by over 500%, with every trust offering video consultations in 2020, compared to just 6% in 2019.

The NHS is committed to reducing its impact on the climate emergency, with changes in outpatient practices offering a major opportunity for reductions in carbon emissions. The ambition of reaching net zero carbon emissions by 2040 set out in the 'Delivering a Net Zero NHS', will provide continued impetus to outpatient transformation. The impact on the NHS's carbon footprint and the wider environment will be largely through a substantial reduction in patient journeys to hospital facilities, but also through limiting the need to build and service outpatient estate.

2. The potential benefits of outpatient transformation

As well as contributing to the overall ambition set by NHS England, scoping and implementing the required transformation in urology has multiple benefits to patients, clinical teams, providers and the environment.

Patients

Healthcare needs to provide integrated care that is more accountable and responsive to patient needs. COVID-19 has necessitated the NHS embracing remote appointments and emerging evidence suggests that this enhanced flexibility is popular with many patients, who welcome the associated increases in convenience and efficiency. A 73% increase in GPs accessing specialty advice through online systems streamlines patient care, facilitating earlier interventions and better informed referrals. Technology is also supporting patient empowerment, with patients taking more responsibility for educating themselves about their condition and organising their follow up care, reducing non-essential hospital visits.

Clinical teams

Having an armoury of different communication channels and technology-supported techniques with which to manage patients according to their need, can play an important role in supporting clinical teams to make the most of their available time. Priority can be given to essential face-to-face appointments while streamlining other patient interactions and reducing wasteful “did not attend” appointments.

Job planning will be critical to ensuring that new ways of working are implemented to the benefit of clinical teams, as well as the patients they serve. New technologies are enabling clinicians to work from home, helping to deliver against the NHS ‘net-zero’ target and supporting a more sustainable work-life balance.

Providers

Effective implementation of the range of technology-enabled changes to the urology outpatient service can help drive quality alongside generating improvement in efficiency. Reducing traditional outpatient attendances, for example through the implementation of remote consultation clinics and one-stop clinics, has the potential to free up resources. Staff can be redirected to other duties, while reduced physical demands for space may also allow providers to think creatively about how their clinic space is used.

Efficient services are vital to regaining control over the backlog of care that has built up during the 2020/21 COVID pandemic. For example, care systems which have adopted the use of specialty advice systems, in particular for pre-referral dialogue, have demonstrated greater resilience; with a number having emerged with no outpatient backlog of new patients awaiting first appointments.

The Environment

Reduced patient reliance on cars, public transport and hospital transport to get to appointments, also contributes to the NHS agenda to deliver a ‘net zero’ national health service by reducing the carbon footprint and environmental impact of its services. The wider NHS outpatient transformation programme has already demonstrated that delivering remote consultations can play a significant role in reducing carbon emissions, whilst also saving patient time and easing parking pressures at hospitals. Providers can calculate carbon savings using tools such as the Sustainability Toolkit.

Triggered by the COVID-19 pandemic, outpatients delivered 26 million remote consultations between April 2020 and April 2021. This is estimated to have saved a colossal 690 million patient miles and 130,466k tonnes of C02, whilst also saving patients 20.4 million hours and freeing up 11.8 million hospital parking spaces.

3. An overview of outpatient transformation in urology

A patient-centric approach to healthcare should ensure that treatment and care is delivered in the right place, at the right time, by the most appropriate clinician. Outpatient transformation is critical to this agenda and, in urology, the GIRFT Academy team has identified five key components that will deliver maximum impact to patient experiences and outcomes, as well as supporting a sustainable NHS. These are:

- **Specialist advice (advice and guidance):** empowering GPs to provide optimum urology support to patients closer to home, aided by guidance from specialist urology teams
- **Remote consultations:** providing choice to patients about the way in which they interact with their treating clinical team
- **Personalised follow up - patient initiated follow up (PIFU):** using PIFU to empower patients to manage their health with support from health services by providing new solutions for contacting health providers, as and when patients choose
- **Using remote monitoring (RM):** using remote monitoring of investigations to reduce low value follow up appointments and ensuring that patients only remain in secondary care follow up when such supervision is essential
- **Expanding one-stop outpatient services:** to enable a larger cohort of urology outpatients to undergo clinical assessment, investigations and management-planning in a single visit to the outpatient department

These five elements help to strengthen opportunities for shared decision-making and patient empowerment, whilst minimising unnecessary and inefficient outpatient activity.

4. Urological outpatient transformation delivery

This section of the guide provides detailed consideration of the key areas for quality improvement in developing outpatient services. Each of the transformation topics is linked to a specific set of supporting materials, including case studies, which will provide practical assistance to those who are undertaking quality improvement work on their own outpatient service.

4A Developing a specialist advice service

Good practice points:

- **Optimise stakeholder engagement**
- **Ensure capacity for appropriate response times**
- **Provide clear and consistent guidance to primary care clinicians**
- **Define pathway entry points**
- **Communicate to raise awareness and understanding**
- **Provide multiple communication channels between primary care and the specialist urology team**

About specialist advice

Specialist advice (often known as advice and guidance) is an application that sits within a range of platforms, of which the NHS national eReferral system is the most widely used. Specialist advice exists to support dialogue about individual patients between primary and secondary care providers. These systems can be utilised both to support pre-referral dialogue (sometimes referred to as pre-referral triage), and to allow clinical advice to be obtained by primary care clinicians from specialists in secondary care.

The utilisation of specialty advice by urology services remains highly variable across England. However, what has become clear during the 2020/21 COVID pandemic is that care systems which have adopted the use of specialty advice, in particular for pre-referral dialogue, have demonstrated greater resilience; with a number having emerged with no outpatient backlog of new patients awaiting first appointments.

A primary care clinician (or designated administrator) uploads a clinical request on the referral system, which is assigned to a specific urology department (see illustration of a screenshot of an eReferral page). The request appears in real time on a worklist which is accessed by the urology team and responded to in one of the following ways:

- The provision of appropriate advice
- A recommendation that a formal referral is made
- A request for additional clinical information
- Conversion of the request for advice to a referral for outpatient assessment

Benefits of specialist advice

The benefits of an effective specialty advice service, in whichever form it is used, should be to:

- Ensure patients can receive as much care as possible in a community setting
- Reduce unnecessary outpatient/ hospital visits for patients
- Ensure outpatient/ diagnostic attendances add real value to the investigation and treatment of the patients' conditions
- Improve patient access (via primary care providers) to specialist advice
- Provide advice on treatment whilst the patient is waiting to be seen
- Ensure that patients access the correct provider and service for their needs, at the correct point in the investigation and treatment pathway
- Minimise rejection and re-direction of referrals

Image 1: screenshot from eReferral page. Further information on using the system is available [online](#).

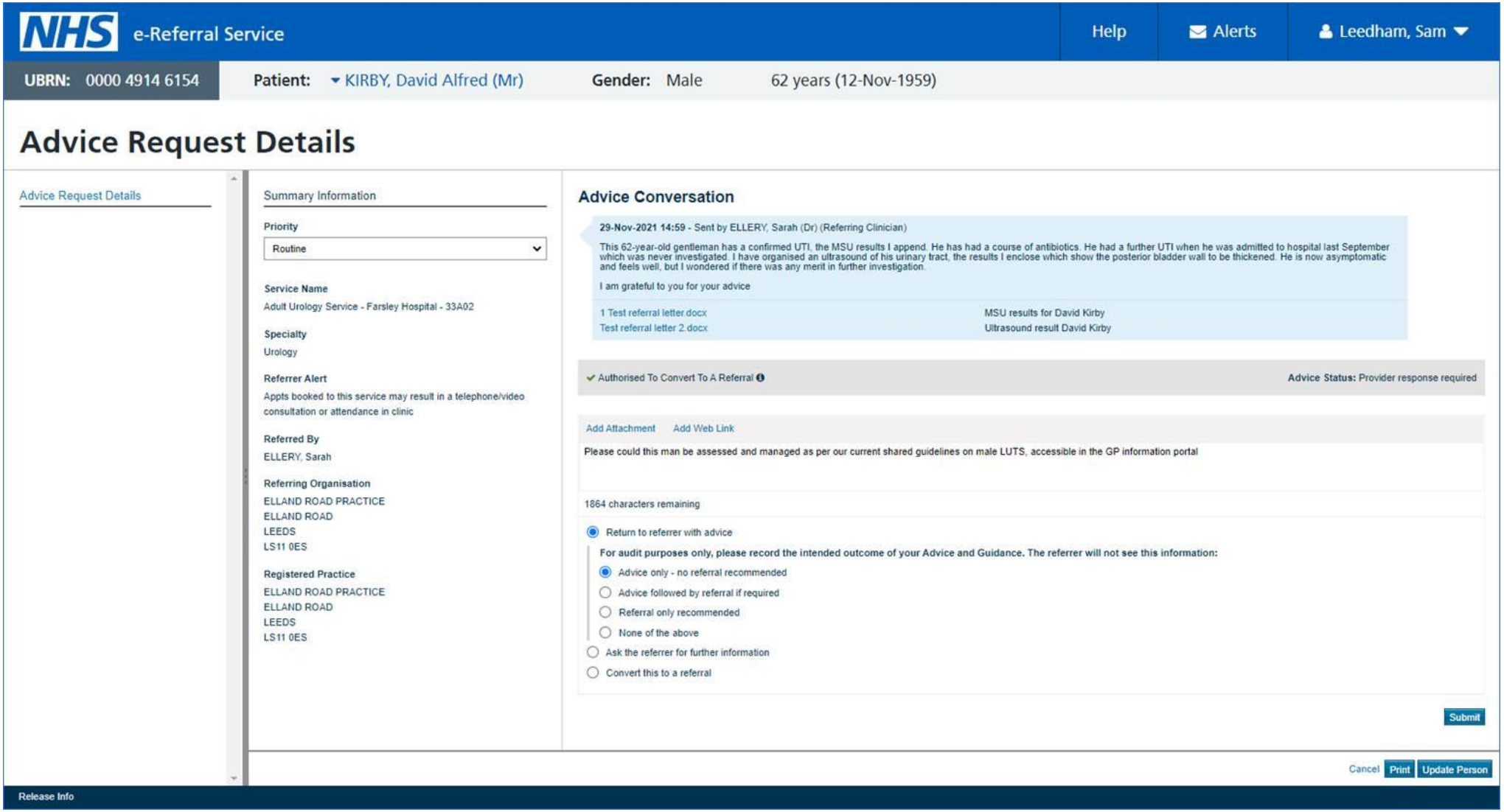


Table 1: Overview of specialist advice: advantages and disadvantages to patients, primary care and specialist services

Advantages to patients	Advantages to primary care	Advantages to specialist services
Rapid access to specialist advice	Rapid access to specialist advice	Reduced requirement for new patient OPD capacity
Shorter waits for first outpatient department (OPD) consultation	Fewer repeat attendances in primary care by patients awaiting first OPD attendance	Shorter waits for first OPD consultation, improving operational performance
More care provided closer to home and/or in the community Avoidance of unnecessary OPD appointments that provide little added value	Clear understanding of when specialist review is required Education resource which may guide management of future patients with similar conditions	Ability to template clinics to provide more time for complex patients Ability to easily triage patients to correct clinics
Access to straight-to-test diagnostics Reduced number of OPD visits to achieve diagnosis and treatment plan	Reduced risk of rejection or redirection of a subsequent referral	Only patients that require the service are seen by specialists
Patients do not book an appointment that may subsequently be rejected or re-directed to another service		
Disadvantages to patients	**Disadvantages to primary care**	**Disadvantages to specialist services**
None	Perception of increased workload being 'pushed' back into primary care. (This should be offset by reduced patient visits awaiting first OPD).	Increased workload of managing / responding to specialty advice requests. (This should be offset by reduced requirement for OPD capacity).

Specialist advice delivery considerations

The first step to establish a specialist advice service is early involvement of all key stakeholders. Initial discussions between stakeholders should be based on the premise that the proposal is not about referral management but, rather, dialogue aimed at improving patient care, with benefits to all stakeholders.

Specialist advice should be considered as a move away from relatively uninformed patient referrals from primary to secondary care, to a more considered appraisal of the most suitable next steps for a patient, based on discussion between the primary care clinician and urology specialists.

Key stakeholders summary	
Initially involve	Subsequently involve
Primary care clinicians (GP's and nursing)	Pharmacists / system formulary committee members (prescribing guidelines will need agreement)
Secondary care clinicians (consultants and nursing)	Outpatient booking staff
Business management teams (primary and secondary care)	Radiology
Commissioners	Pathology
	Other community providers (e.g. continence services, community nursing, physiotherapy etc.)
	Independent sector providers of NHS urology services

Ensure capacity for appropriate response times

To meet the aims of a specialist advice service, outlined above, it is essential that requests for advice are responded to in a timely manner. The recommendation is that >90% should be answered within 2 working days. To achieve this, providers of specialist services must ensure that the required clinician time is made available through job planning. This time must be considered as direct clinical care (DCC).

To ensure a high-quality service, it is essential that the specialist advice service is adequately resourced. There are currently a range of different reimbursement models focused on time blocks or number of requests responded to. The advisor role can be undertaken by appropriately trained individuals from different clinical disciplines (e.g. doctor, specialist nurse, advanced nurse practitioner), which would be determined by the structure and staffing of individual departments.

Provide clear and consistent guidance

It is essential that primary care clinicians understand how best to use an advice service, and in which clinical situations guidance should be sought from specialist providers.

Providers of specialist advice services should provide consistent clinical information and guidance in response to advice requests. A cornerstone to achieving this is developing system-wide guidelines and pathways for common conditions. Agreed guidelines, such as the examples provided below, allow specialist providers to signpost primary care clinicians to this existing guidance, improving response efficiency and avoiding the need to write extensive responses to common queries.

- South and West Devon formulary and referral: Urology Male Lower Urinary Tract Symptoms
- Portsmouth Hospitals NHS Trust guidelines: Chronic testicular pain pathway

Define pathway entry points

For the implementation of a specialist advice service to achieve maximal benefits for patients and system providers, there must be clearly defined entry points to the service as a whole (e.g. one-stop clinics, straight-to-test, virtual clinics, nurse-led services, specialist clinics). This will enable the outcome of pre-referral dialogue to result in patients entering specialist services at a point that offers the highest chance of meeting their needs, in the fewest number of visits.

Prior to roll out of a specialist advice service, extensive communication is required to all areas of the system. This will ensure a smooth transition from the existing service configuration. Communication will likely require initial reinforcement, focused on any system partners who are struggling to adopt the new service configuration.

Provide multiple communication channels

A system setting up a specialist advice service is strongly encouraged to consider providing alternative direct means of electronic communication between primary care and specialist providers. The experience of established services is that without such means, a significant number of non-clinical requests will come via the specialist advice system (e.g. expedite appointment requests, waiting list queries etc.) which do not require clinician input and can be managed by departmental administrative staff.

University Hospitals Plymouth has observed a 30% reduction year on year in the number of patients needing an outpatient appointment since specialty advice was introduced in 2016. At Portsmouth Hospitals University NHS Trust, when pre-referral triage/specialty advice was launched in 2020, there was a reduction in patients requiring a new patient consultation of around 30%. 62% of contacts resulted in advice only, with only 38% converting from a GP contact to an appointment. The wait for a new patient appointment is now typically <10 days and has remained consistently below 4 weeks for the last 12 months, which is attributed to specialty advice.

Read our case study on specialist advice

4B Optimising the use of remote consultation clinics

Good practice points:

- **Consider patient suitability**
- **Ensure patient choice and secure patient consent if a remote consultation is agreed**
- **Ensure an appropriate clinic template is in place**
- **Embed a fully digitalised service with up-to-date hardware and software**
- **Review workforce deployment to deliver the best experience for patients and clinical teams**
- **Manage patient experience throughout the process of arranging, conducting and following up a remote consultation**

About remote consultations

A remote consultation provides contact between clinical teams and patients without face-to-face consultation. There are a number of approaches:

- Telephone communication
- Video consultation
- Postal or e-mail contact, where notes and results are reviewed and a letter sent to the patient, providing a management plan and an option to contact the urology team if necessary.

Benefits of remote consultations

The COVID-19 pandemic has been a catalyst for the expansion of remote consultations in urology with successful minimisation of footfall in hospitals and use of public transport. Published evidence suggests that a large number of outpatient consultations in urology can be conducted by telephone or video without compromising the quality of clinical care.

- *Patient Benefits:* Virtual clinics increase patient convenience and reduce the amount of time spent on travelling and in waiting rooms. Family members can provide support either in the person's home or by a conference call link. Patient surveys have shown high levels of patient satisfaction with virtual clinics.
- *Clinical benefits:* Efficient use of remote consultations releases time for urologists to spend longer with patients who have complex problems. Remote consultation clinics and combined remote/face-to-face clinics are more likely to run to time and prove less stressful than traditional clinics. Reductions in 'did not attend' (DNA) rates have been seen. NHS England has calculated that using remote consultations where appropriate could decrease DNA rates by 1.5% on average, saving 120,000 appointments per year.
- *Environmental benefits:* The NHS accounts for 5% of all road transport emissions in the UK. The virtual clinic model reduces the amount of travel by patients and therefore has environmental benefits.

Virtual clinic delivery considerations

Consider patient suitability

The decision on whether an appointment will take place remotely should always be clinically led and based on individual care needs and preferences, for example, a patient's ability to use the required technology. Virtual clinics are unsuitable for consultations that require a clinical examination or a procedure to be performed and implementation will therefore vary by sub-specialty. For this reason, we do not recommend a specific target for the percentage of consultations to be virtual. Examples of clinical activity that lends itself to the digital setting include:

- A remote consultation may be a useful step to ensure pre-investigation has taken place prior to a one-stop clinic e.g. the RAPID diagnostic pathway for prostate cancer
- Consent for surgery can be performed virtually using systems, such as Concentric, that facilitate provision of electronic procedure-specific information and allow patients to consent electronically from home once they have absorbed the necessary information
- Potentially suitable conditions for virtual clinics in urology would include:
    - Urinary stone disease
    - Recurrent urinary tract infections
    - Female lower urinary tract symptoms, if the GP assessed for prolapse prior to referral
    - Bladder pain syndrome.

Ensure patient choice and secure patient consent if a remote consultation is agreed

Patients should be given choice as to whether they would prefer to have a telephone, video or face-to-face appointment. Clinicians must obtain implied or explicit consent from the patient for their remote consultation to take place. The provision of sufficient, accurate information is an essential part of seeking consent and must therefore be possible in the remote consultation format. This information can be given to the patient before their appointment or as they are joining the remote consultation, for example via the provider's website.

Ensure an appropriate clinic template is in place

Remote consultations require the use of a clinic template with bookable slots. Patients expect to have the virtual consultation conducted on time. Remote consultation appointment slots and face-to-face clinic slots can be managed within the same clinic template. This allows flexibility if patients need to or wish to attend face-to-face at short notice. A mix of remote consultations with face-to-face consultations reduces crowding in waiting areas of outpatient departments, providing a better patient experience and enabling adequate social distancing to be maintained when required.

Embed a fully digitalised service with up-to-date hardware and software

Video appointments require provision of a suitable professional environment, whether that is at the clinician's home or a hospital setting. Dual screens should be available to allow clinicians to easily share content whilst maintaining eye contact with the patient and their family. If a clinician is working from home, they will need to have access to a quiet, private space in which to conduct their consultations. A standard trust screen background should be used to ensure the patient feels comfortable in the virtual environment, and to maintain privacy for the clinician.

Review workforce deployment to deliver the best experience for patients and clinical teams

Remote consultation clinics can be performed using the existing workforce. In order to aid smooth running of the clinic, it is essential that a receptionist is not only able to supervise face-to-face appointments but also to help any patient having difficulty signing into their remote consultation. Ultimately, a reduction in face-to-face visits will require a review of workforce requirements in outpatient areas. Clinical nurse specialists (CNSs) have been heavily involved in telephone consultations for many years. There are opportunities to review management of patients requiring post-operative advice, results and long-term care and to expand CNS activity in these areas. CNSs must ensure that their virtual clinics are timetabled and job planned. Telephone consultations must not be slotted in ad-hoc between other activity.

Manage patient experience throughout the process of arranging, conducting and following up a remote consultation

Making sure that patients being seen using a remote consultation know what to expect and are supported with technological issues, is a core component of a successful virtual service which delivers high levels of patient satisfaction. There is a growing body of specific guidance and information, which is included in the additional links section of this document.

> ***"It was nice to be able to stay in my own home and receive excellent care via video."***
> *Patient feedback on a remote consultation.*

Some potential considerations for managing patient experience include:

- Administrators should call the patient to arrange the appointment slot (older or vulnerable patients may need assistance). Some patients, carers and family may require more reassurance and guidance; additional time and resource may be required for this process
- Ask the patient if they would like a family member or friend to join them during the consultation and specify that they do not need to be in the same physical location as the patient
- Share appropriate patient information in advance of the appointment
- Issue electronic questionnaires to gain a better understanding of the patient's condition prior to the appointment in order to allow for a more focused discussion during the consultation
- During the consultation, verbally explain key information about the consultation process, check that the technology is working, and ensure that the patient is aware of who is on the call and what is planned for the session
- Ask patients how they would like to receive news of their results prior to the appointment. This will ensure that each individual patient can decide whether they would prefer to receive potentially difficult news face-to-face or via a remote consultation
- There should be consideration by trusts regarding patient requests to record remote consultations

Read our case study on remote consultation clinics

4C Using patient initiated follow up (PIFU)

Good practice points:

- **Ensure that PIFU is an appropriate option for the patient, taking into account their personal circumstances**
- **Optimise patient communications**
- **Standardise the approach to delivering PIFU for all patients**

About PIFU

Delivery of patient initiated follow up (PIFU) is part of the outpatients transformation requirements set out in the 2021/22 NHS Operational Planning Guidance, and is a key part of the NHS' response to the COVID-19 pandemic, helping providers and systems manage waiting lists and to see the patients with the greatest need more quickly. PIFU is an important tool to support the reduction of face-to-face outpatient visits, an ambition of the NHS Long Term Plan. COVID-19 has accelerated this and has resulted in a re-think of how to run urology services more efficiently, reducing risk to the patient and informing the re-evaluation of outpatient clinic appointments.

PIFU is used when a patient (or their carer) can initiate their follow-up appointment as and when required. Rather than being given a date for a further appointment, the patient will be offered time-limited, direct access to the department if they have a new symptom or a change in symptoms.

The personalised care agenda focuses on the broad concept of patients' care being based on individual needs rather than past precedents. PIFU is one of the options that should be available for appropriate patients as part of a tailored care package. Follow up visits should be for the benefit of the patient rather than due to an, often arbitrary, hospital designed timeline. Personalised stratified follow up (PSFU) is another term that relates to ensuring personalised follow up for cancer patients and is seen as part of the PIFU pathway, allowing cancer patients to follow up on any symptoms they are concerned about. These cancer pathways are best incorporated into a clinically triggered cancer surveillance pathway so combining patient initiation due to symptom change with clinical triggered contact due to an abnormal test result.

PIFU is not a new concept and encompasses a range of familiar terms including, open access follow-up, patient led follow-up, patient triggered follow-up, patient-initiated appointments, supported self-managed follow-up, self-managed follow-up, see on symptoms (SOS), open appointments, open self-referral appointments or patient-activated care.

Benefits of PIFU

PIFU provides patient-centred, personalised care which is flexible and empowers patients to access healthcare as and when it is needed. It avoids unnecessary, routine, low value 'check-in' appointments, saving the NHS and patients time and resource. Clinicians can target their time on patients with active problems and waiting list control will benefit from the reduction in unnecessary follow up appointments. PIFU can be used both for consultant and specialist nurse-led clinics, and across the full range of urological conditions. Experience has shown that appropriate patients are happy to be moved to a PIFU pathway and see the benefits of empowerment in relation to their care.

Once again, the reduction in outpatient attendances will have a positive environmental impact.

PIFU delivery considerations

Ensure that PIFU is an appropriate option for the patient

PIFU could be appropriate in the following urology-specific scenarios:

- Open appointments where a patient is discharged at the end of a specified period if the patient has not made contact with the hospital. Examples might include recurrent or complex urinary tract infections (UTI) and post-bladder outlet obstruction (BOO) surgery
- PIFU, where a patient is contacted by the hospital after a defined time period to assess whether it makes sense for them to be discharged or remain on a PIFU pathway, if they have not already been in touch with the hospital. This would be suitable for BPS/IC patients and intermittent self-catheterisation patients
- In a clinically triggered follow up, where a patient has the ability to contact the clinic because of a change in symptoms but is also referred back into the service following an abnormality in a diagnostic test. This is typically used for cancer patients

Optimise patient communications

For PIFU to be successful, communication with the patient must be clear and informative. Key principles for laying strong foundations for successful PIFU include:

- Joint agreement between patient and clinician that PIFU is suitable
- Clear patient information provided to include:
    - The symptoms/concerns that suggest contact with the specialist team would be required
    - Details on how to contact the department, including a designated telephone/email contact with a clinician, usually a specialist nurse
- Review of the patient's follow up appointment request with a view to providing either reassurance, a follow up appointment (preferably remote rather than face-to-face) or cessation of the pathway
- If a patient opts for PIFU, they have the option to opt out of PIFU at any time during their pathway

Standardise the approach to delivering PIFU for all patients

A clear standard operating procedure for the PIFU pathway for all parties (patients, clinicians and the administration team) should be agreed to ensure consistent standard of care. NHS England has developed a PIFU Standard Operating Procedure (SOP) template, which is helpful to ensure that PIFU access criteria are clear and well understood. This will ensure that PIFU is reserved for appropriate patients and not used by those who are better managed in primary care, or more actively through specialist care.

There is no nationally defined limit to when a clinician should contact a patient to extend a PIFU pathway or discharge the patient. Instead, the time period should be decided by the clinician in consultation with the patient, with consideration of the patient's condition. For example, you may wish to contact a patient with painful bladder syndrome at 12 months but may choose to contact a patient with stones at two years, if there has been no patient-initiated contact in the interim.

Read our case study on PIFU and see example process charts for open appointments and PIFU

4D Minimising follow up appointments using remote monitoring

Good practice points:

- **Following discussion with the patient, ensure that remote monitoring is an appropriate pathway, taking into account their personal circumstances**
- **Optimise the system for performing investigations, and accessing and reviewing results**
- **Create standard templates for communications with patients with flexibility to individualise information if necessary**

About remote monitoring

A further way to reduce face-to-face and remote consultations that follows the personalised stratified follow up approach, is to use investigation results to determine if and when an appointment is needed. NHS outpatient transformation programme guidance calls this approach 'remote monitoring'.

Remote monitoring (RM) involves the use of medical devices, applications, clinical investigation results or other forms of assessment to trigger contact with the patient in order to manage their condition. It is appropriate to use RM in circumstances where a symptom questionnaire or result of investigations will reliably detect significant changes in a patient's condition. The lack of a consultation, remote or face-to-face, means that subtle markers of concern could be missed. There is also a lack of the opportunity to offer information, advice or reassurance in person. Despite these limitations, there is the potential for RM to contribute to reducing pressure on consultation time, and to minimise the inconvenience that patients experience with the organisation of clinical consultations. RM avoids unnecessary, routine, low value 'check-in' appointments but differs from PIFU as the contact is clinically-triggered, rather than patient-initiated.

In urology, RM has been used, as recommended by NICE, for the follow up of patients with stable prostate cancer, although it would be applicable to a number of other conditions, such as renal cancer or Bosniak 2F cysts. Extending this approach, trials have been carried out which link RM with the use of online patient portals. These can be used by patients to check results, view patient information and upload test or questionnaire results.

Benefits of remote monitoring

Patients who are suitable for an RM approach will benefit from reductions in the anxiety, inconvenience and expense that can be associated with standard outpatient appointments. Clinicians' time is freed up from low healthcare value appointments and can be redirected to more productive clinical activity. At scale, RM can deliver wider health service benefits through freeing up outpatient estate and reducing the environmental impact of follow up work.

Remote monitoring delivery considerations

Ensuring RM is appropriate for the condition and the individual patient

Establishing a formal arrangement for RM requires some investment in time and resources. It is therefore appropriate to concentrate efforts on those conditions that are particularly suited to this approach:

- Conditions with relatively large numbers of patients suitable for RM follow up
- Conditions where investigation results provide reliable and sensitive indicators of changes that require further assessment

Not all patients are suitable for an RM approach. Those suitable for RM will have:

- A clear understanding of their condition and the role of RM
- Access to appropriate technology if an electronic system is integral to the RM model in use

It is recommended that the Trust RMS has clear standard operating procedures outlining which team members will have the responsibility:

- To minimise the risk of losing individuals
- To resolve issues regarding missed tests
- To not contact individuals who have died or moved out of area
- To contact newly registered individuals who qualify for monitoring
- To make clear what other healthcare professionals should do with an abnormal result in the absence of the responsible clinician

Generally, it is recommended that the RMS is:

- Easy to use and compatible with a trust's current IT system
- Secure and safe (regularly backed-up etc.)
- Accessible throughout a trust's IT system
- Able to record and distribute the metrics needed for comparison of other sites
- Easily adaptable to future changes in care
- Suitable for other living with cancer programmes in the trust
- Able to support a patient portal going forward

Optimising the RM system

Careful design of the RM system will be critical to its success. A system can run using existing trust IT systems or be set up as a stand-alone IT product. There are now several established RM NHS services for urological conditions which can be adapted for local use, so that there is no longer any need to design RM systems (RMS) from scratch. For example, documentation from the East Midlands Cancer Alliance contains the following criteria for RM in prostate cancer:

Create standard templates for communicating with patients with flexibility to individualise information

To maintain a patient-centred approach, it is important that information flowing back to patients can be tailored to their individual situation. Good practice also requires that patients retain the ability to contact the clinical team directly, in the event of changes in circumstances or questions arising.

Read our case study on remote monitoring

4E Expanding one-stop outpatient clinics

Good practice points:

- **Provide patient information to manage expectations prior to the clinic attendance**
- **Ensure that investigation slots are efficiently used**
- **Match patient and clinician numbers to ensure that backlogs do not develop during the clinic session**
- **Ensure that a full range of investigations can be carried out, so that a minimum number of patients fall onto a multi-stage pathway**
- **Provide time for detailed counselling of patients after tests have been performed, so that they are able fully to absorb the information that is being given to them, and meet high standards of practice with regard to shared decision-making and consent**

A one-stop outpatient service rolls what would traditionally have been several hospital attendances into a single, longer, visit. In urology, one-stop haematuria clinics are established in almost every trust, so that anyone with this symptom can be rapidly assessed and a diagnosis made. In addition, one-stop services are in use in some trusts for the assessment of men with suspected prostate cancer and for men with lower urinary tract symptoms. However, one-stop clinics for other conditions are not in widespread use. One reason for this is the risk that in-demand investigation appointments will be wasted if they turn out not to be required once a patient has undergone their initial clinical assessment.

For more established, larger urology departments, multi-condition one-stop clinics should be considered. Running a one-stop clinic for a large number of new outpatients, with a variety of conditions, is feasible because, with a large number of patients, demand for tests will average out and be reasonably well-matched to the needs of the attending patients. Flexibility is built in by having adaptability in place. For example, an ultrasonographer will be able to scan different uro-genital organs, depending on the case mix that is seen. These large, one-stop clinics are known as ‘mega-clinics’ and have been successfully established in both purpose-built outpatient facilities and in units with traditional outpatient estate. Small units or units with constraints on outpatient space may consider a one-stop model based on specific urological pathways such as one-stop LUTS.

Benefits of one-stop clinics

The primary advantage of one-stop clinics is their ability to provide the patient with a comprehensive assessment and diagnosis in one hospital attendance. Experience has shown that the majority of patients can receive appropriate reassurance and/or a management plan by the end of their attendance, with many being discharged from specialist care or being added to a waiting list for a procedure at that point.

Those units that have adopted the one-stop clinic approach report high levels of clinician satisfaction, with staff enjoying the ability to carry a clinical assessment to a conclusion. Departments also report reducing waiting times for outpatient appointments as the streamlining of care appears to be inherently efficient in the use of resources. The reduction in journeys to and from hospital has obvious environmental benefits.

One-stop clinic delivery considerations

Provide patient information to manage expectations prior to the clinic attendance

It is of fundamental importance that patients attending a one-stop clinic are fully informed about the one-stop process. They need to understand the tests that might be carried out and the length of time that they will be at the clinic.

There are numerous examples of patient information sheets for urology one-stop services. Some examples can be found in Section 6E of the additional resources section of this guide.

Ensure that investigation slots are efficiently used

One of the main obstructions to developing one-stop services has been the concern that there will be under-utilisation of the appointments for diagnostic tests that are designed into the clinic template. For single-condition clinics, this is less of an issue as investigation use is predictable. However, for multi-condition clinics it is important to monitor and adjust the availability of investigations in a way that maximises attainment of a one-stop pathway while minimising the time where investigation support is lying idle.

Match patient and clinician numbers to ensure that backlogs do not develop during the clinic session

For a one-stop service to run efficiently, timing of clinical assessments, investigations and final clinical reviews have to be aligned so that hold-ups in the pathway don't lead to a breakdown of patients' smooth transition through the clinic. Over-booking patients into one-stop services is disruptive in a way which is not seen with conventional outpatient clinics.

Ensure that a full range of investigations can be carried out, so that a minimum number of patients fall onto a multi-stage pathway

For multi-condition clinics, there will need to be a wide range of investigations available including, but not restricted to, flow rate assessment, residual urine checks, urinary tract and genital ultrasound, and flexible cystoscopy. With a large patient cohort being seen by a number of clinicians, the demand for investigations can be matched with test availability. However, there is also a need to build in flexibility, so that numbers of different investigations can be adapted by demand. For example, a specialist nurse might be able to carry out flow rate checks or flexible cystoscopies, depending on need.

Provide time for detailed counselling of patients after tests have been performed, so that they are able fully to absorb the information that is being given to them, and meet high-standards of practice with regard to shared decision-making and consent

There is a risk that in concentrating a clinical pathway into one visit, patients may be rushed in their deliberations about the different options for treatment that are available to them. It is incumbent on those designing clinic flows, and clinicians running the clinics, to ensure that sufficient time is set aside for careful counselling of patients. Additionally, patients will need to be able to review information at home and have ready access to the clinical team should additional information or discussion be needed.

5. Good practice case studies

5A Developing a specialty advice service

Implementing a specialist advice service

Portsmouth Hospitals University NHS Trust

Motivation and aims

Achieving a more responsive outpatient service:

- to meet the needs of our population in a timely way
- to avoid unnecessary clinic visits that provide little added value to patient
- to allow access to straight-to-test diagnostics

In 2019, patients being referred for non-2WW (two week wait) urology services were facing waits of over 18 weeks for a first outpatient appointment, leading to multiple negative impacts on patients and operational pressures on primary and secondary care services. The department was also encountering large numbers of patients in the wrong sub-specialty clinics. Specialist advice was in use for clinical queries, not pre-referral triage.

What was done

Portsmouth Hospitals University NHS Trust and the Portsmouth and South East Hampshire CCGs worked collectively to develop a shared specialty advice service, for a combined population of almost 700,000.

The teams developed shared guidelines and pathways for common urological conditions and agreed that, from January 2020, all clinical queries and referral/pre-referral dialogue (excluding 2WW and emergency referrals) would take place via the specialist advice system within the NHS eReferral service.

The specialty advice service is delivered by 9 consultants. This work is undertaken a week at a time by each consultant, as part of a consultant of the week on call model. During that week, consultants are free from usual elective commitments and are job planned daily (Monday-Friday) to undertake this specialist advice service work. The service allocates 3 PA's of DCC per week to manage the average of 340 advice requests received per month.

Successes and lessons learned

The implementation of this model resulted in:

- >90% response to requests within 48 hours
- 30% reduction in requirement for non-cancer new patient OPD clinic slot capacity
- A 38% conversion of specialty advice contacts into OPD appointments
- The wait for a new appointment reduced from >18 weeks to <14 days.
- A reduction in a standard clinic template from 16 to 14 patients, allowing clinicians more time for the remaining complex patient that require clinic review
- No backlog of patients awaiting OPD consultations post-winter 2020/21.

Key points of good practice

- Optimise stakeholder engagement from the outset
- Ensure clinician capacity for timely responses to be provided
- Provide clear and consistent advice
- Support the service with guidelines / pathways for common conditions
- Provide alternative means of electronic communication for non-clinical queries

5B Optimising the use of remote consultation clinics

Nurse-led telephone triage and its impact on achieving the prostate cancer best practice pathway

Royal Wolverhampton NHS Trust

Motivation and aims

Achieving a new faster diagnostic standard for prostate cancer by April 2020 requires a patient to receive a cancer diagnosis, or to have cancer ruled out, within 28 days of GP referral. Increasing numbers of men are being referred making it challenging to implement this best practice pathway.

As a proactive urology department, we decided to:

- Introduce a nurse led telephone triage service for referrals
- Refer straight to test with an mpMRI and biopsy if appropriate
- Evaluate if this delivered a faster pathway and improved patient experience

What was done

The urology advanced nurse practitioners (ANPs) were selected to undertake telephone triage for suspected prostate cancer patients, given their expert knowledge of prostate cancer and understanding of contraindications to standard investigations. The ANPs, with cancer managers and consultant cancer leads, met with the commissioners to assess how the best practice pathway could be delivered. A protocol, information leaflet and telephone triage document (to record the consultation) were developed.

Comparison was made between three referral pathways;

- telephone triage and straight-to-test,
- triage to outpatient appointment and
- referral to appointment as per standard pathway.

Telephone triage of patients as a new way of assessment was challenging as the ANP is used to performing holistic and advanced health assessment. Detailed patient history-taking could sometimes be difficult over the telephone; the clinical history is of critical importance when requesting MRI scans. Patients who required an interpreter or had capacity issues were not suitable for telephone triage and required a standard clinic appointment. The triage assessment document was invaluable as a trigger to obtain all of the relevant information. This was updated several times during the pilot period. Communication of the outcome of patient assessments used a new dedicated triage email account.

Successes

- 80% of patients were highly satisfied with their experience of telephone triage straight-to-test*
- The patient journey was expedited, with triage patients having their MRI requested at a median of three days from referral, compared to 11 days when attending a clinic appointment*
- An MRI was performed at a median of 15 days from referral for triage straight-to-test patients, compared to 22 days for those referred under the existing pathway*
- Triage and straight-to-test as appropriate, of all prostate referrals by the ANPs will continue as standard practice based on a PSA test and a negative MSU
- Nurse-led telephone triage of suspected prostate cancer referrals has been identified as innovative practice and shared within the West Midlands Cancer Alliance, on the FutureNHS collaboration platform and via an NHS England innovation mailout. This model has now been adopted by other hospitals
- The urology ANP's won the Nursing Times award in the cancer care category in recognition of the implementation of this best practice pathway

*Based on a patient satisfaction survey

Key points of good practice

- Engagement of relevant departments for implementation of a radiology tracker to expedite MRI appointments and the histopathology department to review their system for prompt pathology reporting
- Service demand requires an ANP's to cover one timetabled session 5 days a week and 2 sessions of face-to-face clinic appointments a week

5C Using patient initiated follow up

Urology Patient Initiated Follow Up

University Hospitals Plymouth NHS Trust

Motivation and aims

There was a need to develop patient initiated follow up pathways. This was in response to the NHS Long Term Plan ambition to reduce face-to-face outpatients by a third, to reduce travel, enable shared decision-making and to mitigate risk from backlogs. In addition, staffing constraints meant that continuing to work in the same way was no longer sustainable.

The aim was to implement patient initiated follow up (PIFU) pathways to specific urological conditions.

What was done

Working with the nurse specialist, two PIFU pathways were established: patient initiated contact and open appointments. Patients are identified as appropriate for PIFU at their consultation, at which point a discussion takes place ensuring a shared decision is taken about PIFU. The patient is given the relevant information, informing when to call, and answering frequently asked questions. The patients are allocated a timescale, within which they are able to call for advice and where appropriate book an appointment. Where no contact is made, dependant on the pathway, the patient is either discharged or clinically reviewed to agree next steps.

Successes and lessons learned

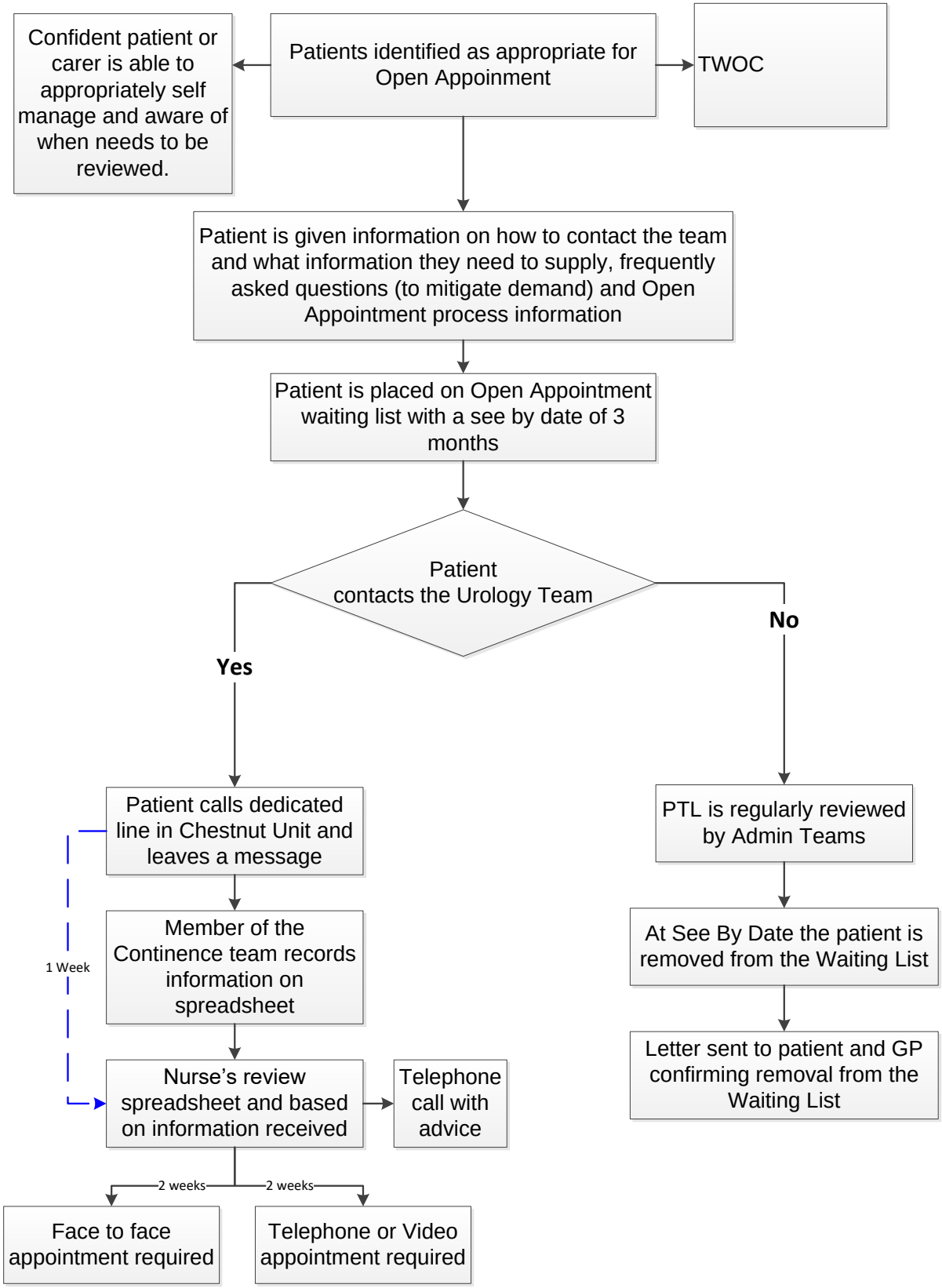
- PIFU pathway is an option in urology. These two pathways show there may be further areas that can be considered for this patient focused management
- Patient information needs to be clear and concise
- Urology teams need a shared understanding of PIFU and the urology specific criteria for putting patients on a PIFU pathway

Key points of good practice

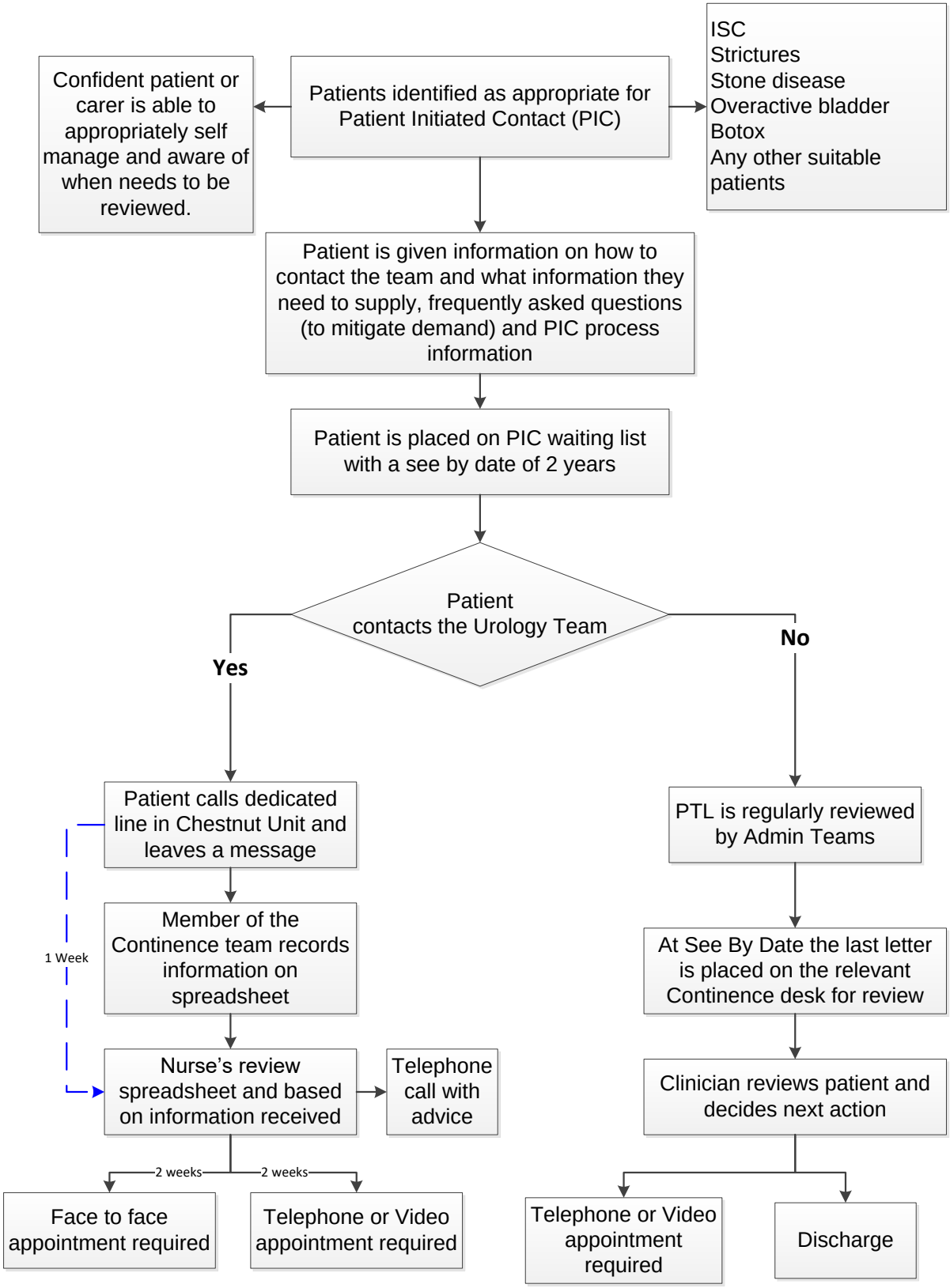
- Ensure that the pathway development is clinically identified and led
- Secure patient-centred change
- Provide clear, concise materials to support clinical understanding of PIFU

Please see the following pages for process maps on open appointment and patient-initiated contact pathways in urology.

Urology open appointment process:



Urology patient-initiated contact process:



5D Minimising follow up appointments using remote monitoring

Personalised stratified follow-up by remote monitoring with digital access for patients with stable cancer

Wirral University Teaching Hospital NHS Foundation Trust

Motivation and aims

The NHS cancer survivorship initiative recognised unmet needs among cancer patients, particularly at the end of their treatment. The NHS Long Term Plan stated that, by 2021, patients who have completed their cancer treatment will move to a 'follow-up pathway that suits their needs and ensures they can get rapid access to clinical support where they are worried that their cancer may have recurred' - which is referred to as personalised stratified follow-up (PSFU). We aimed to deliver PSFU for patients who had completed treatment using remote digital access. We offered this to patients with prostate and kidney cancer who had received successful surgical treatment and were considered to have stable cancer. We aim to extend this to other patient cohorts in the future.

What was done

A remote monitoring follow-up protocol for patients who had stable cancer was designed. After MDT discussion, an end of treatment summary was written, and patients were offered PSFU. Patients were invited to an educational event where they met the clinical nurse specialist (CNS), cancer care coordinator, community wellbeing project manager and Macmillan support manager. For men who had received a radical prostatectomy, this also included a physiotherapist and erectile dysfunction specialist. Small groups gave patients the freedom to speak and ask questions. During the COVID-19 pandemic, these sessions were delivered through MS teams. Patients were given access to their medical records via the 'HealtheLife' patient portal, where they could see their clinic letters and blood results in real time. There is also a messaging system between the patient and their cancer care coordinator. Discussions are in progress to provide access to radiology and pathology results as well.

Successes/ Lessons learned

The PSFU by remote monitoring with digital access has transformed the outpatient follow up for patients with stable cancer. We currently have 300 men with stable prostate cancer and 75 renal cancer patients on remote monitoring. The digital system gives an automated reminder about tests that are due, for example a PSA test or CT scan; and prints out the blood request form as well. This approach is patient-centric and environmentally friendly. It saves time and money for patients and the NHS. The outpatient capacity and consultant time saved by remote monitoring is being used for seeing new patients. It took some time for us to develop and incorporate into the existing electronic health record (Cerner, Millenium). We are hoping to extend this other cohorts of patients.

Key points of good practice

- Robust clinical follow up protocol tailored to risk-stratified cancers
- A comprehensive end of treatment summary is essential to develop a shared understanding of the planned care to patients, and the primary and secondary care teams
- A well-planned educational event to explain how remote monitoring works is crucial to develop understanding and buy-in
- Online access allows fast, reliable communication and avoids patient anxiety about waiting for results
- An online messaging service allows ready access for patients to health care professionals
- A dedicated cancer care coordinator is essential for the success of the approach

5E Expanding one-stop outpatient clinics

Male LUTS one-stop outpatient clinic
Imperial College London NHS Trust

Motivation and aims

Lower urinary tract symptoms (LUTS) are a substantial reason for referrals to the urology clinics across the UK. This places significant pressure on overstretched resources. In the standard (old) pathway at our university hospital, patients waited for 20 weeks for a new appointment and 55 weeks for a follow up appointment. Enabling definitive management plans on the same day of the first visit through designing a one-stop LUTS clinic can reduce this 35-week gap.

What was done

As one of Imperial's Flow Coaching Academy quality improvement projects, we introduced a new one-stop male LUTS clinic following a successful pilot.

This new one-stop clinic comprised consultations before and after the required diagnostic tests (flow rate, post-voiding bladder scan, flexible cystoscopies and transrectal ultrasound) on the same day.

This resulted in a definitive management decisions being made on the same day in a greater number of patients.

Successes/ key points of good practice

- The one-stop model reduced the follow up appointments from 60% in the old pathway to 5% in the new pathway
- The one-stop model increased the number of patients offered surgical management at their first appointment from 10% (old) to 57% (one-stop)
- There was also an increase in the clinical discharges (from 25% to 32%) at their first consultation
- Patient decisions aids (PDAs) were developed to assist patients in reaching a decision on the most suitable treatment option for their condition

Lessons learned

- Employing a one-stop clinic model for LUTS patients can reduce the patient pathway by 35 weeks, while providing more consistent and higher quality care and reducing variability
- Definitive plans regarding surgical management or discharge are made at the first visit, due to the availability of all investigations
- Patient reported satisfaction surveys were positive (98% preferred the one-stop model and 100% were satisfied or extremely satisfied)

6. Additional information

6A Introduction

Recommended document	Author	Overview
NHS Long Term Plan	NHS England and Improvement	The NHS Long Term Plan stated in its first chapter that outpatient services would be fundamentally redesigned.
NHS 2021/22 Operational Planning Guidance	NHS England and Improvement	The NHS operational planning and contracting guidance 2021/22 highlights embedding outpatient transformation in order to recover elective activity

6B Benefits of outpatient transformation

Recommended document	Author	Overview
Delivering a 'Net Zero' National Health Service	NHS England	A report by then Chief Executive Simon Stevens setting out the campaign *For a Greener NHS* and an evidence-based, quantified path to a net zero NHS. Published October 2020.
Sustainability toolkit	Pete Waddingham, Programme Manager at Yorkshire & Humber AHSN	Toolkit for providers to assess high-level environmental impact.
Integration and innovation: working together to improve health and social care for all	Department of Health & Social Care	Government white paper setting out legislative proposals for the Health and Care Bill. Updated 11 February 2021.
The Doctor will Zoom You Now	National Voices, Healthwatch, Traverse	Insight report on getting the most out of the virtual health and care experience, key findings from research June-July 2020.

6B Developing a specialty advice service

Recommended document	Author	Overview
Referral optimisation implementation guidance (to be published early 2022)	NHS England	Information on referral optimisation
FAQs for specialty advice	NHS England	Questions and answers related to specialty advice
Instructions and information on advice and guidance in the e-Referral system	NHS Digital	Toolkit for the NHS e-Referral service, including screenshots and instructions for referrers, consultants and provider clinical teams

6C Optimising the use of remote consultations

Recommended document	Author	Overview
Remote consultation clinics guidance (to be published early 2022)	NHS England	High level guide on remote consultation clinics.
BAUS virtual clinic good practice videos	BAUS	Available in members' section of the BAUS website – videos providing clear advice on how best to set up and run your remote consultation clinic.
Patient information about video consultations	BAUS	Information, including a video, to share with patients to inform them of what to expect before, during and after their consultation.
Universal Personalised Care: Implementing the comprehensive model	NHS England	Delivery plan for the model of personalised care set out in the NHS Long Term Plan. PIFU is one of the options that should be available for appropriate patients as part of a tailored care package.
Video consultations in Secondary Care	Edge Health for NHS England and Improvement	A report published in September 2021 by Edge Health, for NHS England and Improvement, highlighting a growing and largely positive evidence base around the use of video consulting in the NHS.
Video consultation information for NHS Trusts and Foundation Trusts	University of Oxford, Trish Greenhalgh, Sara Shaw, Lucas Seuren, Joseph Wherton	Advice document published in 2020 for NHS Trusts and Foundation Trusts introducing video consultations in response to COVID-19.

6D Using patient initiated follow up

Recommended document	Author	Overview
NHS outpatient transformation programme PIFU information	NHS England	High level information on PIFU from the NHS outpatient transformation programme
PIFU implementation guidance	NHS England	Implementation guidance for PIFU
PIFU frequently asked questions	NHS England	FAQs on PIFU
PIFU standard operating procedure	NHS England	Standard operating procedure template for PIFU

6E Minimising follow up appointments using remote monitoring

Recommended document	Author	Overview
PSA remote monitoring leaflet	University Hospitals of Leicester NHS Trust	PSA remote monitoring information sheet for patients
Supported self management for prostate cancer patients	Prostate Cancer UK	Prostate Cancer UK website description of Hillingdon Hospital use of PSA tracker within supported self-management for prostate cancer
Innovation to implementation: Stratified pathways of care for	NHS Improvement	A flexible resource package to support teams implementing stratified care

people living with or beyond cancer A 'how to guide'		pathways for those living with and beyond cancer. Contains detailed information about setting up remote monitoring with urology examples from Bristol & Bath, St Georges and Derby.
Remote PSA monitoring presentation	Royal United Hospitals Bath NHS Foundation Trust	Presentation on remote monitoring for prostate cancer patients

6F Expanding one-stop outpatient services

Recommended document	Author	Overview
One stop diagnostic clinic	Salford Royal NHS Foundation Trust	Urology one-stop clinic information sheet
Urology one stop clinic	Guy's and St Thomas' NHS Foundation Trust	Urology one-stop clinic information sheet
The urology one stop clinic	North Bristol NHS Trust	Urology one-stop clinic information sheet

7. Delivery checklist

Outpatient transformation component	Key points of good practice
6A Developing a specialty advice service	• Optimise stakeholder engagement • Ensure capacity for appropriate response times • Provide clear and consistent guidance to primary care clinicians • Define pathway entry points • Communicate to raise awareness and understanding • Provide multiple communication channels between primary care and the specialist urology team
6B Optimising the use of virtual clinics	• Consider patient suitability • Ensure patient choice and secure patient consent if a remote consultation is agreed • Ensure an appropriate clinic template is in place • Embed a fully digitalised service with up-to-date hardware and software • Review workforce deployment to deliver the best experience for patients and clinical teams • Manage patient experience throughout the process of arranging, conducting and following up a virtual clinic
6C Using patient initiated follow up (PIFU)	• Ensure that PIFU is an appropriate option for the patient, taking into account their personal circumstances • Optimise patient communications • Standardise the approach to delivering PIFU for all patients
6D Minimising follow up appointments using remote monitoring	• Following discussion with the patient, ensure that remote monitoring is an appropriate pathway, taking into account their personal circumstances • Optimise the system for performing investigations, and accessing and reviewing results • Create standard templates for communications with patients with flexibility to individualise information if necessary
6E Expanding one-stop outpatient clinics	• Provide patient information to manage expectations prior to the clinic attendance • Ensure that investigation slots are efficiently used • Match patient and clinician numbers to ensure that backlogs do not develop during the clinic session • Ensure that a full range of investigations can be carried out, so that a minimum number of patients fall onto a multi-stage pathway • Provide time for detailed counselling of patients after tests have been performed, so that they are able fully to absorb the information that is being given to them, and meet high-standards of practice with regard to shared decision-making and consent

8. Areas for further research

There are several areas where additional research could be focused to provide the most useful insight, in order of priority:

- Giving bad news by video or phone
- Quality assessment of patient satisfaction and shared decision making
- Benefits of PIFU pathway both from patient and from the provider perspective
- Research into the clinical value of follow up in a number of areas, including small, asymptomatic renal stones, LUTS, neurogenic lower urinary tract dysfunction, ileal conduits etc
- Environmental impact of outpatient activity and the impact of changing practice

Glossary

Organisations/groups

BADS	British Association of Day Surgery
BAUN	British Association of Urological Nurses
BAUS	British Association of Urological Surgeons
GIRFT	Getting It Right First Time programme

Acronyms

2WW	two-week wait
ANPs	advanced nurse practitioner
BOO	bladder outlet obstruction
BPS	bladder pain syndrome
CNS	clinical nurse specialist
DCC	direct clinical care
DNAs	did not attend rates
eReferral	the NHS electronic referral system
IC	interstitial cystitis
ISC	intermittent self catheterisation
LUTS	lower urinary tract symptoms
MSU	midstream specimen of urine
OPD	outpatient department
PAs	programmed activity – a block of time, usually equivalent to 4 hours, in which contractual duties are performed including direct clinical care (DCC) and supporting professional activities (SPAs)
PDA	patient decision aids
PIC	patient initiated contact

PIFU	patient initiated follow up
PSA	prostatic-specific antigen (blood test)
PSFU	personalised stratified follow up
RM, RMS	remote monitoring, remote monitoring system
SOP	Standard Operating Procedure
SOS	See on symptoms
TWOC	trial without catheter
UTI	Urinary Tract Infection

Contributors

Andrew Dickinson	Chair of GIRFT Academy outpatient transformation group and Consultant urologist at University Hospitals Plymouth NHS Trust
Jenny Akins	Urology Advanced Nurse Practitioner at Royal Wolverhampton NHS Trust
Stefan Anastasescu	Urology Advanced Nurse Practitioner at Kingston Hospital NHS Foundation Trust
Clare Bent	Consultant radiologist at University Hospitals Dorset NHS Foundation Trust
Daniel Burke	Consultant urologist and Clinical Director of urology at Manchester University NHS Foundation Trust
David Hrouda	Consultant urologist and Clinical Director for urology at Imperial College Healthcare NHS Trust
Victoria Lavin	Consultant urologist at Newcastle Upon Tyne Hospitals NHS Foundation Trust
Vicki Robinson	Specialty redesign lead at the National Outpatients Transformation Programme at NHS England & Improvement
Richard Robinson	Consultant urologist at Portsmouth Hospitals NHS Trust
Simon Williams	Consultant urologist at University Hospitals of Derby and Burton NHS Foundation Trust
Manraj Phull	Chief Sustainability Officers Clinical Fellow, NHS England and Improvement; Urology Registrar
Nick Watts	Chief Sustainability Officer, NHS England and Improvement
Kieran O'Flynn	GIRFT co-lead for Urology and consultant urologist at the Northern Care Alliance NHS Foundation Trust
John McGrath	GIRFT co-lead for Urology and consultant urologist at the Royal Devon and Exeter Foundation Trust
Simon Harrison	GIRFT co-lead for Urology and retired consultant urologist
Alice Fabre	GIRFT Academy urology series lead editor, Director at Pool Health