Setting up a One-stop Urology Clinic in London in 2014
-Challenges and Lessons learnt

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Liverpool
25th September 2014
July 2012
What Can a One Stop Clinic Achieve?

- Mean wait for new appointment dropped from 7 to 2 weeks for all referrals
- Mean wait for commonest investigations (ultrasound & cystoscopy) eradicated
- Mean wait for diagnosis dropped from 3.7 to 1.0 months (p=0.004)
- Median number hospital attendances dropped 50% to one visit (p<0.001)
- 33% discharged at first visit compared to 5.4% in old clinic (p<0.001)
What Can a One Stop Clinic Achieve?

- More patients **(76.3%) seen by consultant** in one stop compared to old clinic **(42.3%)** *(p<0.05)*
- More flexible cystoscopies **(92%)** performed by referring clinician in one stop compared to old clinic **(3.6%)** *(p<0.05)*
- **26% fewer letters** generated in one stop (equivalent to 1344 letters annually)
- **75% rated satisfaction >9/10**
- **76% who`d been to old clinic preferred one stop**
“We are seeking a urologist with an interest in diagnostic urology”

“the successful candidate will be expected to streamline diagnostic services and set up one stop clinics”
The Challenges of Setting up a One Stop Clinic

- Where to start!
- Getting supply and demand right
- Venue
- Diagnostic Equipment
- Staff
- Funding
- Meeting CCG needs
- Demonstrate Outcomes
The Challenges of Working in North London

- Centralisation of cancer services
- Staff working on multiple sites
- Barnet, Enfield and Haringey (BEH) clinical strategy
- Need to save money
- Merger with Royal Free
- New CCGs
- Competition from other providers
- Itinerant population & very diverse population
- Travelling & Traffic for patients… and staff
Where to Start!
What does a one-stop clinic need?
Set up a Steering Group

- Consultant lead
- Nursing Lead
- Manager
- Integration lead
- Radiology
- Invite others – e.g. decontamination

...meet regularly

...allocate time!
Where were we when I started?

- Large follow-up back-log – 5000+ patients
- Previous back-log project RFH discharged 1500 patients – single locum consultant – 18M
- New diagnostic clinics in place on RFH site
  - Coordinator
  - Pre-investigation
  - f/u cut
- Good process for haematuria diagnosis
  - CT slots agreed
Getting the Numbers right
The Backlog

- Why is it important

- Patients awaiting follow-up clogging up outpatient capacity for new and follow-up

- Adverse effect on current RTT

- very limited capacity for follow-up in one stop service

- Without specialist follow-up capacity one stop benefits negated
The Backlog

- Size of the problem
- Large number patients awaiting follow-up
The Back-log

- **Solution**
  - Discharge clinics – consultant delivered, focused – 1500 patients cleared in 18 months
  - Build additional short-term capacity – waiting list sessions, additional appointments
- Team effort
- Novel approach – virtual clinics, telephone clinics
- Educate staff (protocols, PILs etc) & limit follow-up!

....punch the bruise
Supply and Demand

- Number referrals
- Where from?
- Match appointments to referrals
- Plan for rise in demand
- Aim for slightly over predicted referrals

….we knew demand ↑ x 2 after diagnostic clinics
Venue
Venue - What does a one-stop clinic need?
Venue

- Central for patients
- Parking
- All required facilities
  - Waiting area
  - Rooms for 6 doctors
  - Room for ultrasound
  - Room for flexible cystoscopy
  - CT and other imaging
  - Flow rates, urine dip stick
Venue
Performing Flexible Cystoscopy in Outpatients?

- Flexible cystoscopy is a clean procedure – not sterile

- Considerations
  - Waiting area
  - Changing area
  - Toilet
  - Patient dignity
  - Infection control and decontamination

......Engage with **infection control** and **decontamination lead** from start
Performing Flexible Cystoscopy in Outpatients?

- Can flexible cystoscopy be performed in an un-modified outpatient room?
  - Many NHS units already do – others insist on “clean room”
  - National guidelines class flexible cystoscopy as a “minor procedure”
  - No need for clean room with specialised ventilation / air changes
  - “Natural ventilation” acceptable

….there is a best practice tariff for outpatient flexible cystoscopy
Performing Flexible Cystoscopy in Outpatients? 2012 Guidelines

Journal of Hospital Infection 80 (2012) 103–109

Available online at www.sciencedirect.com

Journal of Hospital Infection

journals homepage: www.elsevierhealth.com/journals/jhin

Guidelines

Guidelines on the facilities required for minor surgical procedures and minimal access interventions

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Performing Flexible Cystoscopy in Outpatients? 2012 Guidelines

- Definition Minor procedures:
  - Other endoscopy via natural orifices
  - e.g. cystoscopy and gastroscopy

- Recommended ventilation:
  - Natural ventilation
    - including the presence of opening windows but with a fly screen, is acceptable

......seek local advice from infection control & decontamination
Equipment
Flexible Cystoscopy Options

Choice Framework for local Policy and Procedures 01-06 – Decontamination of flexible endoscopes: Operational management
flexible cystoscopy options – conventional scopes & endoscopic washer disinfectors (EWD)
Options for flexible cystoscopy – Genesis Medical - Sterile Endo sheaths

**PROS**
- Prolongs life scope
- Shown to work in outpatients
- Only sterile system – disposable working channel
- No need to modify outpatients
- Less reliant on washers
- Highly mobile
- Fewer scopes required
- Cost effective
- Fully traceable
- Several million sold – no breach or cross contamination

**CONS**
- Novel and relatively un-proven technology
- Not accepted as standard practice
- Infection control argue fails to fulfil best practice guidelines frame work guidelines – however guidelines do provide for sheathed scopes
- Concerns around manual re-processing
- No national guidance supporting use
Options for flexible cystoscopy – other challenges

- Lock into PFI contract with scopes
- Acquisition by tertiary Trust has changed management structure
- Re-configuration of services has taken over day unit

…we still do not have flexible scopes in place 18 months later

…engage with management and infection control early!

…Clear National Guidelines on Outpatient Flexible cystoscopy arrangements would help
Diagnostic Imaging

- Buy in from radiology essential
- Invite radiology leads & managers to steering group – make sure you provide what they need and explain not extra scans
- Ideally link clinic directly to trust objectives to get board level approval to resource
- Decide if you are going to adapt clinic rooms for PACs or have patients walk around
- Carve out CT scanning and consider how will get bloods done
- Consider how to factor in prostate MRI
Staff
Staff

- One stop clinics are hard work and staff heavy – ideally 5-6 medical staff to see 40 new patients in half day clinic
- Critical mass of staff numbers to run a continuous service
- Strong clinical leadership & coordination for clinics to run
- Requires full commitment of entire cohesive department
- Requires training – flow rates, ultrasound assistance, flexible cystoscopy
- Requires motivation
Staff – Impact of NHS Merger & Centralisation

- When I started there were 9 consultants in Trust
  - 2 locums
  - 5 Part-time
  - Only 2 fulltime urology consultants in Trust
- Training in basic techniques such as urine flow and residual and collecting dip-sticks variable
- No dedicated urology out patients manager or regular urology clinic staff
- Merger has integrated with Royal Free so management arrangements and size of department changed
Staff

- Invite nursing leads to planning
- Agree who will commit to one-stop service and ensure the staff compliment is right to deliver a continuous service – if needed recruit
- Identify a nursing lead / coordinator to “champion” the clinic
- Ensure nurses trained for their role and “buy in” and are part of development
Funding
Funding

- Consider the profitability of the service from the outset
- Ensure the CCGs will fund it before full implementation
- Agree an appropriate Tariff for a new visit and associated tests
- Ensure other staff such as radiology are appropriately funded and job-planned to attend and provide a sustainable service
- Agree what budget services such as radiology come out of and involve managers from outset

...failure to work out money can mean good and efficient service looses money
Engage with the CCG
Meeting CCG Needs

- Engage from start – they fund it
- Ensure spec meets their requirements
- Link to primary care management & referral guidelines
- Consider if community setting required – in our area GCGs want to manage simple urology in primary care setting
- Engage with GPs to educate and promote clinic
- Ensure service meets targets for RTT and 2WW pathways
Demonstrate Outcomes

GREAT SUCCESS
Demonstrate Outcomes

- Before and after – show the difference
- Use standardised data capture
- E.g. consultation satisfaction, waiting times
- Link outcomes to Trust objectives and external standards
- Continually audit
Is “one stop” appropriate for every patient?
Is “one stop” appropriate for every patient?

- Some tests are too complex for one visit
- Some pathways need multiple visits – e.g. raised PSA requires several PSAs, MRI, biopsy, possible GA
- Some patients prefer time to think & reflect
- Time to think is important before big decisions
- Some patients enjoy multiple hospital trips
Conclusions & Lessons learned

- Set up planning group as first job – it is a team effort
- Involve all relevant Parties from outset
- Get team “buy in” from department
- Management support essential
- Link to Trust objectives
- Infection control big stumbling block – guidelines would help!
- Liaise with CCG – especially for tariff
- Ensure capacity and demand calculations correct
- Collect outcomes – before and after
- Deal with backlog and New-patient service
….Questions?