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The British Association of Urological Surgeons

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BRITISH ASSOCIATION of UROLOGICAL NURSES

Urology: A guide to Urological Investigation Units (UIU)

June 2023

GIRFT is part of an aligned set of programmes within NHS England.

Executive summary

Who should read this guide?

This document is aimed at clinicians who provide urological care, and managers who are responsible for providing or commissioning urological services.

What is the guide's aim?

The guide describes the key features of a Urological Investigation Unit (UIU) and will allow clinicians and managers to perform a 'stock-take' of their current service and what would be required to deliver a contemporary outpatient urological service. In particular, it describes the types of facilities that are needed, the array of services that can be provided and the workforce that is ideally suited to providing those services. Additionally, case studies and example business planning materials are included to facilitate the development and implementation of a UIU.

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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. The GIRFT Academy aims to identify good practice and provide guidance on service improvement, particularly focussing on common conditions and frequent interventions, thereby maximising impact.

The starting point in the quality-improvement process is the recognition that some aspects of care, including the delivery of care, are suboptimal. While this is apparent to some of those who are delivering services, the GIRFT methodology of data analysis and clinically-led conversations with front-line staff, which culminated in the publication of the National Specialty Report in 2018, definitively demonstrated that we can do better. The next step is to understand where we should be heading.

The GIRFT Academy developed this guide on the provision of Urological Investigation Units based on the GIRFT team's experience of how effective such units have been in delivering out-patient urological care. As discussed below, a vast majority of patients attending urology departments in England will not require in-patient surgery but will be managed in the outpatient setting either through consultations, diagnostic procedures or therapeutic interventions. By co-locating these services and the staffing expertise, there is greater scope for one-stop models of care, enabling an efficient throughput for diagnostic tests and an extended repertoire of therapeutic procedures. They also provide the ideal environment for professional development and training of the extended urological workforce, in particular the nursing workforce.

In visiting urology units around England as part of the second round of deep-dives, it was clear that service leads, service managers, executive leads and commissioners would value a document that clearly set out the specification of UIUs as well as detailing potential staffing models. It should be noted that UIUs can complement the national drive to extend the provision of Community Diagnostic Hubs, as highlighted in the Richard's Review, and there are examples in this guide where the UIU service is located in a community setting.

It is our ambition that improving the provision of UIUs across England will improve the delivery of patient care and, in turn, improve patient experience when receiving such care.

Melanie Walton, *Chair of GIRFT Academy UIU group. Consultant urologist at the Royal Devon University Hospitals NHS Foundation Trust*

John McGrath, *GIRFT co-lead for Urology and Consultant urologist at the Royal Devon University Hospitals NHS Foundation Trust*

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

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

1 Case for change

1.1 Introduction

As a specialty, urology is noted for increasingly delivering care to patients in the outpatient setting. This extends beyond clinic consultations and includes a broad repertoire of diagnostic tests and an ever-evolving range of therapeutic treatment options. It is currently estimated currently that around 10-12 of every 14 patients seen in urology have their care delivered in either an outpatient or an ambulatory setting. Only a minority of patients will need in-patient care, typically for intermediate or major surgical interventions.

The urology workforce has diversified into a broader multi-disciplinary team of professionals and there has been a marked increase in the role of specialist nurses, advanced practitioners and newer roles such as physician's associates.

Typically, outpatient clinics, endoscopy suites and procedure rooms have been located in separate areas of the hospitals and are often shared with other medical and surgical specialties. This can lead to constraints in access to the various facilities and is associated with a less flexible model in terms of coping with the usual peaks and troughs in demand for outpatient capacity. For patients, this can mean multiple attendances and the need to navigate different areas of the hospital. Locating facilities in separate areas also leads to a workforce that is spread across the hospital site and therefore less able to work in a team-based approach. This can in turn impair training opportunities for the workforce.

The GIRFT national report on urology, published in 2018, recommended that urology departments should seek to develop and establish dedicated Urological Investigation Units (UIU) in order to address many of the constraints noted above. In its simplest form, a Urological Investigation Unit is a dedicated facility where consulting rooms, procedure rooms and administration support are co-located, thereby allowing the multi-disciplinary team to work collectively in an efficient and flexible manner.

This document offers a detailed specification for a UIU and expands on the specific considerations that relate to its various elements - the facilities, the workforce and the clinical services.

1.2 Benefits of a Urological Investigation Unit

Urological services are increasingly shifting towards an outpatient setting and it is estimated that there are approximately 3 million outpatient consultations in urology taking place per annum in England. UIUs offer a more efficient way of working with potential to benefit patients, the healthcare organisation and the workforce. Furthermore, UIUs can support the NHS commitment to be 'net zero', and the reasons underpinning this are discussed below.

Co-locating staff and services in a dedicated facility makes it possible to increase the number of 'one-stop' pathways that the department can offer in high volume areas such as haematuria, lower urinary tract symptoms and low risk bladder cancer. This greatly reduces the need for patients to undertake multiple visits to the hospital and therefore reduces the travelling time and inconvenience for patients, even if the UIU is not in their local hospital.

The model also supports the current work to consider how existing treatments can be moved down the 'intensity gradient' – in the case of UIUs, by moving procedures that were conventionally done in a day case theatre into appropriately equipped procedure rooms. This includes procedures such as

local anaesthetic trans-perineal prostate biopsy, trans-urethral laser ablation, vasectomy and certain bladder outlet procedures.

In UIUs that are community-based, there is the opportunity to offer patients a consultation or procedure in a lower acuity setting and this appears to improve patient experience compared to attendances at an acute hospital site where services are more likely to be disparate.

By having administrative control over the various consulting and procedure rooms, the service can alter the room usage to meet the unpredictable surges in demand that occur in individual pathways. This mitigates against imbalances in access times for patients awaiting investigation or treatment due to the increased flexibility.

In relation to staff development, the UIU is an ideal setting in which to offer supervision and professional development for nursing and allied health practitioners, in keeping with the need to develop an expanded, multi-disciplinary workforce. Urology area networks (UANs) may want to consider an academy model, whereby they can offer experience and training to practitioners from around the UAN given the high volume of co-located work that takes place in a UIU. This can support smaller units where the ability to balance training with service delivery is more challenging.

There are also early indications that a UIU is a more attractive workplace for outpatient teams and can help to address recruitment issues. This could reflect the more team-based approach to clinical care as well as the positive feedback received from patients.

As a healthcare system, the NHS is committed to net zero by 2045 and there are many opportunities to support this ambition through UIU working. Examples include reducing the number of outpatient attendances and particularly repeat attendances, and offering local anaesthetic, non-admitted diagnostics or treatment pathways in preference to admitted or general anaesthesia pathways, where appropriate.

1.3 Planning and design questions

These short questions and associated commentary should help establish the fundamental ambitions, considerations and requirements for establishing a UIU. They are based on the experiences of existing UIUs and what would make a good starting point for the planning, design and opening of a UIU.

1

What is the UIU setting out to achieve?

- More efficient and streamlined approach to outpatient care and one-stop models of care.
- Improvements in performance measures such as RTT, cancer waiting time targets, admission avoidance, and avoiding unnecessary admitted pathways.
- Maximising training and wellbeing for an extended multi-disciplinary workforce.

2

What procedures and services will be offered?

- Pathways and services: one-stop haematuria clinics, assessing lower urinary tract symptoms, rapid assessment of men with suspected prostate cancer.
- Diagnostic tests: flexible cystoscopy, local anaesthetic trans-perineal prostate biopsy (LATP), urine flow testing and prostate volume assessment.
- Therapeutic treatments: intra-vesical administration of botulinum toxin, intra-vesical chemotherapy, trans-urethral laser ablation (TULA), extra-corporeal shockwave lithotripsy (ESWL) and erectile dysfunction clinics
- Other services: provision of bladder, bowel and stoma care as well as access to 'hot clinics'. (See section 'Services delivered in a UIU' on page 17)

3

What location will be used and what sites will be covered?

There are different models of provision of UIUs, ranging from those that are provided on acute sites to those that are 'standalone' in community hubs. This aspect is considered in greater detail in Section 2.1 and will depend on local availability of facilities / real estate. (See section 'Location' on page 7)

4

Who is in your project team?

It is important to have a project manager with a specific remit to develop the UIU. The project manager will identify other stakeholders to be involved – when necessary - in the planning stages. These stakeholders might include; Nursing staff, medical staff, HSDU, estates, finance, management and operations, supply chain, admin, histology, domestic services, IT, transport, resus team, switchboard, pharmacy, infection control, comms team.

5

Is the footprint and layout of the site sufficient for its ambitions?

Requirements include sufficient storage space to store equipment and adequate quantities of consumables. Ensuring a reliable stock level will mitigate global supply chain issues and prevent breaks in service. The space must provide for procedure rooms, and a post procedure recovery area for patients. For staff, an office / MDT room and break area is advised. Consider if the footprint is future-proofed for further expansion of the service. Storage requirements are frequently underestimated.

6

What workforce requirements will there be?

Consider the current workforce and how it needs to be adapted to meet the requirements of a UIU. Specifically, consider the opportunity to develop the specialist nurse workforce. (See section 'Workforce considerations' on page 13)

2 Location and structure of UIUs

2.1 Location

Key quality actions:

- Consider the pros and cons of on-site versus off-site location

There are several different models for UIUs, including units which are on the main Trust site, for example in converted wards, or units set up off-site in converted spaces, for example in a community hospital, or sometimes in purpose-built facilities.

The model chosen will depend on the availability of local real estate and capital investment, linked to what the ambition is for the UIU – in other words, what services will be provided and what role the UIU will play in the Urology Area Network, as well as the population to be covered and the spaces that are available and suitable.

There are advantages and disadvantages to the various UIU models, but a central tenet of either approach should be the cohorting of resources and services into a single location.

Table 1 Advantages and disadvantages to UIU location models

	On-site	Off-site
Advantages	• Avoids cross-site working for staff, who can combine flexibly with other duties, e.g. working in a clinic while covering on-call. • Support from other units and services on site, including borrowed or shared equipment, enables wider range of services. • Seamless access to investigations for in-patients. • Acutely unwell or deteriorating patients can access other on-site services.	• Can release capacity on the acute site. • More likely to be a dedicated facility with dedicated nursing support staff. • Improved staff morale if a team-based working environment is created. • As a 'cold' site, may avoid the disruptions that can occur when based on acute sites, for example due to winter pressures. • Lower acuity setting for patients which can improve patient experience. • Car parking may be more convenient for patients and staff.
Disadvantages	• Higher acuity setting for patients. • Less likely to be a dedicated, co-located space. • Competing interests with other specialties. • Nursing support staff may be circulated out of the department and skills / knowledge depleted. • Pressures from other aspects of the service, including acute care.	• May not have access to on-site services, including: decontamination of equipment, imaging, pharmacy, support managing deteriorating or more complex patients. • Requires cross-site working for staff. • Transport needs for equipment, samples to laboratory and other consumables.

2.2 Structure and space

Key quality actions:

- Establish a co-located space for consulting, diagnostic and therapeutic attendances.
- Ensure consultation rooms have the IT requirements for telephone and video consultations
- Plan for procedure rooms to be large enough to accommodate equipment for the range of procedures offered
- Plan necessary recovery areas and toilet access for specific procedures, e.g. BCG therapy

Many UIUs are established in existing outpatient facilities or repurposed wards. More recently, units are being established in purpose-built facilities following proof of concept that a majority of urological outpatient work can be delivered in stand-alone units. The number and types of rooms needed in a UIU will depend on catchment population, range of services that are planned as well as staffing. Capacity and demand modelling will allow individual services to predict their own requirements.

While this guide sets out ideal requirements for a UIU, urology units should not be deterred from initially taking a more incremental approach to the establishment of their UIU by utilising facilities that are currently available. This can happen parallel to progressing a case for a comprehensive UIU facility, which is future-proofed against the projected future clinical demand and the anticipated increase in services provided as the service transitions into the outpatient setting.

Administrative facilities, offices and staff areas

The UIU will need to have an appointed clinical manager (typically a senior nurse) supported by a service manager, with adequate facilities to undertake their role and meet with staff.

Facilities for administrative staff will need to be factored in to the UIU layout. In cases where space is limited, some management activities can be located elsewhere, but there is clear advantage to having core administrative staff present to support the scheduling and delivery of clinical activities on-site.

For clinical staff, office space is likely to be a combination of fixed desks for staff who are permanently based at the unit as well as ‘hot-desking’ facilities for clinicians who work at the UIU on a sessional basis during the working week.

In the interests of staff wellbeing, a staff room should be available where staff can take breaks. Showering and changing facilities will need to be provided on-site as well as laundered ‘scrubs’ for staff undertaking invasive procedures.

In the interests of sustainable transport plans, cycle storage and links to public transport should be encouraged.

Reception and waiting areas

Reception staff should be available to receive patients and to register them on the patient administration system. Ideally, this should feed through automatically to the clinic nurse or other clinician. Reception working hours must cover the full duration of clinical activities to allow for efficient working without disruption to clinical staff.

Waiting areas should be designed to ensure that there is access to water fountains and toilet facilities, given the nature of urological conditions that patients present with in urology and the tests they undergo. (See section below on recovery areas and toilet facilities). They should be large enough to accommodate patients and their relatives comfortably, as well as providing safe social-distancing should it be required.

When setting up a UIU, it is important to consider whether children will be seen at the UIU. In this case, a separate area or room appropriate for children should be provided. Alternatively, the UIU can run dedicated paediatric sessions where only children are seen.

Consulting rooms

Consulting rooms should offer sufficient space for the maximum attendance of a clinician, nurse, patient and a relative, and a trainee, alongside necessary equipment. National guidance can be followed in terms of room layout and equipment.

UIUs may wish to incorporate dedicated consulting rooms that are used for video or telephone consultations, in which case it is necessary to have the appropriate AV and IT facilities. Patient confidentiality must be ensured when staff are undertaking telephone or video consultations.

There should be adequate provision for more sensitive conversations, such as CNS support in the context of a new cancer diagnosis and the provision of holistic needs. Wherever possible, this should be a dedicated space to avoid interruptions or instances where there is no appropriate area for these important conversations.

It is worth considering that consulting rooms may serve multiple functions and consider in advance any additional needs this will present. For example, if a room may be used for local anaesthetic trans-perineal biopsies, the doors will need to be wide enough for the equipment to be brought in. Likewise, a room that will be used for TULA will need laser protection measures. In case of resuscitation scenarios, there must be sufficient space to accommodate the emergency team, resus equipment and trolley for transfer.

Procedure rooms

A UIU should be utilising procedure rooms rather than operating theatres on the whole. This sets patients' expectations about their recovery and can prevent problems with specification in terms of room size, ventilation requirements and staffing requirements. Procedure trolleys need to have a head down tilt function, therefore clinic room couches are not appropriate for procedures.

Procedure rooms should have a clean area and dirty area for equipment. It is normally preferable to have a central store for equipment for all procedure rooms rather than storage areas in each room, with procedure trolleys restocked daily from the central store.

As with consultation rooms, the size of procedure rooms will depend on the equipment used and local plans for the types of procedure undertaken. If X-rays are to be done in a procedure room (for example, extra-corporeal shockwave lithotripsy - ESWL), the walls should be lead-lined. This is more

straightforward to build in at the start than to retrofit. Likewise, one of the rooms should be made laser-safe for trans-urethral laser ablation of bladder tumours (TULA).

It can be helpful to plan to cohort patients who require longer to recover, for example after a prostate biopsy, so that procedure lists can continue without delay.

Recovery areas and toilet facilities

Reclining chairs are ideal for recovering patients post-procedure and are preferred to beds in terms of aiding earlier recovery. Reclining chairs can be placed in a bay with curtains, with one trolley available for use when necessary.

The UIU must provide sufficient toilet facilities for the number of patients waiting, being seen or recovering after treatment. Access to toilets is particularly important for patients attending for cystoscopy as they are likely to need to void post-procedure. Likewise, patients undergoing investigations, such as a flow test, or having a trial without catheter (TWOC) will need easy access to toilet facilities.

An additional toilet should be available exclusively for use of patients undergoing intra-vesical BCG therapy, not to be used by other patients. On days when BCG is not administered, this toilet can be cleaned in line with infection control guidelines to allow use by other patients.

Changing facilities adjacent to the clinical procedure room are useful to provide privacy for patients. It is also sometimes useful to provide patients with a small plastic basket in which to place their belongings while they undergo their procedure.

There should be a sluice with a sluice hopper, set up by trained individuals.

Oxygen cylinder with consumables should be available if no piped oxygen available.

Phlebotomy room

Provision of phlebotomy is an essential requirement of a UIU, as it saves patients having to move elsewhere to have their bloods done. The room should have a reclining chair.

Click to see a case study on a UIU business case >

Click to see example UIU layout >

3 Equipment and storage

Key quality actions:

- Plan for requirements of equipment, including laser safety in designated rooms, clean and dirty storage areas, decontamination for scopes
- Consider which rooms will be used for video consultations and video meetings and ensure IT equipment is provided
- Planning additional storage space can allow the scope of the UIU to expand in the future
- Storage for extra equipment (consumables) stocks can mitigate intermittent supply issues

Problems with a lack of storage space are frequently raised with existing UIUs. Often this is the result of an increasing scope of the procedures offered by the UIU over time, which leads to new equipment being required without planned storage space. Existing UIUs have also suggested that having storage space to keep a larger stock of items has helped mitigate the impact of intermittent supply issues. As UIUs are high productivity services, the volume of consumables required to be stored should not be underestimated.

3.1 Clinical equipment and decontamination

Table 2 Suggested UIU equipment list

Examination couches for consulting rooms	Blood sugar monitoring device
Patient trolleys – capable of tilting	Blood taking equipment
Procedure trolleys	ECG
uroFlowometer	Urine testing equipment
Endoscopic stacks	Flexible cystoscopes
Trans-rectal ultrasound machine	Histology and biochemistry accessories
Hand-held contact laser	Patient refreshment facilties
2 or 3 Bladder scanners	Diathermy and suction
Specific procedure chairs / leg-supports – for trans-perineal procedures	Full range of indwelling and ISC catheters with accessories
Ultrasound	Supapubic catheter (SPC) kits
Urodynamics equipment	Hoist
Automatic dynamap for vital observations	Drug/TOO storage and secure cupboards
Resuscitation trolley and emergency boxes (or nearby access to one), equipment to manage local anaesthetic toxicity – in line with local safety policies	Stock of S-curve dilators and other accessories utilised during flexible cystoscopy

Particular consideration should be given to the plans for decontamination of equipment such as cystoscopes in the UIU. There is a range of options available, including reusable cystoscopes, disposable cystoscopes, and disposable sheaths. Some of the disposable elements may also be recyclable.

Where decontamination is available on-site, reusable cystoscopes could be used. This avoids the waste associated with disposable cystoscopes, although the decontamination process itself also has an environmental impact.

Decontamination off-site may also be an option, where cystoscopes are collected each day to be decontaminated elsewhere and then returned. This option requires a sufficient stock of cystoscopes to be kept at the UIU for all the procedures that will take place before stock is replenished.

Disposable cystoscopes generate obvious waste but may enable a UIU to be established on a site which does not have on-site decontamination. Other cystoscopes can be used with replaceable sheaths.

3.2 IT equipment and services

In addition to normal IT equipment requirements for an outpatient setting, there are several requirements specific to UIUs. Ideally these should be included in the initial planning and business case for the UIU, as it can be difficult to retrospectively apply for the funding and equipment provision. Considerations for the UIU include:

- In areas where flexible cystoscopies or other diagnostic procedures will take place, a desktop PC is needed for the clinician to easily make a record of the intervention. Procedure codes are available for all interventions performed in outpatients and these should be recorded. Likewise, a separate workstation will be needed for nursing staff to record details of the patient episode.
- Consider installing video conferencing equipment to enable MDT meetings and other clinical meetings, such as ‘X-ray meetings’. This makes it easier for the UIU to include colleagues and specialties working on other sites.
- Video-conferencing equipment should also be considered if remote consultations that require video links are to take place from the UIU. For example, if staff deliver both in person and remote clinics at the UIU

UIUs should seek to streamline and rationalise the process for data entry, using a standardised or proforma approach to records, in order to reduce staff time spent on administration. Electronic data capture should be used, minimising the use of paper records.

4 Workforce considerations

In the past, the urology ward was often the area where nurses first developed their interest in a career that involved specialist urological practice. However, an unintended consequence of increasing day case rates in urology has been the widespread loss of a dedicated in-patient urology ward in most Trusts. UIUs have the potential to enable nurses and allied health professionals to gain an insight into urological practice and allow development of knowledge and expertise. This allows work to be delivered more effectively by a wider, multi-disciplinary team. In the context of a Urology Area Network (UAN), a UIU can be developed further along the lines of an academy model to support workforce training and development across the network.

Successful UIUs have highlighted the benefit of an integrated leadership approach to the development of the extended workforce in UIUs. The senior nursing and medical leadership group should have a shared vision for the future delivery of urological care, supported by operational management. There needs to be mutual support and a coordinated plan for how the unit will modernise its services and maximise the skills of its workforce. All individuals should be encouraged to further their professional development and extend the repertoire of services that can be offered.

4.1 Management and administrative support

UIUs should have a dedicated manager, usually equivalent to a ward manager or band 7, who has oversight of the unit. Their responsibilities will include:

- Workforce planning, as described in this guide.
- Co-ordination of the roster: off duty, sickness or leave.
- Budget management for the unit and ordering of equipment.
- Supporting education and training of UIU staff and their specialist development.
- Governance and policies for the UIU, including risk assessments and corporate compliance.

UIUs should also employ administrative and clerical staff or secretarial support to send out clinic appointment letters and reminder texts, respond to non-clinical appointment queries and direct patients on arrival. The number of staff will depend on the volume of activity in the UIU.

A receptionist rota covering normal working hours will likely require a minimum of three full-time receptionists. It is important that reception staff working hours match the UIU clinic operating hours. UIUs often share reception staff with other departments, however dedicated urology reception staff can be trained for urology related queries or advice, such as for patients waiting to pass urine into the urine flowmeter.

4.2 Clinical support staff

Health care assistants (HCAs) and Nurse Associates as non-registered staff are key members of the UIU team and can perform a variety of vital roles, including:

- Phlebotomy.
- Working as ‘runners’ for procedure rooms, disposing of equipment, collecting and returning samples to labs.
- Preparing procedure rooms, stocking and sterilising equipment.
- Chaperoning patients, including from the reception area to the procedure room or consultation room and during a procedure or consultation.
- Carrying out basic tests, without interpretation or reporting, for example urine tests, uroflowmetry (flow rate test) and bladder scanning.

- HCAs can undertake additional training to assist clinicians with procedures including flexible cystoscopies, prostate biopsies and urodynamics.
- Assistant practitioners, who have greater autonomy than HCAs can be offered as a development role.

4.3 Nursing staff

A range of nursing roles will work in UIUs, from Registered Nurses (RNs) beginning to build up experience in urology to highly experienced Nurse Consultants providing clinical leadership of the unit. Nurses who have received the necessary education and training, and are employed at a suitable job description and grade, will have extended roles including delivering procedures, prescribing and decision making.

The nursing workforce have specific strengths which are beneficial to the UIU, such as excellent communication with patients and allocated time to provide a more holistic approach to meeting specific patients' needs. This is important for responsibilities such as providing support and information for patients receiving a diagnosis of cancer but also extends to those patients with more complex benign conditions.

Registered nurses

In hospitals where urology clinics and procedures take place in a general outpatient's area, it will often be a Registered Nurse that assists in these clinics with a requirement to work across multiple specialties – typically, colorectal surgery, general surgery and or breast surgery.

In a UIU, Registered Nurses are likely to develop a greater breadth and depth of experience specific to urology and may be trained in:

- Taking basic history and patient information.
- Administration of medication.
- Assisting with treatments, such as extra-corporeal shockwave lithotripsy or local anaesthetic, trans-perineal prostate (LATP) biopsy for example.

Specialist Nursing and Advanced Practice

There is an extensive range of job titles in use describing different levels of advanced practice nursing, which can frequently lead to confusion. There is commonly variation in the use of these titles between hospitals. It is also the case that roles are not always banded and remunerated consistently within or between Trusts, so it is imperative that the banding accurately reflects the roles and responsibilities of the individual practitioner. There should be consistency across the urology area network and alignment nationally.

Clinical Nurse Specialist (CNS) is the most common job title in specialist practice nursing within urology. CNSs are viewed as clinical experts in their disease area and deliver care as defined by agreed protocols for given pathways. CNSs have a high knowledge base and, within pathways, may carry out assessments, order and interpret investigations and deliver prescribed care. CNSs and may manage entire episodes of care, without the patient seeing a consultant or another doctor. Roles may include:

- Prostate cancer surveillance
- Renal cancer surveillance
- Stone clinic
- Andrology
- Continence

Advanced nurse practitioners (ANP) are likely to have a similar role to the CNS in the urology investigation unit, sometimes with additional autonomy and decision-making roles depending on their training and experience. Some of the diagnostic work can be performed by CNS or ANPs as well as their roles in clinics. It is recognised that this will vary trust by trust. A more advanced role would accept more responsibility, and higher level of decision making.

Advanced Clinical Practitioners (ACPs) are recognised advanced level practitioners usually educated to Masters Level (up to date guidance should be sought from Health Education England). The portfolio of procedures that individuals will offer will depend on their specific job plan and training – examples are listed below. There should be regular opportunities to review the role of individuals and to offer continuous professional development in order to create attractive and rewarding careers. The section below sets out some of the more common role titles and how they might be deployed in a UIU. It is important to note that unlike some of the staff based in a UIU, and like the medical workforce, most of these individuals would not be based permanently in a UIU but would attend clinics and procedure lists as part of their job plans.

Table 3 Potential roles for independent CNS practice

Typically from Band 6 and above (more protocol led services)	**Typically from Band 7 and above (working towards masters level practice, with autonomous decision making)**
Male lower urinary tract symptoms	Flexible cystoscopy +/- laser ablation or botulinum toxin
Prostate cancer surveillance	TRUS and/or LA transperineal biopsy
Renal cancer surveillance	Stent removal and other adjuvant activity
Stone clinic	Bladder biopsy
Andrology	
Continence	

Surgical Care Practitioners (SCPs) are healthcare professionals such as a theatre nurse or operating department practitioner, who receive further training to perform an advanced role. This includes assisting procedures in theatres but can also include performing roles as part of the on-call team, and performing diagnostic tests independently, and reviewing patients in clinic. It is likely that with workforce demands and an increase in robotic surgery, SCP numbers will increase over coming years. It is important when planning for such roles to ensure job plans are as wide and as varied as possible to encourage time out of theatre and enable advanced level practice.

Consultant Nurses/Practitioners All of the above roles can develop to consultant level. The distinction is the level of autonomous practice and levels of responsibility. Consultant level practice can mean taking responsibility for entire episodes of care without the need to be under a named medical consultant from acceptance to discharge. Consultant Nurses/ Practitioners will carry out all the roles above but are more likely to play a role in decision-making outside the standardised protocols and in the interpretation of investigation results. Consultant Nurses will normally have a leadership role within the UIU and work on education, training and development of the urology nursing workforce.

4.4 Imaging Staff

Carrying out ultrasounds in the UIU requires the availability of an ultrasonographer or radiologist. Where there is sufficient a volume of activity, they may be based in the UIU for clinics. Lithotripsy treatment requires the support of radiography staff, often dedicated to providing the service. Co-location of mobile or permanent cross-sectional imaging would require further imaging staff on site; realistically it is most likely that imaging reporting would be undertaken remotely.

4.5 Medical Staff

UIUs require dedicated consultant support and input in order to provide the optimum care for patients. There should be an active consultant presence undertaking not only outpatient activity but also being available in a supervisory role, thereby allowing for senior decision making when required. This is necessary to ensure that streamlined and efficient care is optimised and repeat visits by patients are minimised where possible. To achieve this, consultants should be assigned a sessional workload that is achievable, and which is consistent with making themselves easily available to other staff within the UIU.

A significant proportion of urological care in England is provided by staff and associate specialist doctors (SAS doctors), many of whom work with a high level of independence in their practice. They should be supported in their professional development to match their career needs as well as being offered opportunities to engage in service development. GPs with a specialist interest are also ideally suited to working within the UIU.

The UIU also provides a perfect environment for education and training of medical students and doctors in training posts, with multiple learning opportunities available concurrently.

5 Services delivered in a UIU

Outpatient consulting

Outpatient facilities located within a UIU are well placed to allow for the development and delivery of one-stop services such as dedicated LUTS clinics, suspected prostate cancer diagnostics and the investigation of patients with haematuria. Technology required for video and telephone consultations should be available as standard to allow for a significant proportion of follow-up consultations to be undertaken remotely. (See the GIRFT guide to urology outpatient transformation)

Endoscopy

Cystoscopy is an ideal procedure to undertake within a UIU, for initial investigation, stent removal and cystoscopic follow-up, as well as for administration of intra-vesical botulinum toxin. Community units are encouraged to explore the different options for decontamination or reuse of cystoscopes including single use, sheathed systems, options for worktop decontamination or access to on or off-site reprocessing facilities.

Prostate biopsy

Local anaesthetic trans-perineal prostate biopsy is now standard care for prostate cancer diagnosis across the majority of units in England. Access to MRI scanning could allow for a one-stop approach in suspected prostate cancer and hence minimise the length of the patient pathway where possible. However, it should be noted that there are still very limited examples where such an approach is being regularly delivered. LATP should take place within a procedure room rather than an operating theatre, with recovery facilities available for those patients requiring it.

Imaging

Access to imaging will vary between UIUs and be dictated by local services. There are options to include plain X-ray, ultrasound or co-location of mobile or permanent scanners for cross-sectional imaging.

Urodynamics and flow tests

UIUs should aim to offer free flow testing and bladder scanning as a minimum. Where possible, pressure-flow testing should also be available. Functional bladder investigations will require dedicated rooms with a footprint to accommodate the specialist equipment required. They will also need easy access to a private toilet area and to the sluice facilities.

Transurethral laser ablation (TULA)

TULA is the treatment of bladder tumours under local anaesthetic using a portable laser via a flexible cystoscope. The commonest laser device in use at present is a handheld, contact diode laser as it appears to be well-tolerated by patients and is sufficiently mobile to be used in the out-patient setting. It requires the same facilities as flexible cystoscopy but with the addition of laser precautions (blinds, warning signs).

Bladder outlet treatments

With recent changes in technology for the treatment of bladder outlet obstruction, some of the more novel therapies can now be offered in procedure rooms under local anaesthetic, and or sedation, in

a UIU setting. This is an area of therapeutics that is likely to continue to change at pace and it will be important for clinical teams to incorporate these office-based procedures in their repertoire for patients diagnosed with bladder outlet obstruction. Not every UIU will need to offer all of these procedures at each site as they can be delivered as part of a network provision of services within a UAN setting.

Circumcision

For men diagnosed with phimosis, a large percentage can undergo a circumcision under local anaesthetic. In certain units in England, nearly all circumcisions are done in this way in a procedure room rather than an operating theatre. Although a formal operating theatre is not required, there should be adequate facilities provided including overhead theatre lighting, an operating table or daycase trolley, suitable ventilation and recovery facilities.

Extracorporeal shockwave lithotripsy (ESWL)

ESWL is an outpatient procedure that is the first line treatment option for a significant proportion of renal and ureteric stones. In some UIUs it would be possible to co-locate a fixed site lithotripsy service if the appropriate infrastructure and footprint was available. This would lend itself well to the use of 'hot' lithotripsy to reduce length of stay, admission avoidance and to reduce unnecessary surgical intervention. Mobile lithotripsy services providing an elective service are also an option.

Vasectomy

Vasectomy performed under local anaesthetic is an ideal procedure to take place within a UIU and can be undertaken within a procedure room but would require the provision of appropriate lighting, a tilting trolley and minor surgical equipment.

6 Planning and business cases

Key quality actions:

- Appoint a project manager to develop the UIU design and business case
- Agree answers to planning and design questions (see page 6)
- Establish a steering group to provide oversight
- Include projected benefits in business plan
- Ensure nursing input to design and building
- Address concerns from sites that feel services or funding are being moved from them

Project management and engagement

Establishing the UIU sits outside normal activities, so existing managers might not have sufficient capacity to progress the design of the UIU on top of managing the current services. Some UIUs have brought in a project manager with dedicated time, for example 1 day per week. The benefits of a project manager can include:

- Minimising the impact of UIU planning on current activity
- Experience writing and presenting business cases
- Working from the beginning of the design and implementation process through to establishing initial clinical activities
- Interpreting the needs and requirements of clinicians and managers and ensuring these are represented in the business case
- Mapping pathways with process diagrams, including where and by who patients will be seen
- Looking at other UIUs for design ideas

It is also helpful to have strategic oversight from a steering group or committee. This may be an existing group in the Trust or brought together for the purpose of the UIU design. This group should meet regularly and its membership can include:

- The UIU project manager
- Chief Operational Officer
- Director for surgery, who would ultimately be presenting the business case to the Trust's decision makers on capital spending
- Finance lead
- Head of Nursing
- Matron, advising on upskilling and expansion of nurse roles
- Nurse practitioners who currently deliver activity that will be moved to the UIU, particularly important during the design stage
- Lead for decontamination or endoscopy to consider equipment and decontamination needs
- HR, given involvement in nurse roles and creation of urology HCA role
- Consultant lead, who would take back updates to colleagues in urology for feedback
- Managers for relevant groups, e.g, surgery care group manager, theatres. They may be involved throughout or at specific relevant points such as planning initial clinical activity

- Head of Estates
- Communications

Not all members of the group will be relevant or need to attend at all stages of the design process. Input from nurses at the design stage is crucial, as some UIUs have had to remedy issues which could have easily been avoided with clinical input, for example, the incorrect drug storage cupboards being installed.

Developing a business case

Some UIUs have been established in response to the Trust's existing plans and therefore a strategic overview has already existed. In other cases, a strategic outline case for the UIU has been agreed before developing the more detailed business plan, or there has been agreement at a senior level of Trust management requesting the business plan be developed.

It is recommended that business cases for UIUs include:

- An overview of how the UIU fits into the Trust's wider strategy or any already agreed strategic plans
- Identify the space needed to run the UIU, including estimated costs to repurpose existing spaces or create new spaces
- Projected benefits, including:
    - Patient volumes seen
    - Ability to make greater use of staff skills and capacity
    - More efficient use of physical space
- Available funding and timelines in the context of financial years

Some UIUs have piloted the service with reduced numbers and supervision, with a plan to scale up.

An example of a UIU business case can be found in section 7.2 below.

7 Example UIUs and case studies

7.1 Example UIUs

UIU Name	Worthing Hospital, University Hospitals Sussex NHS Foundation Trust	York and Scarborough Teaching Hospitals NHS Foundation Trust	Devon UIU at Ottery St Mary Hospital, Royal Devon University Healthcare NHS Foundation Trust
Description	On-site	Purpose built one-stop clinic	Offsite at Community Hospital
Estimated population covered	250,000	800,000	450,000
Services offered	Daily rapid access emergency clinics Nurse-led treatment clinics Telephone clinics Endoscopy LA templates and TULA One stop new patient clinic TWOC clinics 2-week rule PSA Haematuria Local anaesthetic procedures e.g. Bulkamid	Consultant-led new patient clinics for general urology referrals (PSA assessment, haematuria assessment, testicular/penile lumps and bumps, continence, etc) Nurse-led new patient Continence assessment service Flexible Cystoscopy TRUS prostate biopsy TP Prostate biopsy Intravesical Botox therapy Urodynamic Studies Intravesical Therapies ED clinic Stone Clinic Ultrasound investigations	Consultant, trainee and specialist nurse adult and paediatric urology clinics including 2WW clinics, nurse led results and ED clinics. Stone clinic with x-ray support Cystoscopy Bladder treatments LATP prostate biopsies
Staffing	1 UIU ANP and unit manager (Band 8a) 2 Advanced Nurse Practitioners (Band 7) 1.5 WTE Urology nurses (Band 5) 2.7 WTE Healthcare Assistants (Bands 2 or 3) 1.3 WTE reception staff With consultant input	Unit Managers B7 & B6 Staff Nurse B5 x 4 Nurse Associate B4 x 1 HCA B2 x 4 1 WTE front desk, employed by outpatients department Clinicians (example on an average day): Consultant Urologist (x1 or x2 depending on the day) Speciality Doctor/Registrar x 1 Advanced Nurse Practitioner/ACP x 1 Specialist Nurse Benign/Diagnostic x1 Cancer Nurse Specialist x 1 Sonographer x 2	Front desk / reception staff shared with community hospital, but would need to be recruited if this wasn't the case. Clinicians vary across the week. Typical day: Consultant Urologist x 2 Specialist registrar x 2 Surgical care practitioner x 1 Cancer nurse specialist x 2/3

UIU Name	Worthing Hospital, University Hospitals Sussex NHS Foundation Trust	York and Scarborough Teaching Hospitals NHS Foundation Trust	Devon UIU at Ottery St Mary Hospital, Royal Devon University Healthcare NHS Foundation Trust
Space	1 Reception area 3 Treatment rooms, including a larger room for urodynamics 2 Procedure rooms, laser safe with wall plugs for equipment and quality theatre lighting, but no piped gas. Suitable for minor operations including: flexible cystoscopies, local anaesthetic transperineal biopsies, local anaesthetic circumcisions, trans urethral laser ablation (TULA) 1 Flow test room with dedicated seating / recovery area 1 counselling room 3 consultation rooms 1 central office / MDT room 1 room too small for bed, so used for telephone clinics only	Reception area Waiting room with refreshments facilities and accessible toilet Multiple toilet rooms throughout the unit Toilet room with flow machine to wireless printer 4 x consulting rooms with couch, curtain, and desk/chairs/PC. Also wall-mounted examination lights. 1 consulting room contains urodynamic equipment with commode and multi-adjustable bed Procedure room for flexible cystoscopy with adjacent patient changing facilities and accessible toilet. This room has cupboards for accessories such as dilators, syringes, suction kit etc. Also has an operating room light Sluice Secure drug storage room with locking cupboards Storage cupboards for stock and consumables Storage for a wide range of patient leaflets Staff office/MDT room Sister's office Ultrasound room with adjacent changing room Rooms that should have been added to the plan: Dedicated room for cancer Nurse Specialist to discuss new diagnoses with pts Proper break/rest area for staff with refreshment area Twice as much storage for consumables Scrub facilities in the procedure room rather than just a handwashing sink Dedicated recovery area	Phase 1: 1 reception area 4 consulting rooms 1 procedure rooms for LATP and cystoscopy 1 hot desking office Phase 2: 1 laser safe procedure room for TULA and LATP Admission/Discharge area for procedures Dedicated bladder treatment room Flow test room for one-stop LUTS clinic 2 further consulting rooms Office/clinical admin space Health and well being room for staff training, audit and staff breaks

7.2 Business case to establish UIU at Worthing Hospital

University Hospitals Sussex NHS Foundation Trust

Motivation and aims

The Trust had agreed to develop a UIU model, with the preferred option of two units, one at Worthing Hospital and another at St Richard's Hospital. The aims included delivering the GIRFT urology recommendations, increasing the range of tests and treatments that could be conducted in outpatient facilities and overcoming capacity and planning issues. The Trust also aimed to reduce patient re-attendances and the gap between investigations and treatments for patients, reducing delays in pathways. By improving diagnostics, it was hoped that the UIU would support delivery of cancer waiting time targets. The UIU approach also aligned with NHS England's transforming elective care services strategy and the Trust's Patient First Improvement programme and Clinical Services Strategy.

What was done

The UIU approach was agreed first as part of a Strategic Outline Case for urology and the Trust released funding for pre-construction activity. A vacant clinical space was identified at Worthing Hospital which was adjacent to theatres and other pre-construction work carried out including feasibility surveys, design development and a market testing exercise. This was presented in a full business case which was approved by the Trust executive, commencing construction and the establishment of the UIU.

Success / lessons learned

The UIU in Worthing has been transformative, delivering on its aims and in particular improving staff morale. It has created a work hub for all patient facing members of the department and made urology very accessible, with other specialties being able to drop in for advice.

Key points of good practice

Members of the team had experience developing business cases. The team working on the UIU proposal included the Director of Divisional Operations (DDO) for surgery, who liaised with the Trust's executive team to ensure the necessary support and buy in. The team also included a project manager for the UIU and the Urology matron.

The dedicated project manager, who was not from the operational clinical team, was able to drive the project forward and work on capacity planning and refining the design.

Highlighting that the UIU was in line with GIRFT recommendations and other national and local strategies helped with progressing the business case. It was helpful to have team members with prior experience of developing business cases.

Click to download an example of a full business case for establishing a UIU >

7.3 Devon UIU at Ottery St Mary Hospital

Royal Devon University Healthcare NHS Foundation Trust

What was done

Pre-existing flexible cystoscopy and outpatients services were moved from the acute hospital site to a community hospital setting. Nursing staff and health care assistants were recruited from a range of backgrounds, including outside urology.

Success / lessons learned

The theatres background of staff (ODP and scrub nurse) was particularly helpful in setting up cystoscopy lists, both in terms of technical understanding of equipment and planning a procedures list. The theatres background also helped in directing facilities installation (e.g. layout and location of sluice).

Key points of good practice

Before establishing the UIU flexible cystoscopy list, visits were made by staff to a sister community hospital where cystoscopy was conducted in order to gain understanding and expertise. Initially, a mini pilot was run at the UIU with a reduced list and oversight from experienced nursing staff.

7.4 Developing the role of the Advanced Nurse Practitioner

York and Scarborough NHS Foundation Trust

Motivations and aims

Two adjacent hospitals in York and Scarborough NHS Foundation Trust were merged, leading to a much larger and more diverse patient population. This presented challenges including providing equal access to diagnostic services for patients across the region and managing other clinical demands on the team.

The Urology one-stop diagnostic service, located centrally in the merged Trust, facilitated equal access for all patients regardless of location. The redesigned diagnostic service achieved a patient-centred experience where people could have all (or most) of their diagnostic activity in one visit. Previously, multiple hospital visits were needed, as appointments for consultations and tests were separate.

What was done

An Advanced Nurse was trained to augment the surgical team in order to deliver prostate biopsy, flexible cystoscopy assessment and other Urological services at the Urology Diagnostic Centre. The ANP trained on-site alongside the Consultants, who were on hand for advice, supervision and sign-off.

Trained to Masters level in Advanced Clinical Practice, the ANP was able to see patients independently and in many cases manage the patient throughout their diagnostic journey to discharge without intervention by a Urology doctor. Once in post, the ANP was then able to develop the Nurse Practitioner and Nurse Specialist strategy for the department, recruiting and training further nurses to undertake clinical activity previously undertaken by the Urological surgeons.

Successes and lessons learned

- Diagnostic pathway shortened due to reduced demand on other clinicians.
- One-stop prostate biopsy facilitated by ANP available to undertake procedure in addition to cystoscopy and urodynamics where necessary.
- The role of the ANP in this circumstance evidences the value of advanced non-medical practitioners in providing quality care for Urology patients.
- Cross-cover for procedures means reduction in list cancellations

7.5 One-stop clinic for lower urinary tract symptoms

NHS Fife, Scotland (Victoria Hospital- Kirkcaldy, St Andrews Community Hospital, St Andrews)

Motivation and aims

A one-stop BPH clinic was introduced to streamline patient assessment and support for BOO surgery, given the large range of options available. The aim was to improve patient experience and develop a more uniform standard of care.

What was done

A one-stop BPH clinic was set up to provide surgical assessment and counselling for BOO patients. Patients are referred to the clinic by GPs (if refractory or intolerant of conservative treatment, or catheterised) or by colleagues if BOO surgery counselling is required. This clinic is run by a consultant urologist with special interest in BOO surgery and supported by a nurse specialist (or dedicated band 5 nurse) who would follow the patients journey and arrange follow up.

Once referred, the booking officer sends the patients a BOO clinic package with a 3 days bladder diary and specific validated questionnaires (IPSS/IIEF3, OAB score, PGI-C score, Retrograde Ejaculation – Y/N, QoL score) for completion prior to attendance. A nurse specialist's contact details are provided for queries.

Upon arrival, a flow rate and post void residual urine volume is measured (unless catheterised). If surgery is recommended, prostate volume estimation is determined with a transrectal probe (unless a recent transabdominal/MRI volume is available). Flexible cystoscopy is performed only if a diagnostic uncertainty is encountered (prostate volume <40 cc, history/flow suggestive of stricture, recent haematuria). The patient will be placed on the waiting list for treatment following their visit to the one-stop clinic and provided with relevant patient information materials.

Nurse-led follow up is provided in the BOO follow up clinic at three months. Validated parameters will be compared and, if concerns are raised, then a consultant led review will be arranged.

Successes and lessons learned

- Standardised patient pathways and uniform data collection
- Informed shared decision-making process so that patients are fully informed about their options considering current data, weighing safety/side-effects profile against the likely durability of the treatment
- Patients avoid multiple visits (reduces waiting times)
- Excellent teaching opportunity for trainees/students

Key points of good practice

- Patients should be informed that they might be in the unit for a few hours as they will need uroflowmetry, prostate volume, possible flexible cystoscopy, bloods etc
- Ensure 30 minute face-to-face clinic slots are booked
- Easier to set up in a unit that has other one-stop clinic formats
- Counselling should take into account available procedures in the wider UAN, rather than what is only available in the local trust
- The one-stop setting provides an excellent environment for training and facilitates close team working.

7.6 Laser ablation of bladder tumours in an outpatient setting

Ashford and St Peter's Hospitals NHS Foundation Trust, Imperial College Healthcare NHS Trust

Motivation and aims

Ashford and St Peter's Hospital NHS Foundation Trust and Charing Cross Hospital, Imperial College Healthcare NHS Trust are offering innovative bladder cancer treatment in an outpatient setting. This service, first established in 2014, allows patients with bladder cancer to be treated more cost efficiently and improves the patient experience by avoiding the need for a general anaesthetic and overnight stay.

What was done

A business case and new technology case was submitted at the trusts. Laser treatment of NMIBC is undertaken in the outpatient setting (laser safe flexible cystoscopy suite using a portable dual-diode laser), performed by two trained urology consultants. This allows patients to be treated without needing to be admitted to hospital, either as an inpatient or day case, and avoids the use of general anaesthetic. A patient video has been developed to help prepare patients for the procedure. The following groups can be managed:

1. Initial biopsy of red patches
2. Low-risk NMIBC
3. High-risk NMIBC disease in the elderly/high anaesthetic risk groups
4. Post BCG surveillance

Successes / key points of good practice

There are significant cost savings in outpatient laser treatment versus inpatient or day case bladder tumour surgery through released theatre space and time, increased productivity, and shorter waiting times. Ashford and St Peters NHS FT and Imperial College Healthcare Trust were finalists in the best health tech solution for patient safety award at the HSJ patient safety awards 2019, for outpatient TULA. To date over a thousand procedures have been performed in 400 patients.

Lessons learned

- TULA is safe with high levels of patient satisfaction
- TULA offers increased efficiencies and releases theatre capacity
- It is cost effective with financial savings for trusts and commissioners
- Patient morbidity may be reduced with less need for general anaesthesia and the ability to continue anti-platelet drugs/ anti-coagulants
- TULA can be used in the palliative setting

7.7 Circumcisions in an outpatient setting

Royal United Hospitals Bath NHS Foundation Trust

Motivation and aims

The Royal United Hospitals Bath NHS Foundation Trust performs circumcisions under local anaesthetic and in the urology outpatient department (equivalent to a UIU) rather than main theatres. This provides a better experience for patients, frees up theatre time for other procedures and makes better use of staff capacity. These procedures create opportunities for career development in the outpatient department, attracting staff and building a specialist workforce.

What was done

The Urology Outpatients Department at Bath is an on-site unit, with two dedicated procedure rooms. The larger of these procedure rooms is used for minor procedures like circumcisions, as well as flexible cystoscopies. The smaller procedure room is used for local anaesthetic transperineal biopsies. The unit is staffed by a dedicated urology team, which includes around 18 WTE urology nurses across various grades, as well as the consultant team and administrative support.

In the past, all circumcisions were performed under general anaesthetic and in the main operating theatres. This was first changed to circumcisions under local anaesthetic but still in main theatres, and then the flexible cystoscopy suite was adapted so that circumcisions could be performed there.

Adapting the procedure room to facilitate circumcisions involved practical changes including providing suitable bins and sinks as well as an operating theatre light. The changes to the procedure room were approved by sterile services and infection control.

4 circumcisions are performed per half-day list, which is delivered by a consultant surgeon, two nurses at Band 5 nurses and two nurses at Band 3. An outpatient penile procedure kit tray has been developed, which includes 10 selected items and simplifies preparation for nurses by avoiding much larger sets of equipment being counted out.

Successes / key points of good practice

Patients much prefer circumcisions to be delivered in the outpatient department and under local anaesthetic, as these are less disruptive than procedures in the main operating theatres which require earlier attendance and a longer time spent in hospital.

Nursing staff are often enthusiastic for more hands-on experience with procedures and being able to offer this in the Urology department is a recruitment draw. This has helped to build up a specialist urology workforce in the unit and is beneficial to the career development of staff.

Moving circumcisions, and other urology procedures, out of main theatres has freed up theatre operating time for other specialties and procedures. It also means that these procedures are less vulnerable to pressures on operating capacity in theatres.

Lessons learned

The limiting factor is now time and capacity in the larger procedure room, as there is a trade off between listing more circumcisions or more flexible cystoscopies. A business plan is now being implemented to expand to weekend working.

When local anaesthetic circumcisions have been performed in the main operating theatres, the operating teams are less familiar with local anaesthetic urology procedures and so there is less communication with patients.

Booking circumcisions in outpatient lists is not difficult but it is important to agree before introducing the lists whether responsibility for booking these will be with the theatres team or the outpatients team.

7.8 Nurse-led transurethral laser ablation (TULA) in an outpatient setting

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust (WWL)

Motivation and aims

WWL and other trusts in Greater Manchester are offering innovative bladder cancer treatment in an outpatient setting. This service was set up during the COVID-19 pandemic in 2020 to avoid the need for a general anaesthetic. Other benefits are: cost efficient, improved patient experience and potential for a nurse-led TULA service.

What was done

A business case and new technology case was submitted. Laser treatment of NMIBC is undertaken in the outpatient setting was initially performed by two urology consultants. Due to the success of the service there was a need to increase capacity. Our experienced nurse specialist started supervised training in May 2021 and was signed off by the consultants to perform independently after 50 cases with certain conditions (below) as our UIU is away from the acute hospital site:

- Consultant to be on site when Nurse Led TULA service is running
- Recurrent low-intermediate risk (this can be reviewed with experience)
- Tumours <2cm

Successes / key points of good practice

Patients and staff are generally very happy with the procedure which is quick and safe, with low waiting times of less than 30 days for non- target patients. It is certainly an excellent option for patients at high anaesthetic risk.

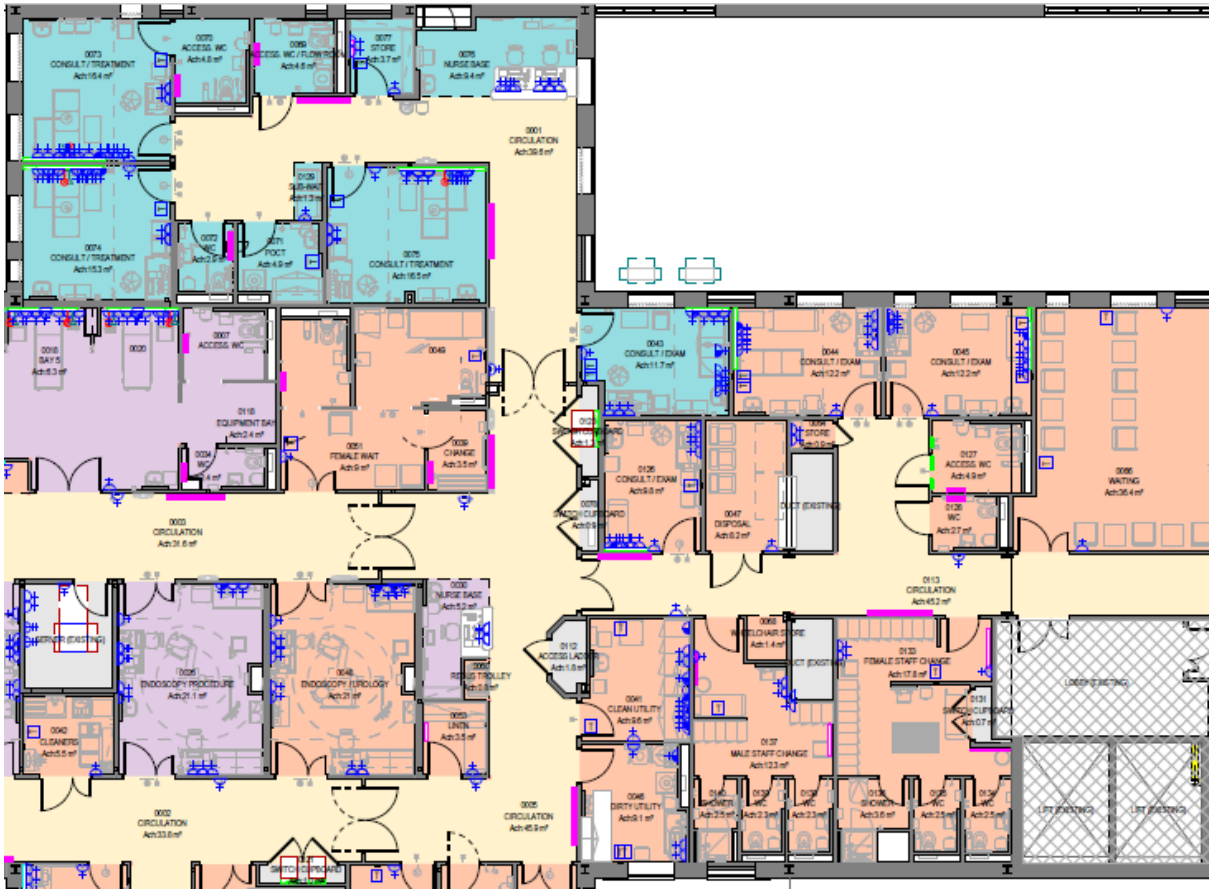
We have shared good practice with other trusts in Greater Manchester and have developed a complete network of prospective data collection to hopefully facilitate further improvements in the Nurse-led TULA service.

Lessons learned

- Nurse-led TULA is safe with high levels of patient satisfaction.
- We would suggest those wishing to set up a similar service consider our recommendations:
    - Minimum cystoscopy experience
        - check flexis for 2 years.
        - Experience with stent removals and bladder botox injections desirable.
    - Need for consultant sign off- suggest 50 directly supervised cases with intermittent case discussions and support after starting independent TULA cases
    - Ensure overall good knowledge base to discuss treatment options e.g. complete GM Cancer Academy module on bladder cancer and TULA
    - Experience in support and education for bladder cancer patients
    - Audit service in 6 months

Appendices

Example UIU layout



Glossary

ACP	Advanced Clinical Practitioners
ANP	Advanced Nurse Practitioner
BCG therapy	Bacillus Calmette Guérin, immunotherapy drug used in treatment of non-muscle-invasive bladder cancer
BOO	Bladder outlet obstruction
CDC	Community Diagnostic Centres or Hubs
CNS	Clinical Nurse Specialist
Cold site	A site which includes only elective or planned work and not emergency or trauma
ECG	Echo cardiagram
ESWL	Extra-corporeal shockwave lithotripsy
HCA	Healthcare Assistant
HSDU	Hospital sterilisation and disinfection unit
ISC	Catheter
LATP	Local anaesthetic trans-perineal prostate biopsy
LUTS	Lower urinary tract symptoms
MDT	Multidisciplinary team
ODP	Operating Department Practitioner
RTT	Referral-to-treatment
SCP	Surgical Care Practitioner
SPC	Suprapubic catheter
TRUS	Transrectal ultrasound scan
TULA	Trans-urethral laser ablation
TWOC	Trial without catheter
UAN	Urology Area Networks
UIU	Urological Investigation Units

Contributors

Melanie Walton	Chair of the GIRFT Academy Urological Investigation Unit expert working group. Consultant urological surgeon at Royal Devon University Healthcare NHS Foundation Trust.
Clare Waymont	Expert working group member. Immediate Past-President of the British Association of Urological Nurses. Consultant urology nurse at The Royal Wolverhampton NHS Trust.
Sarah Hillery	Expert working group member. President of the British Association of Urological Nurses. Lead Nurse for urology and Advanced Nurse Practitioner at York and Scarborough Teaching Hospitals NHS Foundation Trust.
Jonathan Broughton	Expert working group member. Surgical Care Practitioner in Urology at South Tees Hospitals NHS Foundation Trust.
Suzie Venn	Expert working group member. Consultant Urological surgeon at University Hospitals Sussex NHS Foundation Trust.
Janet Jones	Expert working group member. Clinical ODP Manager for Urology, Royal Devon University Healthcare NHS Foundation Trust.
Joseph John	National Fellow for GIRFT Urology and Urology specialty trainee at Royal Devon and Exeter NHS Foundation Trust (Southwest Deanery).
John McGrath	GIRFT co-lead for Urology and Consultant Urologist at the Royal Devon and Exeter Foundation Trust.
Kieran O'Flynn	GIRFT co-lead for Urology and Consultant Urologist at the Northern Care Alliance NHS Foundation Trust.
Edward Nickell	GIRFT Academy Urological Investigation Unit guidance editor.
Sachin Agrawal	Case study contributor. Consultant urological surgeon at Ashford and St. Peter’s Hospitals NHS Foundation Trust.
Edward Jeffries	Case study contributor. Royal United Hospitals Bath NHS Foundation Trust.
Anne Joint	Contributor. Projects Director at Electrolite Consulting Ltd, formerly Project Manager for Urological Investigation Unit at Worthing Hospital for University Hospitals Sussex NHS Foundation Trust.