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The British Association of Urological Surgeons

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BRITISH ASSOCIATION of UROLOGICAL NURSES

Urology: PIFU and remote monitoring templates

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1 Introduction

The NHS has seen major changes to outpatient services in recent years, accelerated by adopting remote consultations and telemedicine during the pandemic. The GIRFT guide to Urology outpatient transformation, published in 2022, set out the vision, reasons and tools for clinicians and managers in urology to maximise the opportunity to take new approaches for the benefit of patients.

This guide provides advice and templates for two key aspects of outpatient services, Patient-Initiated Follow Up (PIFU) and Remote Monitoring (RM). Personalised follow-up, PIFU and remote monitoring can empower patients to manage their health with support from health services, by providing new solutions for contacting health providers as and when patients choose. Reducing the number of unnecessary, routine low-value appointments can mitigate the environmental impact of patient journeys.

PIFU and remote monitoring are crucial to efficiently performing outpatient services. This guide will support trusts to implement best practice and to empower patients through shared decision-making, whilst minimising unnecessary and inefficient outpatient activity.

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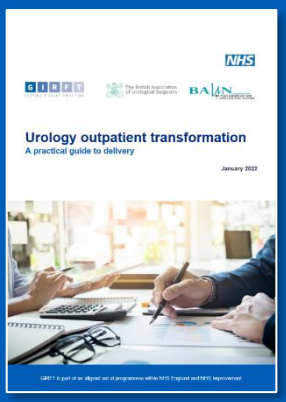
2 The role of Patient Initiated Follow Up (PIFU)

This guide builds on the existing information on PIFU set out in the GIRFT Urology outpatient transformation guide. Click here to read the key quality actions to:

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



PIFU is when a patient or their carer can initiate a follow-up appointment as and when required. Rather than being given a date for a further appointment, the patient has time-limited, direct access to the department if they have a change in symptoms. A PIFU pathway is time-limited and commensurate with the natural history of the clinical condition. The clinician and patient can decide if there is a need for clinical review before the pathway ends or, if there has been no request for follow-up during the agreed period, the pathway can be discontinued.

PIFU is part of the outpatient transformation requirements laid out in the NHS England 2022/23 Operational Planning Guidance and supports the personalised care agenda. PIFU can focus clinical time on those patients who most need it. By avoiding unnecessary face-to-face outpatient visits, PIFU saves time for patients and reduces transport-related pollution.

It is essential that patients on a PIFU pathway are provided with a clear method of contact to arrange access to follow-up care. Barriers to contact undermine the safety of a PIFU pathway. Remote monitoring and personalised stratified follow up (PSFU) differ from, but are related to, PIFU.

The GIRFT urology guide on outpatient transformation described PIFU and set out delivery considerations to ensure that PIFU was an appropriate option for patients, optimise patient communications and standardise the approach to delivering PIFU.

This guide builds on that and provides templates for PIFU pathways. These templates set out which patient groups the pathway is appropriate for, what type of PIFU should be used, the information that should be provided to the patient, the methods of contact for accessing follow-up and the timelines for clinical review or discharge.

Benefits from PIFU and remote monitoring

Effective PIFU pathways and use of remote monitoring should benefit patients and urology services as set out in the table below. Patients save time and money by reducing the number of avoidable attendances at the Outpatient Department (OPD). There are also significant environmental benefits, as unnecessary journeys to and from hospitals account for a high proportion of the carbon footprint of these episodes as well as contributing to environmental air pollution.

Advantages to patients	Advantages to urology services
• Quicker access to follow up when needed rather than on fixed schedule • Saved time by avoiding unnecessary or limited value appointments and attendances • Reduced financial burden with regard to travel and or loss of income • More care provided closer to home and/or in the community	• More timely information on patients through remote monitoring • Clinical time and attention can be focused on patients with the greatest need • Reduced unnecessary attendances for patients in secondary care • Reduced environmental impact due to patient journeys

3 Tips for using the PIFU pathways

1. **PIFU should not be used in place of discharging patients appropriately.**

2. **Consider PIFU for long term conditions requiring follow up.**

3. **Ensure patients moved to a PIFU pathway are logged and tracked on your organisation's IT system. Effective safety nets should be in place.**

Different types of PIFU

There is a range of different types of PIFU, which have traditionally been known by a variety of names and terms, including: Open access follow-up, open appointments, patient-initiated appointments, see on symptoms (SOS) and patient-activated care. The terms 'Short term' and 'Long term' are used in this document and explained below.

	Short term PIFU / no clinical review	Long term PIFU / clinical review
Timeline	An agreed time limited period, for example 3 months.	Varying timespans specific to the patient and their condition. No expected or fixed end-date.
Examples of use	Following a surgical or isolated medical procedure. Where a treatment plan should resolve the issue, leading to automatic discharge without clinical review.	Patient's condition requires ongoing monitoring and contact. This PIFU type works well alongside remote monitoring tools to avoid unnecessary trips to outpatient settings. Clinical review is required before discharge.

Inclusion and exclusion

Inclusion	Exclusion
PIFU is clinically appropriate for the patient and their condition.	PIFU is not clinically appropriate for the patient and their condition.
The patient and/or their carer has had PIFU explained to them and has had the opportunity to ask questions and raise concerns.	The patient is not able to understand how or when to trigger an appointment
The patient has agreed to be managed on a PIFU pathway.	The patient has declined to be managed on a PIFU pathway

Communicating to primary care

When a patient has been allocated to a PIFU pathway, a note should be made in the patients record stating: 'This patient been allocated to a patient initiated follow up (PIFU) pathway and can request a further follow up appointment by contacting [Contact details] should they feel that this is required. Valid for the next [##] months.'

Providing a contact number for patients to initiate contact

Patient initiated contact, for the patient, should be via a designated telephone number with a facility to leave a message. This could be at department level, CNS level or a central point for all PIFU pathways in a trust. It is important that this contact is recorded in the patient's record, so that the reason for review is available to the reviewing clinician.

The use of a PIFU pathway should be noted on the clinic letter to the patient's GP, specifying that the patient has been allocated to patient initiated follow up. This note should state when and how the patient can request a further follow appointment, including contact details. The note should also state for how long the PIFU pathway is applicable.

Click to view example PIFU patient leaflets >

4 PIFU pathway templates

This document will receive periodic updates to add in new PIFU pathway templates.

Urology services are encouraged to share any examples of PIFU pathways that could potentially be included as a template in a future version of this document by email to girft.academy@nhs.net.

1. Andrology
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4. Conservative management of pelvic floor conditions
5. Long term Intermittent Self-Catheterisation (ISC)
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4.1 Andrology PIFU pathway

Clinical condition	Erectile dysfunction treatment (injection, intraurethral)
PIFU Type	Short term / no clinical review
Method for hospital to contact patient following PIFU activation	Telephone
Triggers for contact	Treatment not successful pain or swelling on administration
Review / discharge timeline	6 months

4.2 Botox PIFU pathway

Clinical condition	Lower urinary tract symptoms (LUTS), overactive bladder, receiving botox
PIFU Type	Long term / clinical review
Method for hospital to contact patient following PIFU activation	Face to face on cystoscopy and botox list
Triggers for contact	Worsening lower urinary tract symptoms
Review / discharge timeline	Not applicable

4.3 Bladder Pain Syndrome (BPS) / Interstitial Cystitis (IC)

Clinical condition	Bladder pain syndrome / Interstitial cystitis patients
PIFU Type	Long term / clinical review
Method for hospital to contact patient following PIFU activation	Telephone initially
Triggers for contact	Significant change/ progression of symptoms • Pain • Urgency • Frequency Proven recurrent UTI's
Review / discharge timeline	2 years

4.4 Conservative management of pelvic floor conditions

Clinical condition	Pelvic floor disorders or conditions Disorder or condition being managed conservatively, e.g. • lifestyle adaptation • pelvic floor exercises • drug treatment Self-change of ring pessary
PIFU Type	Long term / clinical review
Method for hospital to contact patient following PIFU activation	Telephone, with imaging arranged as required
Triggers for contact	Persistence of worsening of pelvic floor condition for which the patient feels they might wish further assessment, advice or treatment. Appointment urgency to be defined locally.
Review / discharge timeline	Discharge at 24 months

4.5 Long term intermittent self-catheterisation (ISC) PIFU pathway

Clinical condition	Patients on long term ISC
PIFU Type	Short term / no clinical review
Method for hospital to contact patient following PIFU activation	Telephone initially
Triggers for contact	Difficulty passing catheter: Recurrent UTI's: Haematuria
Review / discharge timeline	1 year

4.6 Post bladder-outlet obstruction surgery PIFU pathway

Clinical condition	Post operative bladder-outlet obstruction (BOO) procedures
PIFU Type	Short term / no clinical review
Method for hospital to contact patient following PIFU activation	Telephone initially
Triggers for contact	Despite appropriate treatment: • Poor flow • Ongoing frequency / urgency / incontinence after 3 months
Review / discharge timeline	Discharged at 6 months

4.7 Post Peyronies surgery PIFU pathway

Clinical condition	Post Peyronies corrective surgery
PIFU Type	Short term / no clinical review
Method for hospital to contact patient following PIFU activation	Telephone
Triggers for contact	Pain or swelling after 4 weeks. Failure of correction of bend. Declining function at 3 months post-operation to the extent that the patient wishes to have intervention.
Review / discharge timeline	3 months

4.8 Recurrent UTIs PIFU pathway

Clinical condition	Recurrent urinary tract infection (UTI) on management pathway
PIFU Type	Short term / no clinical review
Method for hospital to contact patient following PIFU activation	Telephone
Triggers for contact	Despite appropriate treatment: • Recurrent painful micturition with frequency, urgency, nocturia • Pelvic pain or discomfort suggestive of urinary tract infection • Visible blood in the urine • Proven UTI on MSU Not for PIFU: Pain on voiding with back or loin pain or temperature requires urgent medical attention through NHS 111 or GP.
Review / discharge timeline	Discharge back to GP at 12 months

4.9 Stones PIFU Pathway

Clinical condition	Stones
PIFU Type	Long term / clinical review
Method for hospital to contact patient following PIFU activation	Telephone, with imaging arranged as required
Triggers for contact	Appointment for new and worsening symptoms: • New onset continuing loin pain • Unexplained fevers • UTI not responsive to antibiotic prescribed by GP New onset blood in urine
Review / discharge timeline	Non face-to-face clinical review at 24 months with CT scan

4.10 Stones post-operative PIFU Pathway

Clinical condition	Post surgical operation to remove stones
PIFU Type	Short term / no clinical review
Method for hospital to contact patient following PIFU activation	Telephone with imaging arranged as required
Review / discharge timeline	Discharge at 3 months
Triggers for contact	• Pain • Bleeding • Infection

5 Tips for using remote monitoring pathways

Remote monitoring can enable patients to be supported outside of the hospital setting, but requires that robust administrative processes be in place to ensure that clinicians are alerted when tests or investigations have been completed.

Trusts need to provide effective methods for contacting patients with results or to book scans and appointments. The preferred method of communicating with patients is through patient portals or the NHS app.

Remote monitoring pathways are ideally delivered and managed by Clinical Nurse Specialists or other appropriate clinicians working to a protocol. This is the case seen in most urology services. These pathways are offered as examples, but there may need to be local variations and other approaches may be acceptable.

6 Remote monitoring pathway templates

This document will receive periodic updates to add new remote monitoring pathway templates.

Urology services are encouraged to share any examples of remote monitoring pathways they have developed that could potentially be included as a template in a future version of this document.

1. Cystectomy
2. Prostate cancer
3. Renal cancer
4. Renal 2F cysts

6.1 Cystectomy remote monitoring pathways

Cystectomy - Low risk. + / - CIS, pT0, pt1	
Tests and imaging:	**Frequency:**
B12/Folate, FBC, U&E, LFT, Bone profile Bicarbonate	At 3 & 6 months, 1 year and each year to 6 years.
CTU + Thorax	Each year until 6 years
USS	At 6 years, then every 2 years by GP
GFR	Annually
Preferred type of contact with patient	Letter/ telephone (patient choice) by appropriate clinician to review result and contact patient.
Discharged criteria	Discuss with patient (consider co-morbidity / wellness) either discharge or on-going surveillance CT TAP every 2 years

Cystectomy - Intermediate risk. pT2, pT3	
Tests and imaging:	**Frequency:**
B12/Folate, FBC, U&E, LFT, Bone profile Bicarbonate	At 3 & 6 months, 1 year and each year to 6 years.
CTU + Thorax	At 6 months and then each year until 6 years
USS	At 6 years, then every 2 years by GP.
GFR	Annually
Preferred type of contact with patient	Letter/ telephone (patient choice) by appropriate clinician to review result and contact patient.
Discharged criteria	Discuss with patient (consider co-morbidity / wellness) either discharge or on-going surveillance CT TAP every 2 years

Cystectomy – High risk. Node positive, T4 or positive Mets (usually bone) Refer to oncology is spread at 3 months or more	
Tests and imaging:	**Frequency:**
B12/Folate, FBC, U&E, LFT, Bone profile Bicarbonate	At 3 & 6 months, 1 year and each year to 6 years.
CTU + Thorax	At 3 & 6 months, 1 year and each year to 6 years.
USS	At 6 years, then every 2 years by GP.
GFR	Annually
Preferred type of contact with patient	Letter/ telephone (patient choice) by appropriate clinician to review result and contact patient.
Discharged criteria	Discuss with patient (consider co-morbidity / wellness) either discharge or on-going surveillance CT TAP every 2 years

6.2 Prostate cancer remote monitoring pathway

Full detail on remote monitoring for prostate cancer will be provided in the GIRFT guide on prostate cancer. The NHS is making increasing use of digital PSA tracking portals, and an example of a digital PSA tracker patient information leaflet is available online.

Prostate cancer – Active surveillance	
Imaging:	**Frequency:**
PSA	Every 3 months
MRI	At 1 year
Preferred type of contact with patient	Letter / telephone (patient choice)
Discharged criteria	Discharge at 5 years follow up

Prostate cancer – Following radical treatment	
Imaging:	**Frequency:**
PSA test and assessment of urinary, bowel and sexual function impact	At 6 – 12 weeks
PSA with re-referral threshold set by treatment team	Every 6 months
Preferred type of contact with patient	Letter / telephone (patient choice)
Discharged criteria	Discharge at 5 years follow up

6.3 Renal cancer remote monitoring pathways

Full detail on risk stratified follow up for patients with renal cancer is available from page 25 of the GIRFT guide on kidney cancer. The Leibovich score is recommended for risk stratification and the scoring system is available on page 44 of the GIRFT guide (appendix 7.3). Risk groups are stratified by the scoring system into:

Score 0 – 2 Low risk
Score 3 – 5 Intermediate risk
Score 6 or over High risk

Patient comorbidity and suitability for treatment of any potential future recurrence, as well as the patients' own wishes, should also be considered when agreeing a follow-up strategy. The imaging protocol suggested in the GIRFT guide and below may be modified as needed based on such features.

After partial nephrectomy, patients with RCC should be risk-stratified and classified according to the same criteria as patients that have undergone radical nephrectomy. Early identification of local recurrence is particularly important for these patients who may be treated with further surgery or ablation and might expect a good outcome. Therefore, an intermediate risk schedule may be preferred if adopting the minimum standards outlined below. Where there is a positive surgical margin after partial nephrectomy, imaging frequency should be increased to the next risk classification level (i.e. if a low risk ccRCC based on Leibovich score, the patient should be followed-up as per intermediate risk protocol).

Renal cancer - Low risk. Leibovich score 0 - 2	
Imaging:	**Frequency:**
CT TAP	At 1 year, 3 years and 5 years.
Preferred type of contact with patient	Letter / telephone (patient choice)
Discharged criteria	Discharge at 5 years follow up

Renal cancer - Intermediate risk. Leibovich score 3 - 5	
Imaging:	**Frequency:**
CT TAP	At 6 months, 1 year and each year until 5 years.
Preferred type of contact with patient	Letter / telephone (patient choice)
Discharged criteria	Discuss with patient (consider co-morbidity / wellness) either discharge or ongoing surveillance CT TAP every 2 years.

Renal cancer - High risk. Leibovich score ≥6	
Imaging:	**Frequency:**
CT TAP	At 3 and 6 months, 1 year and each year until 5 years.
Preferred type of contact with patient	Letter/ telephone (patient choice) by appropriate clinician to review result and contact patient appropriately.
Discharged criteria	Discuss with patient (consider co-morbidity/wellness) either discharge or on-going surveillance CT TAP every 2 years

6.4 Renal 2F cysts remote monitoring pathway

5 years surveillance with CT (Bosniak cysts are a CT diagnosis), usually allows any underlying malignancy (5-10% risk) to become apparent. Additional MRI or contrast-enhanced ultrasound, with uroradiologist advice, may help differentiate between Bosniak 2 and 2F cysts at initial presentation.

Bosniak 2F Cysts	
Imaging:	**Frequency:**
CT with contrast	6 monthly for 2 years, then annually until 5 years
Preferred type of contact with patient	Letter and re book scan Use patient portal if available
Discharged criteria	No change in scans at 5 years follow up

Bosniak 2F Cysts – example from a health board in Scotland	
Imaging:	**Frequency:**
CT with contrast	At 6 months, at 18 months, at 30 months and at 48 months, then discharged
Preferred type of contact with patient	Letter
Discharged criteria	No change in scans at 48 months (4 years)

7 Further resources

Recommended document	Author	Overview
GIRFT Urology outpatient transformation: a practical guide to delivery	GIRFT	This GIRFT Urology outpatient transformation guide set out the key quality actions for PIFU. This guide and these PIFU templates build on these actions.
Example PIFU patient information leaflets	GIRFT	Example leaflets with information for patients who are on a PIFU pathway.

8 Contributors

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9 Appendix – Example PIFU patient information leaflet

https://future.nhs.uk/GIRFTNational/viewdocument?docID=272054757#