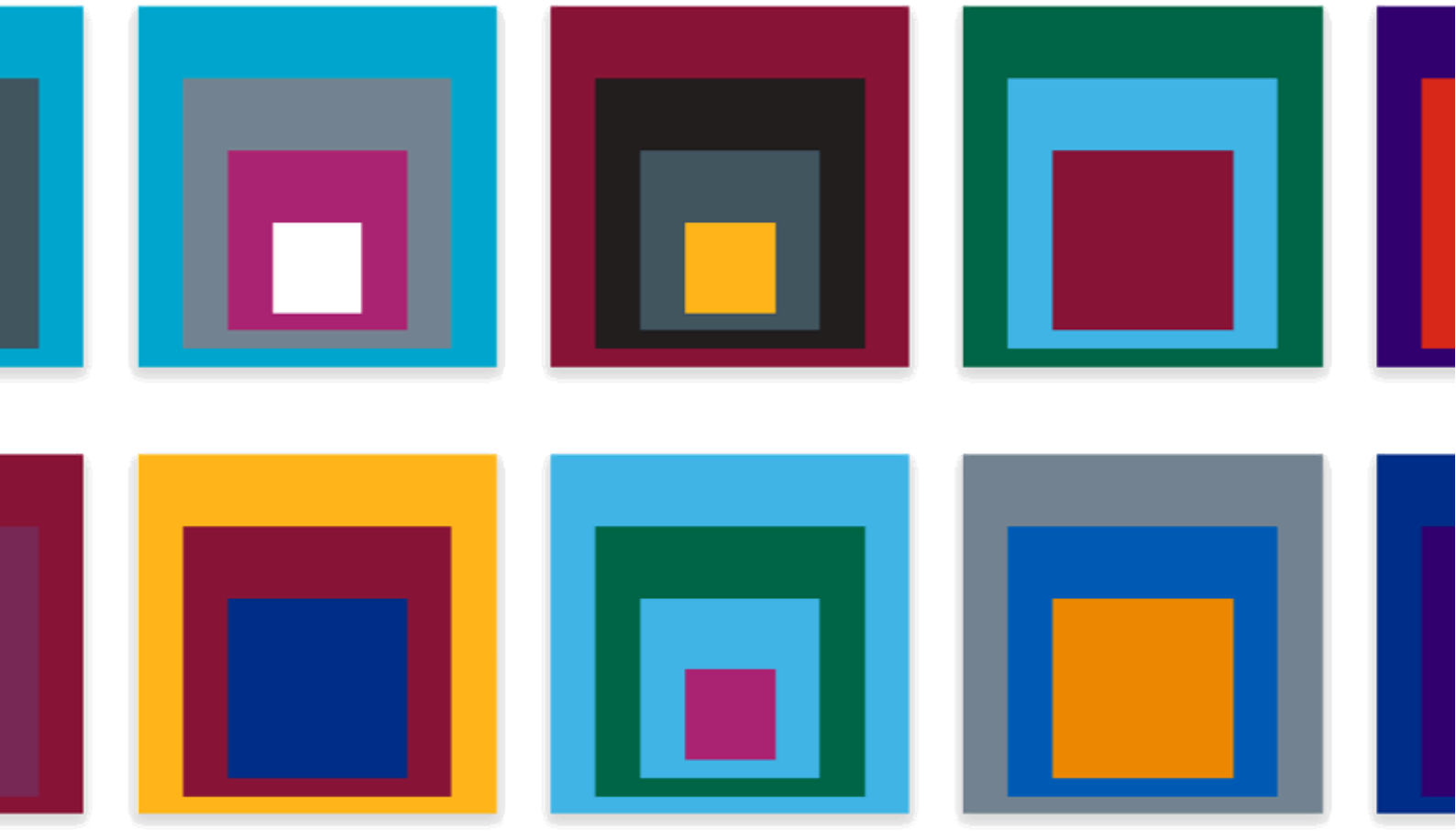
NHS England

GIRFT
GETTING IT RIGHT FIRST TIME

GIRFT Urology: Guidance on follow-up

June 2026



The British Association of Urological Surgeons

BAUN BRITISH ASSOCIATION of UROLOGICAL NURSES

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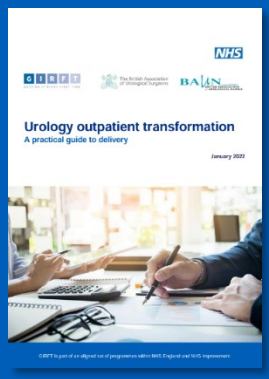
This document collates existing guidance from several GIRFT urology guides, including guidance on conditions and pathways and overarching guidance on outpatient transformation.

The urology outpatient transformation guide sets out the principles for a robust and standardised PIFU system.

The guide and templates for PIFU and remote monitoring provides more detailed tips for implementing PIFU and example PIFU and remote monitoring pathways for common conditions.

The guides referenced are available at: www.gettingitrightfirsttime.co.uk/urology



Introduction

The NHS has made significant progress in the recovery of elective services; however outpatient follow up volumes have remained high and backlogs remain unresolved. Over 1.3 million pathways are awaiting follow-up, of which over 990,000 have no appointment date booked.

Nationally, there are on average two follow-up appointments for every new outpatient appointment. It is recognised that many of these follow-up appointments are of limited clinical value, undermining patient experience, constraining capacity to see new patients and contributing to long waits.

For patients, the most valuable appointments are for clinical interventions, such as a diagnosis, treatment or examination. The least valuable are when nothing is learned and nothing happens – such as going back to be asked if you think you need to be seen. Patients should be trusted and empowered to decide if they need and want to be seen.

The follow-up and remote monitoring protocols in this guide have been developed in conjunction with trusts as part of the GIRFT Further Faster programme. Where possible we have drawn on the existing GIRFT guidance developed with expert working groups, including for bladder outlet obstruction, stones, prostate cancer, kidney cancer and bladder cancer. All of these guides, with further detail on condition specific follow-up, are available on the GIRFT website.

This document collates and summarises existing GIRFT guidance on follow-up for urology, setting out a clear and more readily adopted approach to make the best use of outpatient appointments.

We hope that this supports trusts to reduce their waiting lists by seeing more new and complex patients and making the best use of clinicians and patients' time.

Andrew Dickinson
GIRFT Academy urology outpatient transformation lead and clinical specialist advisor, and consultant urologist at University Hospitals Plymouth NHS Trust

Kieran O'Flynn
Former GIRFT national clinical co-lead for urology and consultant urologist at the Northern Care Alliance NHS Foundation Trust

John McGrath
Former GIRFT national clinical co-lead for urology and consultant urologist at North Bristol NHS Trust

Key principles of follow-up

Discharge when appropriate

Follow-up should only be used when a patient needs a further intervention, such as a procedure or test, and should deliver that intervention in the most time and cost-efficient way possible. Where the evidence base shows it is safe and proportionate to discharge patients, this should be the default.

Risk stratified follow-up

A risk stratified follow-up strategy, rather than blanket policies, can avoid excessive follow-up for low-risk patients while ensuring those patients who most need to be seen are not missed.

Patient Initiated Follow-Up (PIFU) (see our PIFU guide and templates)

Patients are often routinely booked to come back 'just in case' and to be asked if a treatment has worked; in effect, being brought back to find out if they need to be brought back. These are very low value consultations.

Patients can be educated on signs and symptoms that should trigger an appointment. With PIFU, the patient can decide to initiate an appointment, or not, depending on their ongoing concerns.

Robust and clear contact routes for patients to get back into clinical care are essential to maintaining clinical confidence in PIFU. Options include having a centrally managed phone number, contact details for a dedicated healthcare professional and a regularly reviewed answering machine and prompt reply to the patient query. In the future, the NHS app may enable direct communication between the patient and secondary care.

Categories are increasingly used to define PIFU in electronic patient record systems. For example, at Royal Devon University Healthcare NHS Foundation Trust, three types of PIFU are used: discharge to PIFU (open appointment); fixed recall with appointment booked; and review prior to expiry, with patients' results reviewed before an appointment is booked.

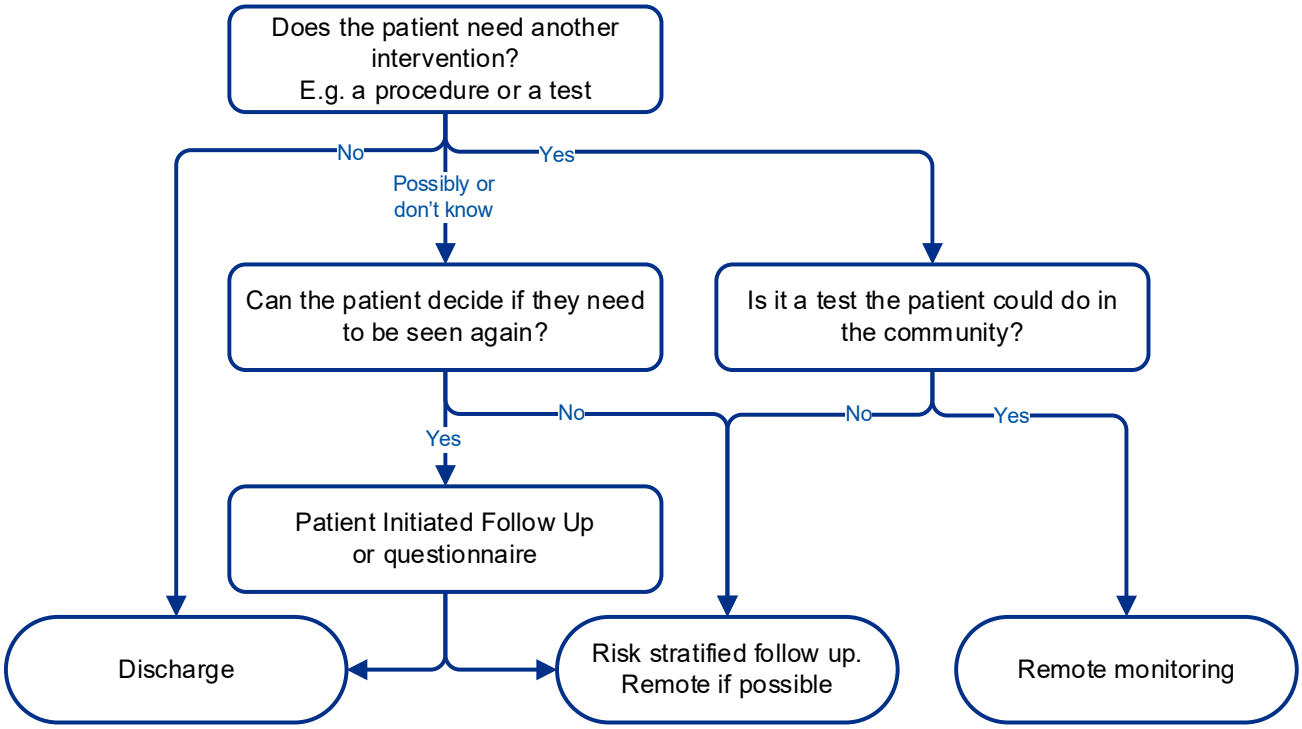
Remote monitoring (see our remote monitoring guide and templates)

Patients are repeatedly brought back to the hospital, often over many years, for tests that could be done at home, at the GP or a local service such as a pharmacy. Usually, they only need to be seen if there is a significant change in the test result. Normal test results can be automatically notified by text, NHS app message or letter rather than an in-person appointment.

Table 1: Moving from low value to high value follow-ups

Low value		High value
Blanket policies for all conditions and patients	▶	Risk stratified follow-up
Patient attends to be asked if they need to be seen	▶	PIFU
Appointment to say nothing has changed	▶	Communication by app, email, text.
Attending for regular tests	▶	Remote monitoring

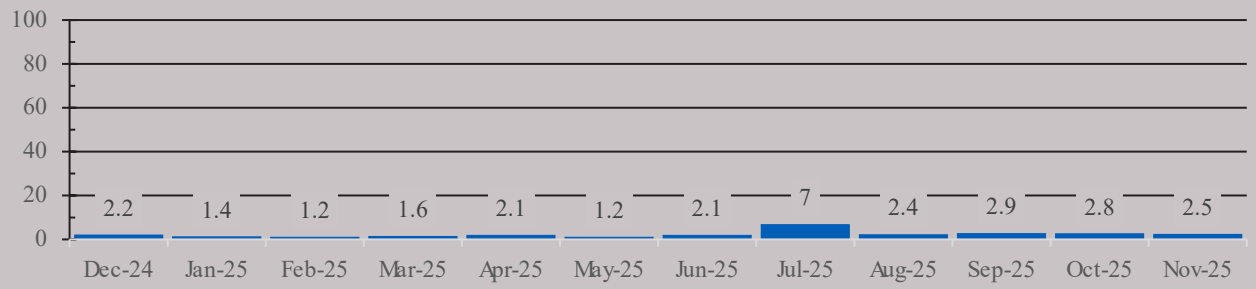
Figure 1: Follow-up decision flow



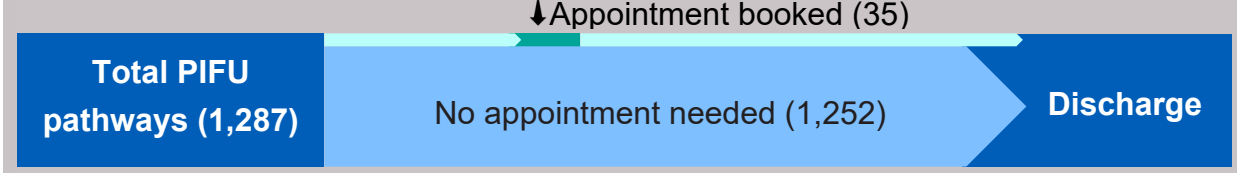
How often do patients on PIFU initiate appointments?

Most patients on PIFU do not need an appointment. For example, at University Hospitals Plymouth, only 2.5% of patients who were on PIFU for a urology condition in 2025 asked for appointments. This trust had an above average PIFU utilisation rate so many other trusts would expect to see an even lower uptake of appointments from PIFU.

Percentage of patients on PIFU in urology who initiated an appointment at University Hospitals Plymouth in 2025.



Example flow with PIFU, based on University Hospitals Plymouth Urology PIFU pathways and appointments for November 2025.



Follow up guidance by pathway

Benign

Follow up for patients with benign conditions should be by exception. Most patients with benign conditions can be either discharged or put on PIFU, whether they've had a procedure or are managing out-of-hospital.

Maximising the success of out-of-hospital management requires that patients have been given information and education on when to return to hospital and access to effective pain relief when appropriate. Clarity about follow up arrangements can reduce patient anxiety and the number of unplanned contacts with NHS services. When patient contact is needed, this can be undertaken by specialist urology nurses or medical staff.

Patient contact should be timed to allow for post-operative symptoms to have settled so that evaluation captures longer-lasting residual symptoms: 8 -12 weeks post-operative is usually appropriate.

Follow up arrangements should be personalised to the patient and make efficient use of resources. Evaluation of key outcome measures should be built in to follow up protocols.

Functional

1. Botox for lower urinary tract symptoms (LUTS)

Clinical condition	Lower urinary tract symptoms (LUTS), overactive bladder, receiving Botox
PIFU Type	Discharge to PIFU (open appointment)
Patient triggers for contact	Worsening lower urinary tract symptoms
Hospital contact following trigger	Face to face on cystoscopy and Botox list
Review / discharge timeline	Not applicable

2. Bladder pain syndrome (BPS) / interstitial cystitis (IC)

Clinical condition	Bladder pain syndrome / Interstitial cystitis patients
PIFU Type	Discharge to PIFU (open appointment)
Patient triggers for contact	Significant change / progression of symptoms • Pain • Urgency • Frequency • Proven recurrent UTI's
Hospital contact following trigger	Telephone initially
Discharge timeline	Discharge at 2 years

3. 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	Discharge to PIFU (open appointment)
Patient 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.
Hospital contact following trigger	Telephone, with imaging arranged as required
Discharge timeline	Discharge at 2 years

4. Long term intermittent self-catheterisation (ISC)

Clinical condition	Patients on long term ISC
PIFU Type	Discharge to PIFU (open appointment)
Patient triggers for contact	Difficulty passing catheter: Recurrent UTI's: Haematuria
Hospital contact following trigger	Telephone initially
Discharge timeline	Discharge at 1 year

5. Recurrent UTIs

Clinical condition	Recurrent urinary tract infection (UTI) on management pathway
PIFU Type	Discharge to PIFU (open appointment)
Patient 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.
Hospital contact following trigger	Telephone
Review / discharge timeline	Discharge back to GP at 12 months

Andrology

6. Erectile dysfunction

Clinical condition	Erectile dysfunction treatment (injection, intraurethral)
PIFU Type	Discharge to PIFU (open appointment)
Hospital contact following trigger	Telephone
Patient triggers for contact	• Treatment not successful • Pain or swelling on administration
Discharge timeline	Discharge at 6 months

7. Post peyronies surgery PIFU pathway

Clinical condition	Post peyronies corrective surgery
PIFU Type	Discharge to PIFU (open appointment)
Patient 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.
Hospital contact following trigger	Telephone
Discharge timeline	Discharge at 3 months

8. Bladder outlet obstruction

Clinical condition	Post-operative bladder-outlet obstruction
PIFU Type	Discharge to PIFU (open appointment)
Patient triggers for contact	Despite appropriate treatment: • Poor flow • Ongoing frequency / urgency / incontinence after 3 months
Hospital contact following trigger	Telephone / app message initially
Discharge timeline	Discharge at 6 months

GIRFT bladder outlet obstruction guide >

GIRFT Urology PIFU templates and guide >

9. Stones (urinary calculi)

Clinical condition	Post surgical operation to remove stones
PIFU Type	Discharge to PIFU (open appointment)
Patient triggers for contact	• Pain • Bleeding • Infection
Hospital contact following trigger	Telephone/app message with imaging arranged as required
Discharge timeline	Discharge at 3 months

Clinical condition	Recurrent stones
PIFU Type	Review prior to expiry
Patient 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
Hospital contact following trigger	Telephone/app message, with imaging arranged as required
Review / discharge timeline	Asynchronous remote clinical review at 24 months with CT scan

GIRFT Acute stones guide >

GIRFT Urology PIFU templates and guide >

GIRFT Greener stones pathway >

Cancer

Cancer follow up should be led by Urology Cancer Nurse Specialists (CNS), and many cancer follow up protocols lend themselves to remote monitoring.

10. Kidney cancer

Patients undergoing surgery or ablation:
See at 4 – 6 weeks post-operatively to discuss, recovery, histopathology results, and agree an individualised follow up strategy.

- Follow up should be risk stratified (see table 2 below) and based on the patient's histology, competing health risks and preferences.
- Positive margin at partial nephrectomy, follow up at the next more intensive follow up level.
- Patients with established follow up regimens for localised RCC should be reviewed in cancer CNS clinics.
- Follow up after ablation: Contrast enhanced cross-sectional imaging at 3 months to ensure primary treatment efficacy. Initial scan at 4-6 weeks for those in initial learning curve. Then as per intermediate risk. High risk strategy for those with early experience in thermal ablation.
- Contact with patients should be via NHS App message if available, letter or telephone in line with patient preference.

Recommended risk stratification:

- Clear cell RCC: Leibovich score.
- Papillary RCC: VENUSS score.
- Oncocytic renal neoplasm of low malignant potential: low-risk protocol unless otherwise decided after MDT review.
- Benign renal oncocytoma confirmed with complete excision: discharge from oncological follow up.
- Chromophobe RCC: UISS prognostic system.
- Collecting Duct Carcinoma: CTCAP 6 monthly for 3 years then annually up until 5 years.

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

Table 2 Minimum recommended imaging strategy after surgery (based on synthesis of EAU 2022, AUA 2021, NCCN and CAU Guidelines)

Risk profile	3m	6m	9m	1y	1.5y	2y	2.5y	3y	4y	5y	> 5y
Low	-	-	-	CT	-	-	-	CT	-	CT	Discharge
Intermediate	-	CT	-	CT	-	CT	-	CT	CT	CT	CT every 2y*
High	CT	CT	-	CT	CT	CT	-	CT	CT	CT	CT every 2y*

CT – CT chest, abdomen and pelvis. MRI abdomen / pelvis with non-contrast CT chest is an alternative for very young patients to minimise radiation, for those with iodinated contrast allergy and patients with chronic kidney disease as defined by local radiology policy.

*After 5 years a shared decision should be reached with the patient regarding ongoing surveillance taking into account their fitness and wishes

GIRFT guidance on kidney cancer: follow up section >

GIRFT guidance on kidney cancer: risk scoring systems >

11. Renal 2F cysts remote monitoring pathway

4 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	At 6 months, at 18 months, at 30 months and at 48 months, then discharged
Preferred type of contact with patient	App message or letter
Discharged criteria	No change in scans at 48 months (4 years)

12. Upper tract urothelial cancer (UTUC)

GIRFT upper tract urothelial cancer (UTUC) guide >

Table 3 Risk-stratified surveillance after radical nephroureterectomy

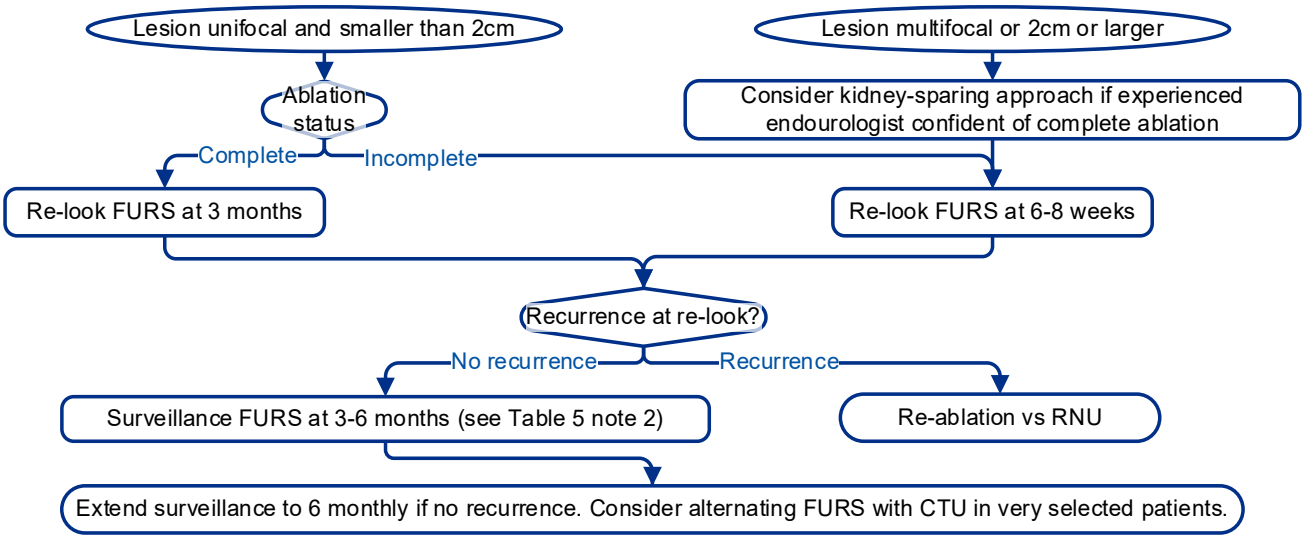
Risk category	Cystoscopic	CT
Post RNU low-risk tumours Low G2/G1 and pTa tumours with negative surgical margins	**Without history of NMIBC:** Cystoscopy at three months. If negative, repeat at 12 months and then yearly to 5 years. **With history of NMIBC: Follow NMIBC protocol based on stage and grade of NMIBC.**	• Annual CT urogram for 5 years. • No requirement for CT chest.
Post RNU high-risk tumours High Grade or ≥pT1 or positive surgical margins	• Cystoscopy and voided urinary cytology at 3 months. • **With history of NMIBC**: If negative, repeat 3 monthly to 2 years, then 6 monthly to 5 years, and then yearly. • **Without history of NMIBC**: If negative, repeat 6 monthly to 2 years, then yearly to 5 years.	Any high grade disease pTa, pT1, CIS or multifocal disease: • CT urography/abdomen and pelvis and chest CT every 12 months. Any pT2+ disease, pN+ disease or positive surgical margin: • CT urography/abdomen and pelvis and chest CT every 6 months for 2 years, and then yearly.

Table 4 Risk-stratified surveillance after kidney-sparing management

Risk category	URS	CT
Low-risk tumours Elective indications for NSS	Unifocal less than 2cm with confirmed complete ablation: second-look at 3 months. If 2cm or larger, multifocal or incomplete ablation: second look at 6-8 weeks, then repeat at 3 months. If recurrence free, 3-6 monthly relooks, surveillance interval tailored to patient (see note 2). Surveillance considered lifelong.	After 1 year: Consider substituting or alternating ureteroscopic surveillance with CT urogram in selected cases.
High-risk tumours In selected patients are detailed in section 4.	Second-look within 6-8 weeks, then 3 monthly for first year, then 3-6 monthly lifelong, surveillance tailored to patient (see note 2).	After 2 years: consider alternating URS with CT urogram in selected cases. Consider repeat staging CT at case-by-case intervals.
Note 1: Cystoscopic surveillance should follow the same protocol as those undergoing nephro-ureterectomy detailed above, as a minimum. It is recognised that patients may have more frequent cystoscopic follow up as part of their upper tract surveillance.		

Note 2: Surveillance interval factors include: initial tumour volume and multifocality, previous upper tract recurrences, any concordant (or prior history) of high-grade bladder cancer, and the patient's performance status.

Figure 2 Pathway for endoscopic management of low-risk UTUC



De-escalation of surveillance

In patients who are considered unsuitable for further treatment, de-escalation of surveillance investigations should be considered on an individual basis using a shared decision-making approach.

13. Prostate cancer

GIRFT suspected prostate cancer guide >

GIRFT Urology remote monitoring templates and guide >

Low risk of clinically significant prostate cancer

Low risk of clinically significant cancer (PI-RADs or Likert 1 and 2) and PSA density < 0.2	• Discharge to primary care with explicit PSA guidance on a threshold for re-referral based on PSA-density for re-referral. (Consider risk factors e.g. family history, ethnicity).
Low risk of clinically significant cancer based on MRI and PSA density (PI-RADS or Likert 3) with PSA density < 0.12	• Inform patient of the low likelihood of clinically significant prostate cancer. • Offer explicit PSA guidance to primary care on a threshold for re-referral based on PSA-density for re-referral. (Consider risk factors e.g. family history, ethnicity). • Follow up in primary care.

Patients on active surveillance

- Retest PSA 3 monthly in the first year and repeat MRI at 1 year.
- Digital rectal examination is not needed for patients on active surveillance who have an MRI at diagnosis and during follow up.
- Intensity of follow up will vary with the risk stratification of prostate cancer and the level of risk at which treatment will be triggered.

Remote monitoring - Prostate cancer on active surveillance	
Imaging:	**Frequency:**
PSA	Every 3 months
MRI	At 1 year
Preferred type of contact with patient	App/letter/telephone (patient choice)
Discharged criteria	Discharge at 5 years follow up

Patients who have had radical treatment

- PSA test and assessment at 3 months to consider functional impact (urinary, bowel and sexual), with access to specialist input for functional impact at this point or through patient initiated follow up (PIFU) for up to 2 years after treatment.
- PSA monitoring every 6 months for 2 years in secondary care and continued annual testing in primary care where PSA is undetectable, with re-referral to secondary care if PSA becomes detectable (see Table 5 PSA testing schedule).
- Implement electronic PSA tracking and consider postal point-of-care testing, where available, to avoid unnecessary attendances.

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

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.

Table 5 PSA testing schedule

Clinical Category	PSA testing schedule	PSA alert	Action if PSA exceeds alert
Active surveillance	3-monthly years 1 and 2 6-monthly years 3 and 4 Annually year 5	Set by clinician at referral to tracker	Repeat PSA in 6 weeks. If below alert, continue tracker. If above alert, trigger telephone review.
Post-radical surgery	3-monthly years 1 and 2 6-monthly years 3 and 4 Annually year 5 If PSA undetectable at 5 years discharge	Should be undetectable (<0.01) If detectable post-surgery, clinician to set individual patient alert	Repeat PSA in 6 weeks. If below alert, continue tracker. If above alert, trigger telephone review.
Post-radical radiotherapy	3-monthly years 1 and 2 6-monthly years 3 and 4 Annually year 5 If PSA undetectable at 5 years discharge	PSA will be low and detectable PSA nadir is the lowest level achieved post-treatment Alert is: · nadir plus 2 ng/ml · or 3 consecutive rises	Repeat PSA in 6 weeks. If below alert, continue tracker. If above alert, trigger telephone review.
Other radical therapies such as HIFU or brachy	Same as radiotherapy		
Watchful waiting	Determined by clinician according to patient status	Determined by clinician according to patient status	Clinical review

14. Bladder cancer

GIRFT Urology guide to suspected bladder cancer >

NMIBC

Category	NICE guidance	EAU guidance
Low	• No urinary biomarkers or cytology. • Cystoscopy at 3 months and 12 months after diagnosis. • Discharge if no recurrence of the bladder cancer within 12 months.	• No cytology • No systematic imaging • Cystoscopy at 3 and 12 months, then annually • Follow up duration 5 years
Intermediate*	• Cystoscopy at 3, 9 and 18 months, and once a year thereafter. • Consider discharging after 5 years of disease-free follow up.	• No cytology • No systematic imaging • Cystoscopy at 3 months, then every 6 months for 2 years, then annually • Follow up duration 10 years
High-risk (NICE) **High and very high (EAU)**	• Cystoscopy every 3 months for the first 2 years then, every 6 months for the next 2 years then, once a year thereafter.	• Cytology** • CT annually up to 5 years, then CT every 2 years • Cystoscopy every 3 months for 2 years, then every 6 months up to 5 years, then annually • Lifelong follow up

* EAU: Intermediate risk HG/G3 subgroup should be followed up as high-risk

** EAU: At the same intervals as cystoscopy

Post cystectomy follow up

Cystectomy - Low risk. + / - CIS, pT0, pt1	
Tests, imaging or treatment:	**Frequency:**
Initial post-surgical review	At 6 – 10 weeks after surgery, then at least once per year for 5 years.
eGFR, Calcium, B12.	Once per year.
Folate if neobladder	Once per year.
CT	Once per year for 5 years.
Urethral wash cytology and/or urethroscopy	Low risk of urethral recurrence: Not routine.
	High risk of urethral recurrence: Every 6 months for 2 years, then once per year for 3 years.
Post-radiotherapy	If received radiotherapy and suitable for salvage cystectomy or further treatment, should receive regular cystoscopy 3 monthly for 2 years, then 6 monthly for the next 2 years, then once in year 5.
Discharged criteria	Consider after 5 years.

Cystectomy – Intermediate risk. pT2 or pT3, and N0, R0	
Tests, imaging or treatment:	**Frequency:**
Initial post-surgical review	At 6 – 10 weeks after surgery, then at least once per year for 5 years.
Oncology review:	Test for PDL1 expression if T2 after neoadjuvant treatment or T3 without neoadjuvant treatment. Refer by 6 – 10 weeks after surgery. Adjuvant treatment to start within 120 days of surgery.
eGFR, Calcium, B12.	Once per year.
Folate if neobladder	Once per year.
CT	Once every 6 months for 1 year and once per year for 4 years.
Urethral wash cytology and/or urethroscopy	Low risk of urethral recurrence: Not routine.
	High risk of urethral recurrence: Every 6 months for 2 years, then once per year for 3 years.
Discharged criteria	Consider after 5 years.

Cystectomy – High risk. T4, N1+ or M1	
Tests, imaging or treatment:	**Frequency:**
Initial post-surgical review	At 6 – 10 weeks after surgery, then at least once per year for 5 years.
Oncology review:	Test for PDL1 expression and refer by 6 – 10 weeks after surgery. Adjuvant treatment to start within 120 days of surgery.
eGFR, Calcium, B12.	Once per year.
Folate if neobladder	Once per year.
CT	Once every 6 months for 2 years, then once per year for 3 years.
Urethral wash cytology and/or urethroscopy	Low risk of urethral recurrence: Not routine.
	High risk of urethral recurrence: Every 6 months for 2 years, then once per year for 3 years.
Discharged criteria	Consider after 5 years.

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.
GIRFT Urology PIFU and remote monitoring templates	GIRFT	This guide sets out advice and tips on using PIFU alongside template PIFU and remote monitoring pathways.
Example PIFU patient information leaflets	GIRFT	Example leaflets with information for patients who are on a PIFU pathway.

Urology PIFU table

Clinical condition	PIFU Type	Patient triggers for contact	Hospital contact following trigger	Review or Discharge timeline
Lower urinary tract symptoms (LUTS), overactive bladder, receiving Botox	Discharge PIFU	Worsening lower urinary tract symptoms	Face to face on cystoscopy and Botox list	Not applicable
Bladder pain syndrome / Interstitial cystitis patients	Discharge PIFU	Significant change/ progression of symptoms: Pain, urgency, frequency, proven recurrent UTIs	Telephone initially	Discharge at 2 years
Pelvic floor disorders or conditions being managed conservatively, or Self-change of ring pessary	Discharge PIFU	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.	Telephone, with imaging arranged as required	Discharge at 2 years
Patients on long term ISC	Discharge PIFU	Difficulty passing catheter: Recurrent UTI's: Haematuria	Telephone initially	Discharge at 1 year
Recurrent urinary tract infection (UTI) on management pathway*	Discharge PIFU	Recurrent painful micturition with frequency, urgency, nocturia, Pelvic pain or discomfort suggestive of urinary tract infection, Visible blood in the urine and/or Proven UTI on MSU; despite appropriate treatment.	Telephone	Discharge back to GP at 1 year
Erectile dysfunction treatment (injection, intraurethral)	Discharge PIFU	Telephone	Treatment not successful pain or swelling on administration	Discharge at 6 months
Post peyronies corrective surgery	Discharge PIFU	Pain or swelling after 4 weeks, failure of correction of bend, and/or declining function at 3 months post-operation to the extent that the patient wishes to have intervention.	Telephone	Discharge at 3 months
Post-operative bladder-outlet obstruction	Discharge PIFU	Poor flow and/or Ongoing frequency/urgency/incontinence after 3 months and despite appropriate treatment:	Telephone/app message initially	Discharge at 6 months
Post surgical operation to remove stones	Discharge PIFU	Pain, bleeding and/or infection	Telephone/app message with imaging arranged as required	Discharge at 3 months
Stones	Review prior to expiry	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	Telephone/app message, with imaging arranged as required	Non face-to-face clinical review at 2 years with CT scan

* Not for PIFU for recurrent UTI: Pain on voiding with back or loin pain or temperature requires urgent medical attention through NHS 111 or GP.

Urological cancer follow up and remote monitoring table

Clinical condition	Tests and imaging	Frequency	Preferred type of patient contact	Discharge criteria
Cystectomy - Low risk. + / - CIS, pT0, pT1	B12/Folate, FBC, U&E, LFT, Bone profile Bicarbonate	At 3, 6 & 12 months, and each year to 6 years.	Letter/ telephone (patient choice) by appropriate clinician to review result and contact patient.	Discuss with patient (consider co-morbidity / wellness) either discharge or on-going surveillance CT TAP every 2 years
	CTU + Thorax	Each year until 6 years		
	USS	At 6 years, then every 2 years by GP		
	GFR	Annually		
Cystectomy - Intermediate risk. pT2, pT3	B12/Folate, FBC, U&E, LFT, Bone profile Bicarbonate	At 3, 6 & 12 months, and each year to 6 years.	App/letter/telephone (patient choice) by appropriate clinician to review result and contact patient.	Discuss with patient (consider co-morbidity / wellness) either discharge or on-going surveillance CT TAP every 2 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		
Cystectomy – High risk. Node positive, T4 or positive Mets (usually bone) Refer to oncology is spread at 3 months or more	B12/Folate, FBC, U&E, LFT, Bone profile Bicarbonate	At 3, 6 & 12 months, and each year to 6 years.	App/letter/telephone (patient choice) by appropriate clinician to review result and contact patient.	Discuss with patient (consider co-morbidity / wellness) either discharge or on-going surveillance CT TAP every 2 years
	CTU + Thorax	At 3, 6 & 12 months, and each year to 6 years.		
	USS	At 6 years, then every 2 years by GP.		
	GFR	Annually		
Prostate cancer on active surveillance - remote monitoring	PSA	Every 3 months	App/letter/telephone (patient choice)	Discharge at 5 years follow up
	MRI	At 1 year		
Prostate cancer – Following radical treatment	PSA and assess function impact (urinary, bowel, sexual)	At 6 – 12 weeks	App/letter/telephone (patient choice)	Discharge at 5 years follow up
	PSA, re-referral threshold set by treatment team	Every 6 months		
Kidney cancer Low risk	CT chest, abdomen and pelvis.*	At 1 year, 3 years and 5 years.		Discharge at 5 years
Kidney cancer Intermediate risk	CT chest, abdomen and pelvis.*	At 6 & 12 months, and each year until 5 years then every 2 years after this.	After 5 years a shared decision should be reached with the patient regarding ongoing surveillance taking into account their fitness and wishes	
Kidney cancer High risk	CT chest, abdomen and pelvis.*	At 3, 6 & 12 months, at 1 year 6 months, each year until 5 years, then every 2 years after this.	After 5 years a shared decision should be reached with the patient regarding ongoing surveillance taking into account their fitness and wishes	
Bosniak 2F cysts	CT with contrast	At 6 months, at 18 months, at 30 months and at 48 months, then discharged	App message or letter	No change in scans at 48 months (4 years)

* For kidney cancer follow up: MRI abdomen / pelvis with non-contrast CT chest is an alternative for very young patients to minimise radiation, for those with iodinated contrast allergy and patients with chronic kidney disease as defined by local radiology policy.

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