Thursday 26 June 15.00–16.00
Poster Session 16: Clinical Governance: Audit and Cancer Pathways
Chairmen: M. Fordham and M. Harrison

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Clinic overload! – A national audit of outpatient service provision

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INTRODUCTION

In October 2000, the council of BAUS published the document 'A Quality Urological Service for Patients in the new Millennium'. In short, this set out guidelines for outpatient workload, manpower and standards of care. A national questionnaire-based audit was conducted to assess, both at regional and national levels, the current clinic-based workload and in particular, to assess what proportion of urologists were able to meet these guidelines.

METHODS

All 520 UK consultant urologists were asked to complete a short postal questionnaire in late summer 2002, which provided information on the grade and numbers of medical staffing in each 'routine' clinic, the outpatient frequency, the numbers of new and follow-up patients seen in these clinics, and the geographical region.

RESULTS

The overall questionnaire return rate was 61% (318/520; regional range 42–75%). The median 'routine' clinics/week was 2 (1–5),

seeing a mean of 13 (1–40) new and 26 (7–80) follow-up patients; 15% (49/318) of consultants did all the routine clinics alone and of the remainder, assistance included specialist registrars in 67% (212/318), staff grade/associate specialists in 32% (102/318), SHOs in 53% (172/318) and PRHOs in 2% (7/318). Only 21% (66/318) of responding consultants followed the BAUS recommendations for outpatient workload/manpower. There was a large variation among differing geographical regions, with the ranges illustrated by Northern Ireland (0%) and East Scotland (46%).

CONCLUSION

Only a minority of urological consultants are able to meet the outpatient workload guidelines, as set out by BAUS Council. In addition, there appear to be significant variations in clinic workload among regions.

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Use of urology theatre time: a retrospective audit

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INTRODUCTION

Efficient use of theatre time is essential if waiting lists are to be reduced. Information about the length of operations could help in using theatre time efficiently. We audited the use of urology theatre time and assessed the time involved in common urological operations.

METHODS

Information was collected on 43 urology lists over 4 months. Times spent in the anaesthetic room and on the operating table were calculated for individual operations and the whole list. The mean duration of the theatre list, mean time for each operation and the time spent in each stage was calculated.

RESULTS

The total allocated time for theatre during the study period was 175 h, but the actual theatre time used was 153 h. Of this time, 19% was spent in the anaesthetic room and 65% in the operating room. Of the total of 43 lists, 37 lists started late, by a mean of 12 min; 23 lists finished late by a mean of 14 min. The mean (95% CI) time spent in the anaesthetic room and on the operating table, respectively, for TURP, TURBT and nephrectomy, were 16 (15–17) and 46 (43–49), 4 (12–15) and 37 (33–41), and 21 (20–22) and 102 (94–110) min.

CONCLUSION

The use of allocated urology theatre time is 84%; delays in starting, finishing and turnover time must be minimized for efficient use, as lapses in this could be expensive (mean theatre costs are £350/h). We also provide a realistic estimate of the mean time needed for common urological operations, which would help in efficient planning of lists.

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Seven years' experience with a computerized audit system for urology

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INTRODUCTION

A computerized urology audit system was set up in August 1995. The diagnosis and procedure codes (second edition 1996), issued by BAUS, incorporating the ICD10 and OPSCS4 codes, were used.

METHODS

A standard data entry form has sections for demographic details, date and mode of admission, diagnostic and procedural codes along with comorbidity, investigations and reports, details at the time of discharge and arrangements for follow-up. There is also space for free text. Specific sub-forms have been created to audit the urodynamic and lithotripsy data. For network and software, the data are entered into a similar form on the secretaries' personal computers, which are networked using NOVELL software. The audit system runs in DATAEASE, a relational database. The final processing of a query is by visual Basic, usually in an Excel spreadsheet. The system is stored on a file server and six different individuals can log in via NOVELL.

RESULTS

This system produces an automated discharge summary and has greatly facilitated several clinical, managerial and training audits. To date over 220 queries have been processed. Examples of these are audits of stone

clearance after lithotripsy, an ongoing ureteric stent audit and a review of changing trends in prostatectomy. Trainee logbooks can also be produced by the system.

CONCLUSION

Seven years of accurate activity data have given us a powerful clinical audit tool which is indispensable for clinical, training and managerial needs.

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A 1-year review of rapid-access referrals to a urology outpatient clinic

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INTRODUCTION

To facilitate the early detection of cancers, a rapid referral protocol has been established, allowing GPs to have patients with specific signs and symptoms seen in specialist clinics within 2 weeks.

METHODS

We undertook a prospective proforma-based audit of all 2-week referrals to a teaching hospital urology department over a 1-year period, assessing the quality of the referrals, the service provided and the cancer detection rates.

RESULTS

Over 1 year, 456 patients were referred via the 2-week protocol; 220 had haematuria, yielding 27 bladder cancers, 14 prostate cancers and one renal tumour. In all, 119 patients had signs or symptoms suggestive of prostate cancer; this group yielded 37 prostate cancers. Eighty-seven patients had testicular swelling, yielding three testicular cancers, one scrotal cancer and one prostate cancer. Eight patients had renal and penile signs and symptoms, yielding one each of penile, prostate and renal tumours. The mean wait to be seen was 10 days; 73 (16%) patients had to wait >2 weeks. In 121 (27%) of the referrals the use of the 2-week protocol was deemed be inappropriate.

CONCLUSION

The 2-week protocol provided a cancer detection rate of 19%, which varied widely depending on the referring criteria. Testicular referrals were particularly poor, with a 4% detection rate. To improve the quality of the service we will be making changes to the referral criteria and feeding back to the GPs. We will then close the audit loop by re-auditing for another year.

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The tip of the iceberg: the 2-week cancer wait

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INTRODUCTION

The NHS Plan, attempting to provide a health service fit for the 21st century, introduced the '2-week rule' for patients with suspected cancer. The aim of this study was to establish the demand from primary care for urological services for suspected cancer, and assess our capacity to meet this demand.

METHODS

All GP referrals were audited during an 8-week period from May to July 2002, and those referred under the 2-week rule recorded. Those patients not referred under the 2-week rule were classified as suspected cancer or benign, based upon information within the referral. During the same period the available appointments for patients with either haematuria or suspected prostate cancer were monitored.

RESULTS

In all, 410 urological referrals were made over the 8-week period; although 43% fulfilled the '2-week rule' criteria, only 8% were referred as such. Weekly there was a mean (range) of 5.4 (2–8, capacity 4) with suspected prostate cancer and 13.4 (4–19, capacity 18) with haematuria. To meet the demand for suspected prostate cancer a separate 'abnormal prostate' clinic has been established. While sufficient capacity exists within the haematuria service, non-attendees increase actual demand while reducing capacity. A direct booking strategy has been implemented addressing this issue.

CONCLUSION

The true number of patients referred with suspected cancer far exceeds those referred under the 2-week rule. Demand-capacity analysis, ignoring the 2-week rule, is a prerequisite to a patient-centred delivery of services. Honourable as governmental intention is, current working of the 2-week rule appears to be detrimental to the delivery of patient care.

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The NHS cancer plan: where do we stand?

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INTRODUCTION

The DoH introduced a maximum 2-week waiting time for an outpatient appointment for suspected cancer in December 2000. The ultimate goal is to offer patients with cancer treatment within 1 month of an urgent referral.

METHODS

We reviewed all urgent suspected cancer referrals from 1 July 2001 to 30 June 2002, to determine the proportion of patients seen within 2 weeks, the appropriateness of the referrals in terms of national and locally negotiated guidelines, and the mean waiting time for various investigations and treatment.

RESULTS

Of 401 patients haematuria accounted for the bulk of referrals (61%); 32% of patients with haematuria were seen within 2 weeks and 38% of the referrals were inappropriate. The mean waiting time for cystoscopy and IVU was 28 days, and to treatment 45 (23–80) days; 90% of bladder tumours were in the early stages. Of suspected prostate malignancies, 77% were seen within 2 weeks; 25% of the referrals were inappropriate. The mean waiting time for TRUS was 28 (2–72) days and for treatment from the day of referral was 81 (21–150) days. Of suspected testicular malignancies, 78% were seen within 2 weeks; 60% of the referrals were inappropriate. The mean time to oncology treatment was 45 (35–65) days. For suspected renal malignancies, the mean waiting time for CT was 10 days and for surgery 39 (21–68) days.

CONCLUSION

A significant increase in consultant clinic sessions, theatre time and investment in support services including radiology will be needed to fulfil the NHS cancer plan. The education of GPs is of utmost importance to reduce the number of inappropriate referrals, which in return may improve the efficiency of the system.

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How patients respond to further haematuria, having previously been assessed and reassured that urinary tract investigations were normal

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INTRODUCTION

Patients are often anxious when they have haematuria and seek medical advice. The aim of this study was to follow-up how patients respond to further haematuria, having previously been assessed and reassured that urinary tract investigations were normal.

PATIENTS AND METHODS

All patients discharged from the Rapid Access Haematuria Clinic between 29 June 1998 and 22 March 2001 (964) who had normal haematuria investigations (MSU, urine cytology, renal ultrasonography, IVU and rigid or flexible cystoscopy) were sent a postal questionnaire 1 year later asking if they had had further haematuria and if so, what action they had taken.

RESULTS

Of 647 replies (68.4%), 171 patients admitted to further haematuria, most of whom (89.5%) had macroscopic haematuria. Seventy patients (41%) consulted their GP and only six were referred back to our department for further investigation. One woman with macroscopic haematuria was, on subsequent re-investigation, found to have a TCC of her left renal pelvis and pulmonary metastasis. No action was taken by 57 patients (33.3%), most stating that they felt nothing was wrong because the recent investigations had been normal. None of the 37 patients who re-presented directly back to the department had any sinister pathology identified.

CONCLUSION

These results show that 26% of patients have continuing haematuria after normal urinary tract investigations and most (67%) will seek medical advice. Although there are no guidelines on how to follow-up these patients, they are often re-investigated despite the very low chance of further abnormalities being detected.

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Surveillance of bladder cancer: time for a UK guideline

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INTRODUCTION

The surveillance of bladder TCC forms a major part of the urologist's workload. Unfortunately, the policy for long-term follow-up of these cancers is not clear. Our study was undertaken to provide national practice data, and begin formulation of a guideline.

METHODS

Consultant urologists in the UK and Ireland (501) were surveyed using a questionnaire to ascertain their policy on the long-term follow-up of different bladder tumours once patients are free of recurrence.

RESULTS

The completed questionnaire was returned by 73% (365/501) and the table summarises the practice of urologists as a percentage of opinion for the long-term follow-up. In all, 55% felt no role was indicated for urine cytology in the long-term surveillance, once cystoscopy had been stopped, whereas 16% used urine cytology for all tumour types and 29% used it for certain tumours/conditions.

	Duration of surveillance			
Tumour type	5 years	10 years	Lifelong	Other
pTaG1	33	47	18	2
pTaG2	16	45	38	1
pT1G1/2	11	41	47	1
pT1G3	7	22	70	1
Invasive (after radiotherapy)	6	23	70	1

CONCLUSIONS

Our study showed the variable nature of bladder cancer follow-up in the UK and Ireland, which has major implications for policy making, resource allocation, and cancer survival. We highlight the urgent need for national guidelines in this area for optimal surveillance of bladder cancer, until prospective evidence-based data become available.

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'Urological cancer pathway': closing the audit loop

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INTRODUCTION

We previously reported a patient pathway audit on 100 randomly selected patients with 'potentially curable' urological cancers, before the NHS 2-week deadline became applicable. As a result we initiated certain changes in our practice. The current study examines whether these changes and the introduction of the 2-week rule helped to expedite the patients' journey.

PATIENTS AND METHODS

The hospital records of 100 randomly selected patients, who underwent radical surgery for cancers of kidney, testis, bladder and prostate after December 2000, were reviewed. Each group consisted of 25 patients. As in the previous audit, the time intervals from GP referral to urology appointment (1UA), then to confirmation of diagnosis, and finally to staging and radical surgery, were recorded. The mean (95% CI) were calculated for each group and for the whole population. The values were compared with the previous findings.

RESULTS

Before December 2000, 34% of patients were seen within 2 weeks, compared with 42% in the current study. However, all patients

referred through the rapid access were seen within 2 weeks. The results show an overall improvement except in the last sector of the patient pathway. The mean intervals (95% CI) in days from GP referral to radical surgery were:

Organ	R-1UA < 2000	R-1UA > 2002	1UA-D < 2002	1UA-D > 2002	D-S < 2000	D-S > 2002
Kidney	41 (18–64)	23 (14–32)	29 (8–50)	26 (14–37)	27 (19–35)	24 (14–33)
Testis	35 (21–50)	12 (5–19)	14 (0–28)	5 (1–9)	11 (3–18)	5 (2–8)
Bladder	49 (30–67)	26 (17–35)	29 (18–41)	20 (11–30)	94 (54–135)	46 (34–57)
Prostate	59 (41–76)	32 (27–38)	180 (77–284)	63 (44–81)	75 (60–90)	91 (81–101)
Total	46 (37–55)	27 (23–31)	64 (35–92)	43 (32–54)	57 (42–71)	55 (57–71)

R-1UA, referral to first urology appointment; D, diagnosis; S, surgery; < 2002, before Dec 2002; >2002; after Dec 2002.

CONCLUSION

The 2-week wait initiative has decreased the waiting times to see a specialist and the introduction of dedicated clinics has decreased the time to diagnosis. However, there was no change in the interval from diagnosis to definitive surgery. That would need investment in capacity and human resources to make substantial progress in the delivery of cancer care.

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Improving outcomes in urological cancers: the impact and cost of 'Multidisciplinary Team Meetings'

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INTRODUCTION

To improve the outcomes of urological cancers guidelines published by the National Institute of Clinical Excellence encourage the management of patients by specific Multidisciplinary Teams with discussion of cancer patients at Multidisciplinary Meetings (MDMs). The aim of this prospective study was to examine the changes in management resulting from review at MDMs in our unit, and their costs.

METHODS

Over a 6-month period, 124 cancer cases were discussed at 10 MDMs. Before the meetings consultants completed a form stating their proposed management and whether they thought this would be changed after the MDM. At the meeting histological, radiological and clinical data were reviewed and a collective decision made about the optimal treatment. Any changes were recorded. Costs examined included salaries, administration and room hire.

RESULTS

Two of 124 cases had their clinical management changed as a result of the MDM. These were identified as potential 'changed cases' before the MDM. Four changes were made to histological reports and one to radiology; none of these affected clinical management. During the study MDMs cost £18 898; this translates to a cost of £152 per case discussion or £9449 per clinical change.

CONCLUSION

Discussion of cancer cases at MDMs made no difference to the clinical management in over 98% of cases. Consultants correctly identified cases requiring discussion, indicating that a selective rather than a 'blanket' approach would be appropriate. This has the potential to reduce the considerable costs involved without affecting patient care.