

## UROGYNECOLOGY TRIAGE CLINIC: OPTIMAL MODEL OF HEALTHCARE DELIVERY?

### Hypothesis / aims of study

Increasing waiting time for hospital appointments and treatment is a major health and political issue. In the United Kingdom, the Department of Health highlighted the need for service redesigning. The NHS Improvement Plan set out a directive to reduce time between referral and treatment to less than 18 weeks (1). The benefits of one-stop nurse led clinics have been well explored and documented, especially in other specialties (2). We commenced a nurse led Urogynecology Triage Clinic (UTC) aiming to reduce waiting time for clinic appointments, investigations and treatment for women referred with urogynecological problems. The aims of this study were to assess the effectiveness of the UTC with respect to time interval from primary referral to first hospital contact, from first hospital contact to outcome and the effectiveness of patient pathway.

### Study design, materials and methods

Three hundred case notes of patients attending the UTC between January 2006 to November 2007 were selected randomly for review. Patients were referred to the UTC mainly by the General Practitioner (GP), but also by other hospital health professionals. Only patients referred with lower urinary tract symptoms were seen in the UTC as patients who had any other associated symptoms were seen in appropriate specialist clinics e.g. hematuria clinic, pelvic floor clinic, perineal clinic. A three day bladder diary and a designed symptom specific questionnaire were posted to each patient to complete and bring to their first clinic visit. Each patient was allotted 30 minute appointments and every patient had a symptom profile, urinalysis, post void residual, vaginal examination and pelvic floor tone assessed. Lifestyle interventions (e.g. weight loss, reduced caffeine intake, dietary interventions) behavioural therapy (e.g. bladder training, pelvic muscle exercises) and drug therapy were initiated as appropriate. Subsequent management was tailored to the patient progress and preference. Patients were discharged when symptoms were no longer bothersome and the patient was satisfied with the outcome. Patients who were still symptomatic were referred on to the appropriate specialist consultant clinics. The intervals between primary referral to first hospital contact and first hospital contact to final outcome were analyzed. The referral pattern, median number of visits and the treatment offered were also analyzed. The above time intervals were compared with the time intervals prior to commencement of the UTC.

### Results

The mean age at referral was 55 (SD=16.9, range=13-96). Almost half, 148(49.3%) of the patients had previous pelvic surgery: 46 (15.3%) had hysterectomy alone, 10 (3.3%) had vaginal repair alone and 14 (4.7%) had a combination of hysterectomy and vaginal repair. Eleven (3.7%) had previous continence surgery and 67 (22.3%) had other gynecological surgery. The mean time interval from referral to first visit was 4.6 weeks (SD=1.97, range=1-11) compared to pre-UTC when it was 15.6 weeks (range=12-32). The mean number of visits were 2.1 (SD=1.33, range=1-9). The mean number of weeks from first visit to final outcome was 8.8 weeks (SD=11.2, range=1-60) compared to pre-UTC when it was 11 months (range=3.0-23.0). The symptom profile and management is shown in Tables 1, 2 and 3.

**Table 1: Symptoms**

Presenting Complaint	
Stress incontinence alone	43 (14.3%)
Urge incontinence alone	48 (16%)
Mixed incontinence alone	62 (20.6%)
Recurrent UTI alone	33 (11%)
Voiding difficulty alone	28 (9.3%)
Incontinence with prolapse	20 (6.6%)
Nocturia alone	6 (2%)
combination of above	60 (20%)

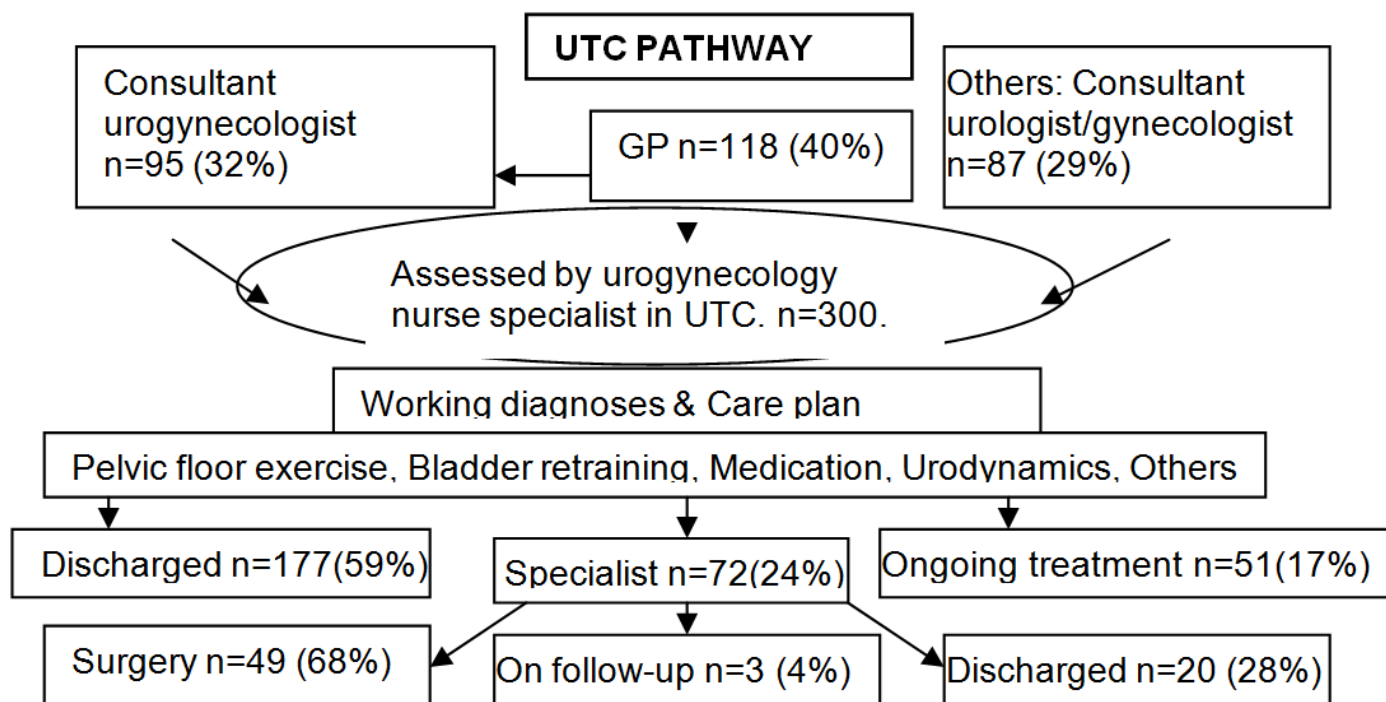
**Table 2: Duration of symptoms**

Less than 6 months	31 (10.3%)
6 months to 1 year	72 (24%)
1 year to 5 years	92 (30.7%)
More than 5 years	105 (35%)

**Table 3: Management:**

Pelvic floor exercises	37 (12.3%)
Bladder retraining alone	38 (12.6%)
Anticholinergics with other modalities	37 (12.3%)
Recurrent UTI protocol	28 (9.3%)
Referred for urodynamics	4 (1.3%)
Referred for post void residuals alone	5 (1.7%)
Trial without catheter alone	12 (4%)
Intermittent self catheterisation	6 (2%)
Combination of above	133 (44.3%)

Figure 1: Outcomes



The patient pathway is detailed in **Figure 1**. Of the 72 that were referred to a specialist clinic, 60 (83.3%) were referred to the urogynecology clinic, 1 (1.4%) to the pessary clinic, 5 (6.9%) to the pelvic floor clinic and 6 (8.3%) to the urology clinic.

#### **Interpretation of results**

Sixty-six percent of the referred patients had long standing symptoms of more than one year (35% > 5 years). This could be attributed to either patient's reluctance to seek help due to embarrassment or the absence of a user friendly service. Almost half had previous pelvic surgery suggesting a possible relationship between bladder symptoms and pelvic pathology and is reflected in the prevalence of mixed incontinence in the majority of the patients. One hundred and eighteen patients were directly referred by the GP's which would effectively decrease the referrals to specialist consultant clinics and foster conservative patient management. Fifty-nine percent of the patients were discharged without the need for urogynecology consultant referral highlighting that the majority of patients can be managed effectively by a specialist continence nurse. The mean time interval from referral to first visit was 4.6 weeks which effectively enables the patient pathway to be completed within the United Kingdom government target of 18 weeks. The mean number of visits of 2.1 and the mean number of weeks from first visit to final outcome of 8.8 weeks are well within the 18 week referral to treatment pathway target (1). None of the patients were treated with anti-cholinergics alone for overactive bladder symptoms in keeping with NICE guidelines (3)

#### **Concluding message**

By service redesigning, the UTC has reduced the number of clinic visits and improved the entire patient journey from referral to treatment. This UTC provides a model for future service redesigning and integration to streamline care and reduce the burden on secondary care.

#### **References**

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2. Cluster randomized trial of a guideline-based open access urological investigation service. *Family Practice* (2003);20: 646-654.
3. The management of Urinary Incontinence in women. National Institute for Health and Clinical Excellence. Guideline No 40 (2006). [www.nice.org.uk](http://www.nice.org.uk).

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<i>What were the subjects in the study?</i>	HUMAN
<i>Was this study approved by an ethics committee?</i>	No
<i>This study did not require ethics committee approval because</i>	The study was part of routine clinical practice.
<i>Was the Declaration of Helsinki followed?</i>	Yes
<i>Was informed consent obtained from the patients?</i>	No