University Hospital Southampton
NHS Foundation Trust

THE RAPID INVESTIGATION SERVICE FOR WESSEX

TESTICULAR SELF-REFERRAL PILOT EVALUATION

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UNIVERSITY HOSPITAL SOUTHAMPTON NHS FOUNDATION TRUST

TESTICULAR SELF-REFERRAL PILOT EVALUATION	
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Objective	To evaluate and review the outcomes from the testicular self-referral service pilot, which commenced in July 2024. The evaluation will provide information and insight to inform proposals for the growth and sustainability of a testicular self-referral pathway. This evaluation outlines the national strategic context, current pilot service delivery, benefits, risks and issues, as well as outcomes including patient experience and colleague feedback.

SUMMARY

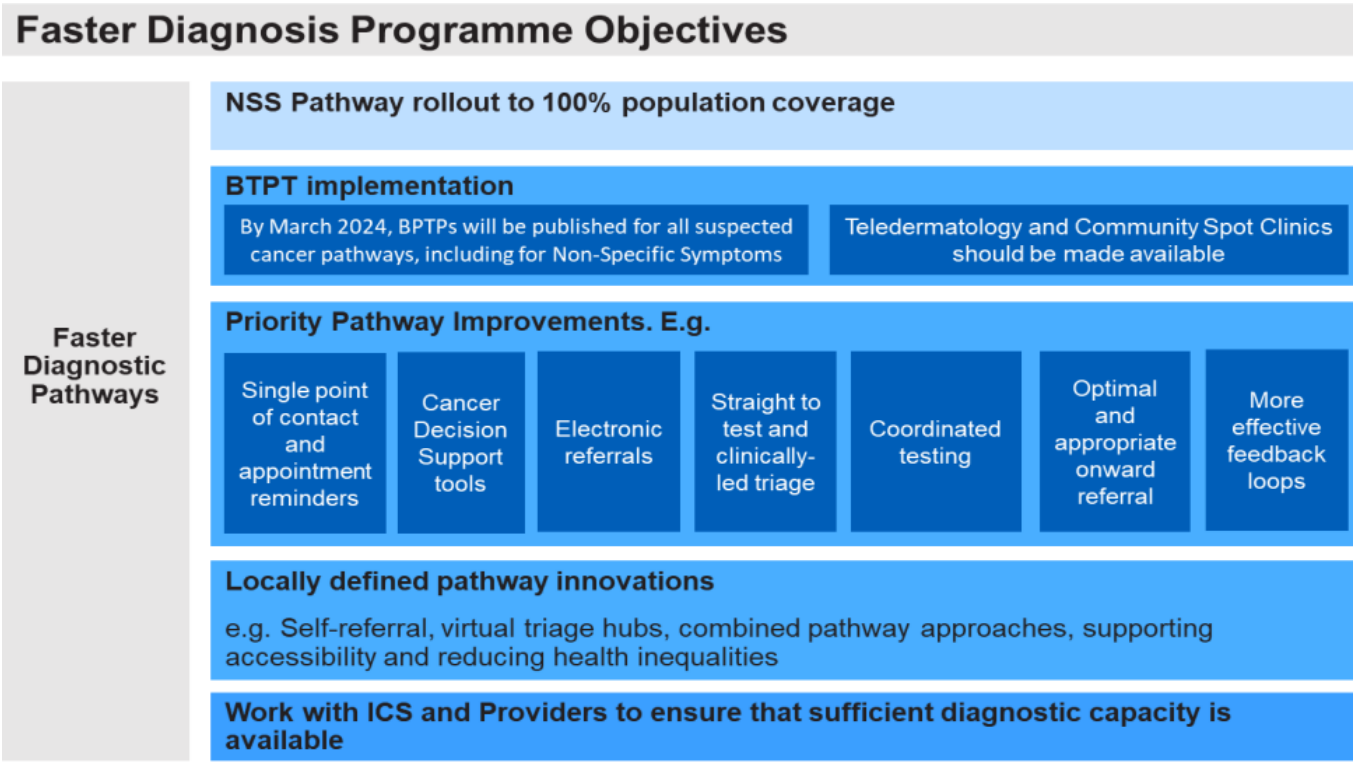
From the implementation of this pathway, the key take home messages from the testicular self-referral pilot are:

- Improved access to people from various ethnicities, with a higher proportion of people from black and minority ethnic (BAME) communities and younger people utilising self-referral, supporting to reduce health inequalities.
- Reduction in the number of people needing to be consulted by a Primary Care clinician, supporting GP capacity.
- The pathway has not required additional staffing to support the service by utilising the existing workforce.
- Self-referral has not significantly increased demand on Urology services.
- Patient feedback indicated people had a positive experience using the service for its convenience and feeling reassured in a timely manner.
- Staff feedback from primary care has found that the self-referral service reduced workload and is welcomed as a service to be continued.

- Whilst no cancers have yet been identified through self-referral, incidental non-cancer diagnoses have been made in 74% of patients.

NATIONAL BACKGROUND TO FASTER DIAGNOSIS FRAMEWORK

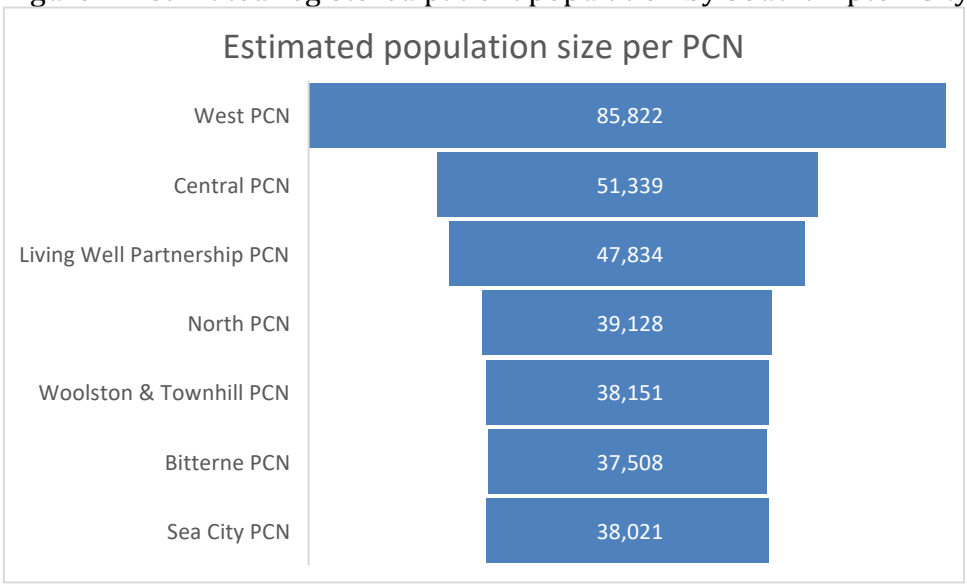
The testicular self-referral pilot service was initiated as part of the Wessex Cancer Alliance (WCA) response to the Faster Diagnosis Framework to deliver the ambition to diagnose or rule out cancer faster and to improve patient experience. This includes locally defined pathway innovations within this framework, as detailed below. Self-referral was cited as part of the transformational change objectives to support patients who are concerned, they have symptoms of cancer or other serious health conditions. The recommended approach to implementing a self-referral pathway is through an appropriate assessment of symptoms before onward referral and for this to be co-designed between primary and secondary care, with patient representative input.



Source: Faster Diagnosis Framework 2022, page 10.

As such, this pilot service was developed in partnership between the Wessex Rapid Investigation Service team working together with clinical colleagues from University Hospital Southampton NHS Foundation Trust and seven Primary Care Networks: Bitterne PCN; Living Well PCN; Central Southampton PCN; Southampton North PCN; Southampton West PCN; Woolston & Townhill PCN; Sea City PCN. The pilot cohort covers all Southampton City practices (c. 99,000 patient population males aged 18-50, out of 175,000 total males in Southampton City footprint, out of 337,000 total Southampton City population (GP registered population of males and females)).

Figure 1. Estimated registered patient population by Southampton City PCN



Data retrieved from NHS England interactive dashboard for patients registered at a GP Practice (October 2025).

THE WESSEX SELF-REFERRAL APPROACH

The testicular self-referral pathway operates using the virtual, centralised service model developed for the non-specific symptoms pathway and is facilitated through a central virtual hub hosted by University Hospital Southampton (UHS).

The service model, designed and implemented by the WCA & UHS, was developed for men aged 18 to 50 years old with a painless, testicular lump registered to a GP practice within the Southampton City locality. The eligibility criteria for locality were contained to Southampton City for the pilot to analyse and evaluate the effectiveness of a testicular self-referral pathway before consideration of sustaining or expanding the service more widely, and to manage demand on UHS Urology services.

For the duration of the pilot, the self-referral service allowed patients to watch an educational video and then self-refer to the RIS by telephone, where they were asked a series of screening questions to assess their symptoms and ensure eligibility criteria were met for the service. If people were considered suitable, they were referred into a urology clinic on a fast-track urgent suspected cancer (USC; previously two-week wait) pathway at UHS where they would have an ultrasound scan (USS) first and then attend and outpatient appointment (OPA) with a Consultant Urologist on the same day.

SERVICE PURPOSE AND OBJECTIVES

The purpose of the testicular self-referral pilot is to provide a service which allows patients to self-refer when they identify that they have or may have a new, painless, testicular lump to access onward management where appropriate. This provides an alternative option to the traditional route through primary care and aims to provide a more specialist and tailored service for this cohort of people.

Objectives for the service include:

- To provide an alternative route for people to report their symptoms
- To speed up the process for accessing a urology clinic appointment for those presenting with a testicular lump
- To remove the need to access a GP appointment prior to referral to a urology clinic
- To provide people with tools and information to understand their symptoms through a bespoke animation to guide self-examination. Where not suggestive of cancer, ensure patients have the correct information on who to contact so their symptoms can be treated as appropriate e.g. registered GP for further examination and management within primary care or presentation to A&E
- To reduce demand on primary care services through bypassing the need for a consultation with a clinician prior to being referred on a USC pathway
- To provide excellent patient coordination and support

The service has delivered in response to the above:

- Direct self-referral access with the RIS having the ability to refer onwards directly to a urology clinic on an urgent suspected cancer pathway
- Increase education for patients around self-examination
- Rapid turnaround from the point of self-referral to referral to a one-stop urology clinic where clinically indicated
- Reduce demand on primary care services
- Single point of contact lines for patients to maximise support and deliver a positive patient experience
- Safety netting and signposting of people outside of secondary care where clinically appropriate

CURRENT SERVICE MODEL

The pilot service model assigned people presenting with a testicular related symptom into one of two management pathways.

1. **Palpable, painless, testicular lump (appropriate referral):** this cohort of people are directed to an online educational video and then asked screening questions to confirm suitability for the pathway and where appropriate, they are referred directly onto an urgent suspected cancer pathway.
2. **Other testicular concern (inappropriate referral)**: after watching the educational video this cohort of people are asked screening questions in the first instance and where inappropriate for the pathway, signposted back to their GP surgery for a consultation.

The criteria for the self-referral pathway were developed in line with NG12 guidelines for suspected cancer recognition and referral. Appropriate alternative pathways exist for those patients not meeting the eligibility criteria for self-referral. The inclusion and exclusion criteria are outlined below:

Inclusion Criteria:

- New, painless, testicular lump
- Aged 18-50

- Registered with a GP practice partaking in the pilot and will remain registered for the duration of the diagnostic pathway which should be concluded in-line with the 28-day Faster Diagnosis timeframe (including temporary residents).

Exclusion Criteria:

- People under 18 or over 50
- People with a painful lump which may be suggestive of testicular torsion or needing urgent care
- People assigned female at birth - including cisgender females and transgender men
- People who are already under the care of a healthcare professional for their testicular symptom(s) or have seen a clinician about the same ailment within the previous 12 months
- Temporary residents registered to a GP practice who are onboarded to the pilot but will not remain registered for the duration of the diagnostic pathway.

The pathway developed for the initial stage 1 testicular self-referral service is outlined below.

Figure 2: Testicular Self-Referral Initial Pathway

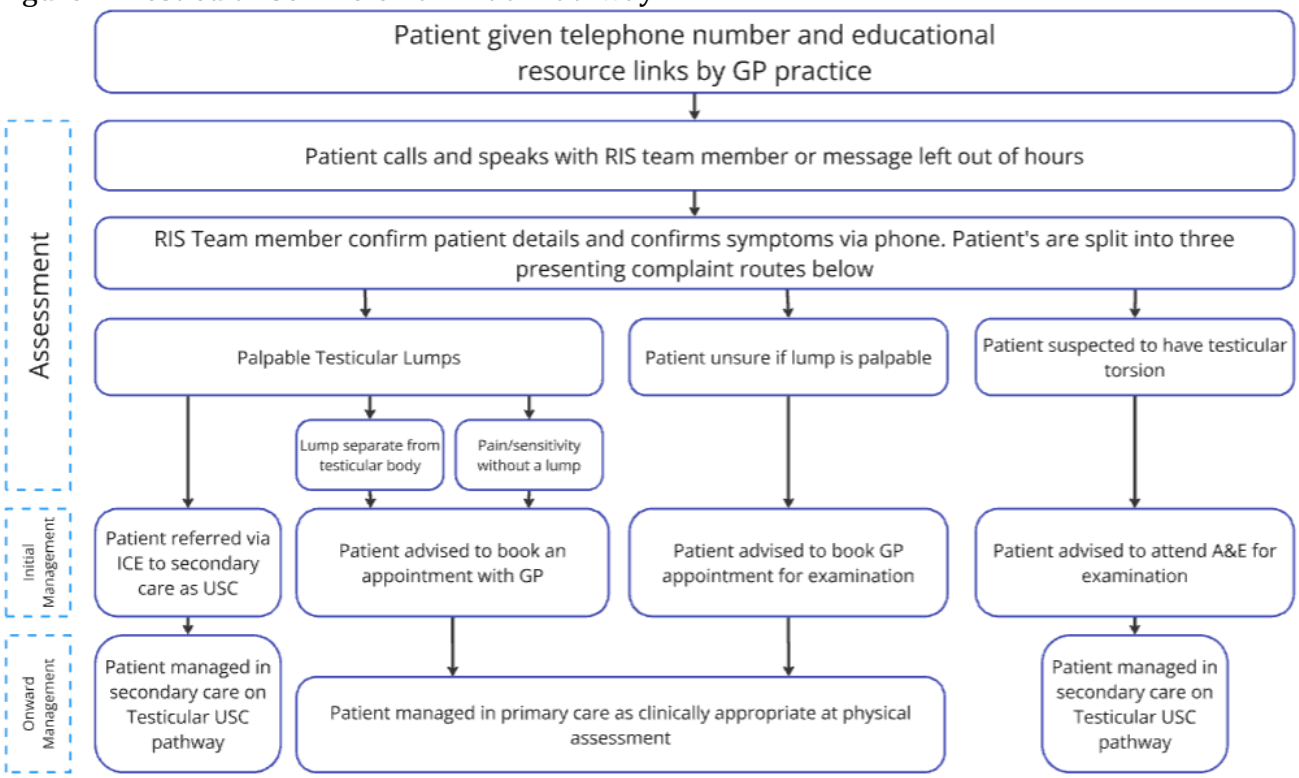
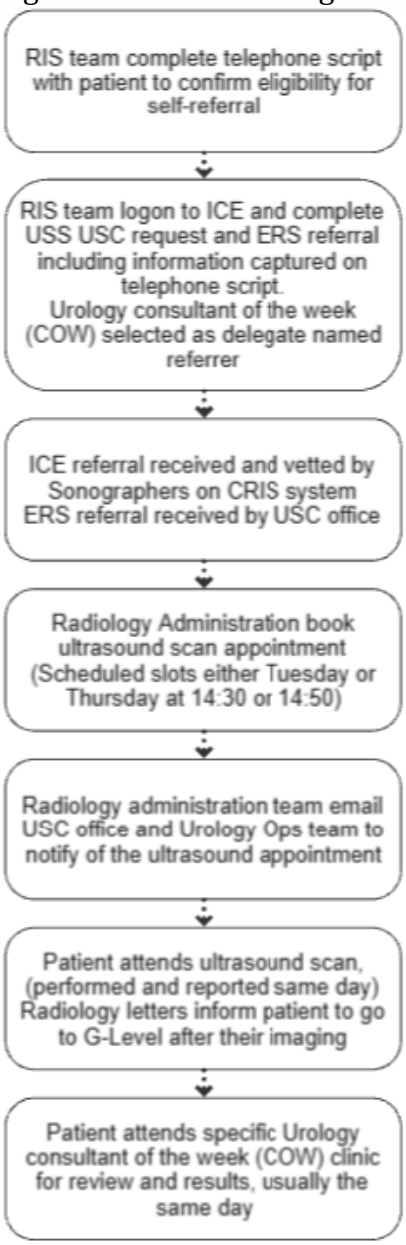


Figure 3: Onward management of USC Testicular pathway



Process Overview

RIS testicular self-referral part 1: Telephone triage

- Patient contacts GP surgery with testicular concern.
- GP surgery indicates for patient to self-refer into the Rapid Investigation Service (RIS) by providing link to a bespoke education video for patient to complete self-examination and help to determine whether self-referral route is appropriate or a consult with their GP or presentation to A&E is necessary
- Patient will call through to the central virtual service hub or leave a voicemail which are picked up twice daily.
- Patient contacts the RIS. Service is explained to patient. Demographics and inclusion criteria checked. Where a patient is identified as not being suitable for the pilot after answering questions, patient is directed to arrange a consultation with their GP.
- Patient is registered in SystmOne by RIS colleague.
- Ultrasound request created on ICE on the ultrasound scan urgent suspected testicular cancer pathway, as well as a USC ERS referral

- RIS team attach details of telephone script answers onto ICE request and include name of Urology consultant scheduled for consultant of the week (COW) within Urology one-stop clinic; the Urology consultant is referenced as named delegate referrer
- Templated letter back to registered GP to notify that patient has initiated self-referral
    1. Urgent suspected cancer testicular proforma completed and submitted using ICE by RIS colleagues. This system is monitored daily to ensure forms are vetted by Radiology Sonographers and booked for ultrasound scan at UHS
    2. USS scan and Testicular clinic appointment with consultant booked by both Radiology administration as well as Urology USC. Confirmation to be sent via SMS/letter along with directions to appropriate clinic site.

The current service workforce is made up of:

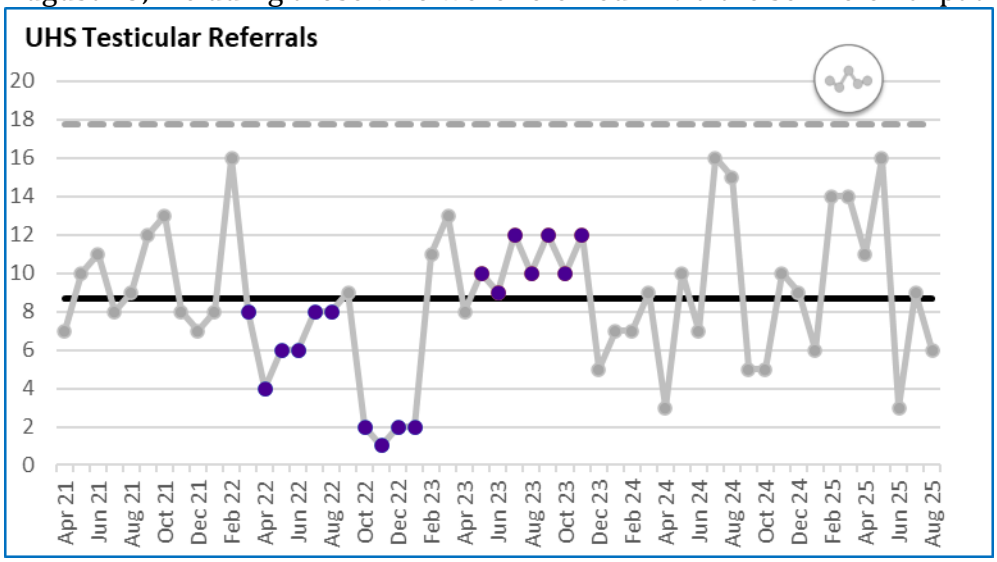
- Band 8A Operations/Service Manager
- Band 5 Patient Navigator
- Band 3 – Administrator x 3

Primary care oversight is also provided by a GP clinical champion. To note all operational/ administrative posts have dual roles, also delivering the non-specific symptoms service pathway at the Wessex Rapid Investigation Service (RIS).

ACTIVITY AND OUTCOMES

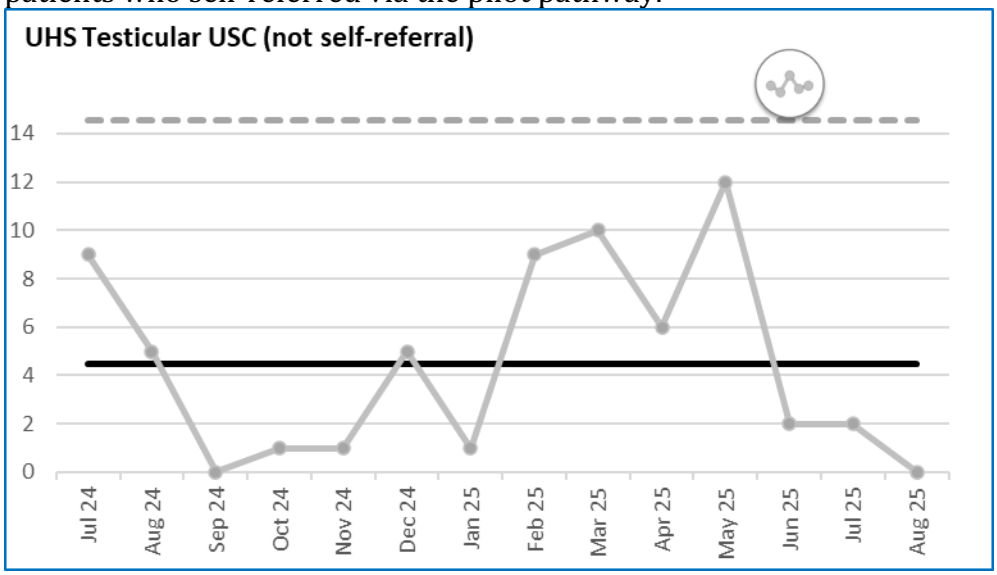
Referral Numbers Comparison

Figure 4 below outlines the testicular referral trend at UHS USC testicular referrals from April 21 to August 25, including those who were referred in via the self-referral pathway.



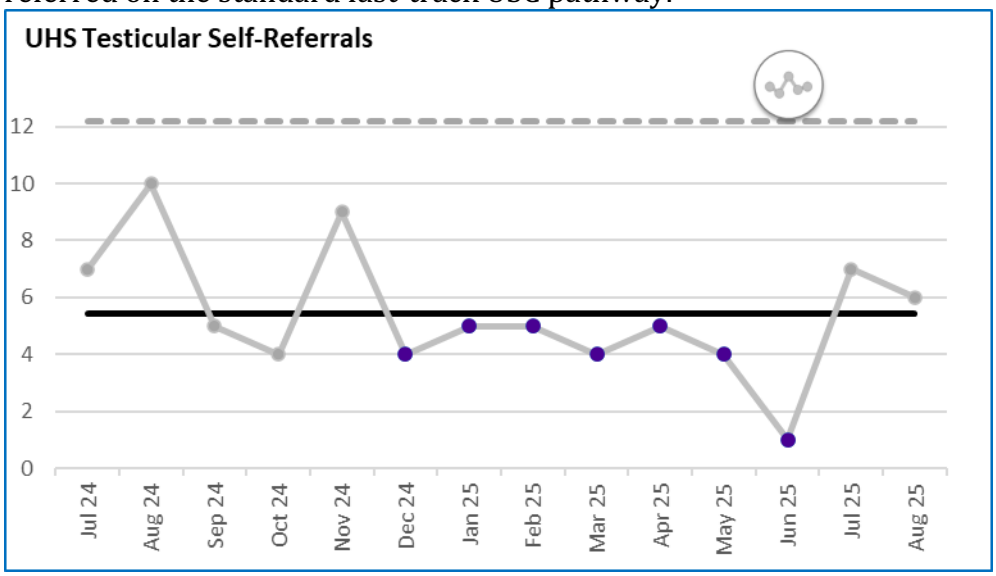
- 139 testicular USC referrals were received by the UHS urology service from July 2024 (start of the pilot) to the end of August 2025, including those who presented via the self-referral route. This data shows that the number of referrals received has not changed significantly since the pilot was implemented. The average number of monthly referrals is 9. This shows the implementation of this pathway has not caused any significant changes in demand on urology or radiology services.

Figure 5 below outlines the testicular referral trend at UHS from July 24 to August 25, excluding those patients who self-referred via the pilot pathway.



- 63 testicular USC referrals were received in by the service from July 2024 to end of August 2025 via the standard referral route (i.e. excluding patients presenting via self-referral). This data shows that the number of referrals received has not changed significantly. The average number of monthly referrals being received via the standard USC pathway is 5.
- To note, the self-referral pathway is not open to all PCNs in the UHS footprint so it is expected that the service will continue to receive referrals via the standard USC pathway. The standard referral route also remains open to patients registered at those PCNs included in the pilot, for those who do not wish to, or are unsuitable to self-refer.

Figure 6 below outlines testicular self-referrals at UHS from July 24 to August 25, excluding patients referred on the standard fast-track USC pathway.



- 76 self-referrals received in total by the service from July 2024 to end of March 2025. The data shows that the number of referrals received has not changed significantly. The average number of monthly referrals is 5.

Referral Outcomes and Conversion Rate

During the pilot, out of 78 self-referrals, there were no cancers diagnosed. The average urology cancer conversion rate at UHS is 23.2%. Conversion rate data is not routinely broken down by urology subsite, however, the testicular cancer conversion rate is anticipated to be lower. Whilst no cancers been diagnosed during the pilot period, it is expected that the conversion rate for this pathway would align with the 6.4% conversion rate found on the local Trust audit (Jan – Apr 23; see appendix 2) if it was rolled out more widely and ran for a longer period of time. Within the testicular pilot, 74.5% of the sample were diagnosed with other incidental findings and 19.2% had a normal examination result. This aligns to the findings of the UHS audit which identified an incidental finding rate of 75.6% and 17.9% had nothing abnormal discovered.

Overall Summary (Jul 24-Aug 25):

Figure 7. An overall summary of outcomes from the self-referral pilot is outlined below.

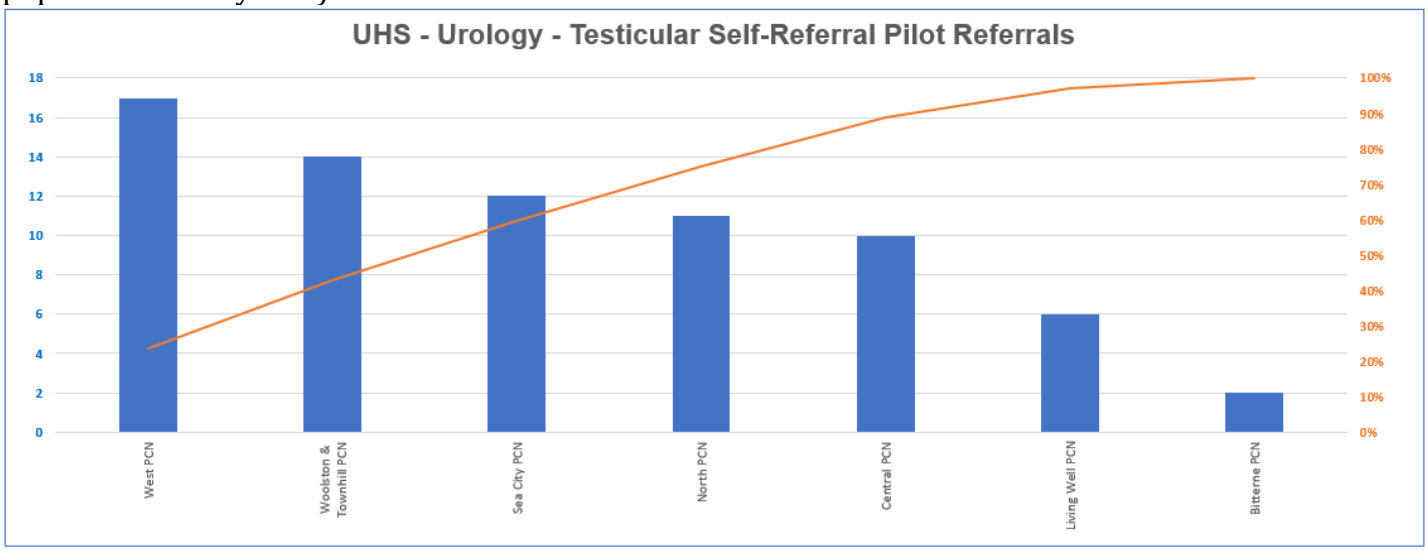
Diagnoses	Number of patients	Percentage of sample
Nothing abnormal discovered (NAD)	15	19.2%
Cancer	0	0.0%
Sebaceous cyst	2	2.6%
Varicocele	17	21.8%
Epididymal cyst	30	38.5%
Scrotolith	3	3.8%
Tunica albuginea cyst	2	2.6%
Hydrocele	1	1.3%
Inguinal hernia	1	1.3%
Epididymo-orchitis	1	1.3%
Spermatocele	1	1.3%
Did not attend	5	6.4%
Total	**78**	**100%**

PCN referral data

Figure 8. Self-referrals received split by PCN

PCN	Referrals	Percentage of sample
West PCN	16	20.8%
North PCN	15	19.5%
Woolston & Townhill PCN	14	18.2%
Sea City PCN	12	15.6%
Central PCN	11	14.3%
Living Well PCN	7	9.1%
Bitterne PCN	2	2.6%
Total	**77**	**100%**

Figure 9. Pareto chart of self-referrals received split by PCN. This referral volumes received by PCN generally correlate with the population size of the PCN e.g. highest proportion of referrals received from Southampton West PCN who have the largest registered patient population (Please refer to Figure 1 for population size by PCN).



Time Lapse Referral to Appointment

Phase 1

Data has been pulled to identify how long people are waiting from self-referral to triage within the Trust (at the point the referral is vetted by Sonographers on CRIS system). This was also compared to the baseline and current sample. The baseline sample comprised patients referred on a testicular USC pathway prior to the pilot going live. The current sample comprised patients referred on the standard testicular USC pathway (not self-referral) after the pilot went live.

For the initial period of the pilot, 22.07.24 to 13.03.25, the average number of days from self-referral (the date the patient was registered on the system by the admin team) to triage was 0 days. USS requested was also on average on the day of referral. First outpatient appointments on average were 13 days following their self-referral being registered. USS was also performed on average 13 days from referral. On average patients received a diagnosis 15 days from referral. This demonstrates a rapid pathway from referral to first seen and is compliant with the Faster Diagnosis Framework, where the target is for 75% of people having cancer diagnosed or ruled out within 28-days from referral, increasing to 80% by March 2026.

Phase 2

For the second phase of the pilot from 14.03.25 to 31.08.25, the average number of days from self-referral to triage was 0 days. USS was also requested on average on the same day as the referral. First outpatient appointment and ultrasounds were both carried out within 9 days of referral on average, and patients also received a diagnosis on day 9. This shows that for phase 2 of the pilot the pathway appeared to become more streamlined, and patients were seen and diagnosed sooner.

Pilot Summary

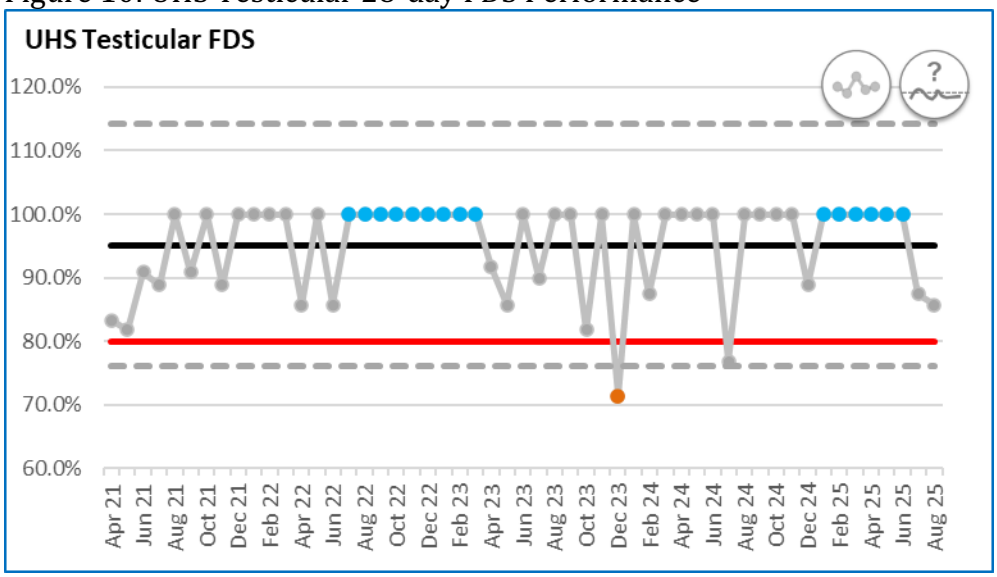
For the full duration of the pilot, 22.07.24 to 31.08.25, the average number of days from self-referral to triage was 0 days. USS was also requested on average 0 days from referral. First outpatient appointments on average were 12 days following referral. USS were performed on average 12 days from referral, and patients received a diagnosis on average 16 days from referral.

CANCER WAITING TIMES: PERFORMANCE

28-day Faster Diagnosis Standard: Testicular

UHS testicular FDS performance is outlined below in Figure 11 This data shows that testicular FDS exceeded the 75% target and also the increased target of 80% expected by March 2025 when last reported (85.7%; August 2025). Performance has not changed significantly and there has been only once instance where the target has been missed since April 2021. Average monthly FDS performance is 95.2%.

Figure 10: UHS Testicular 28-day FDS Performance



PATHWAY ANALYSIS

Background

Pathway analysis was conducted via the NHSE pathway analyser tool to compare 3 separate samples of patients referred to UHS on an urgent suspected testicular cancer pathway.

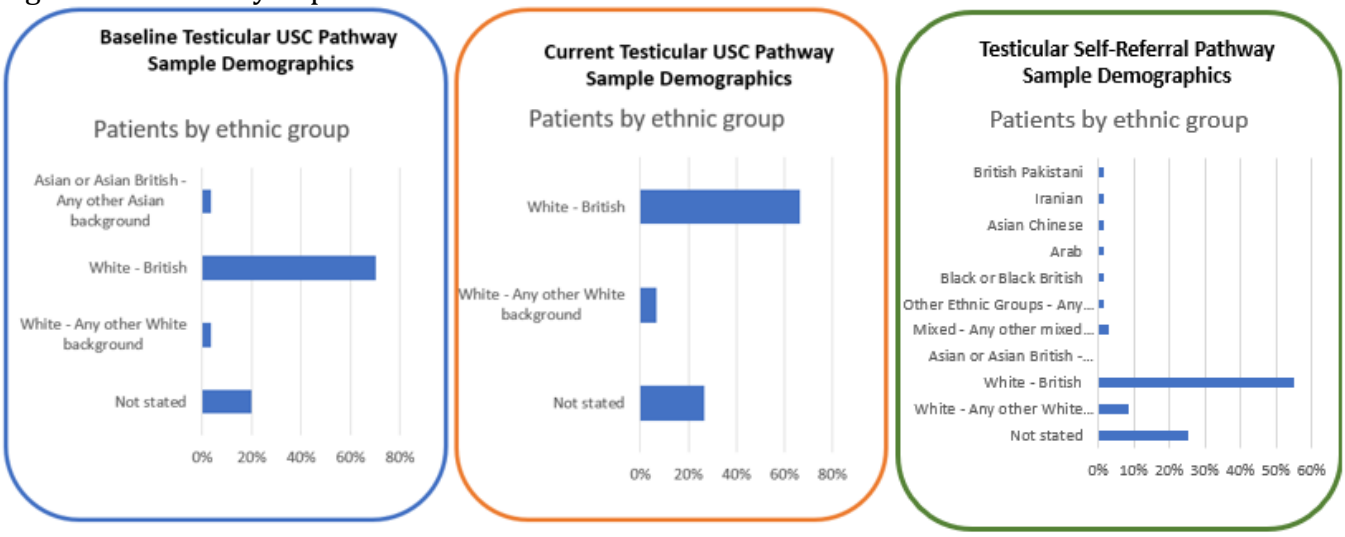
- Baseline Testicular USC Pathway sample: 30 patients referred on a USC testicular pathway between May and July 2024 (prior to the pilot going live)
- Current Testicular USC Pathway sample: 30 patients referred on a USC testicular pathway between October and December 2024 (during the pilot)
- Testicular Self-Referral Pathway Sample: 30 patients who self-referred between July 2024 and January 2025.
    - Please note there were no cancers diagnosed within the testicular self-referral cohort. As such, patients for the baseline and current testicular USC pathway were selected who did not receive a cancer diagnosis to allow a representative comparison between samples.

The output from pathway analysis should be viewed as an opportunity to review and compare the outcomes of the pathways with scope to support opportunities for improvement and embed the self-referral modality as business as usual. The findings are solely focused on the cancer pathway and does not take into account other considerations such as the impact on routine waiting times.

Ethnicity Break Down

A breakdown of ethnicity for all patients is provided for the full pilot period below in Figure 11. This outlines that most patients presenting to the self-referral pathway were White British or White Other. 80.7% of Southampton's resident population are White British/ White Other with non-white minorities representing the remaining 19.3% of the population, making this breakdown representative of the overall population in Southampton based on the pilot sample (Office for National Statistics, 2021 census). The demographic breakdown for baseline and current pathways is demonstrated in in Figure 11 below for comparison.

Figure 11: Ethnicity of patients

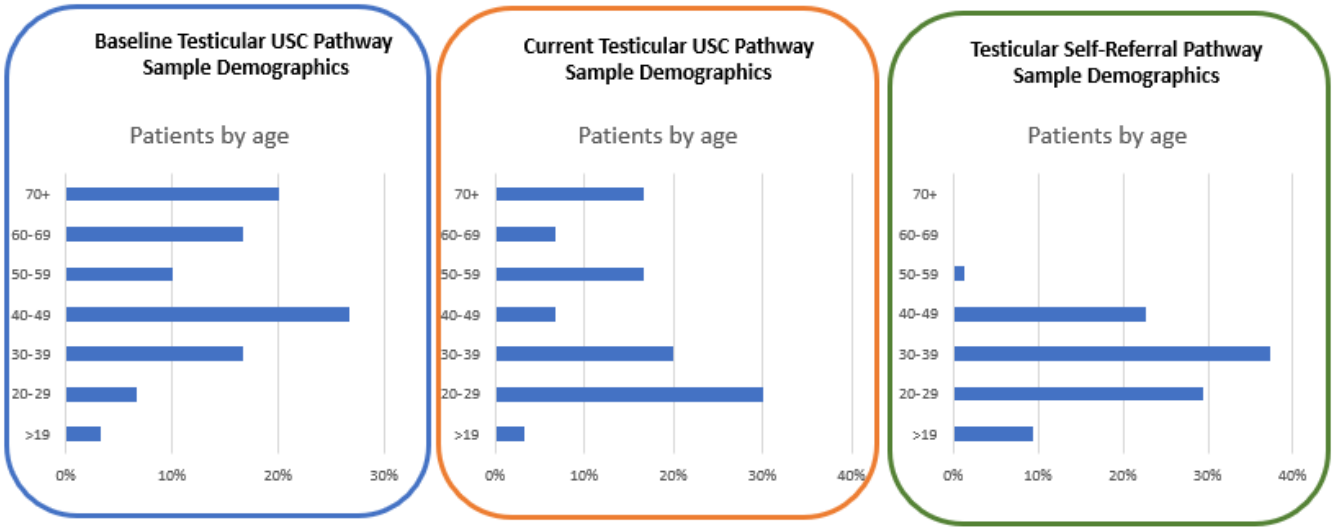


The above figure suggests the self-referral sample is more representative of ethnicity in Southampton's population than the baseline and current samples. This highlights that there has been a greater proportion of people from non-white minorities utilising the self-referral pathway when compared to the standard urgent suspected cancer pathway. This supports the NHS long-term plan in narrowing inequalities through service improvements as it may indicate that self-referral is improving access for people from BAME groups in seeking medical help.

Age Break Down

A breakdown of age for all patients is provided for the full pilot period below in Figure 12. This highlights that most patients presenting via the self-referral pathway were aged between 20 and 39 with the median age being 31. This is also representative of the age of Southampton's population with the greatest proportion of people being aged 20-39 (Office for National Statistics, 2021 census).

Figure 12: Age of patients

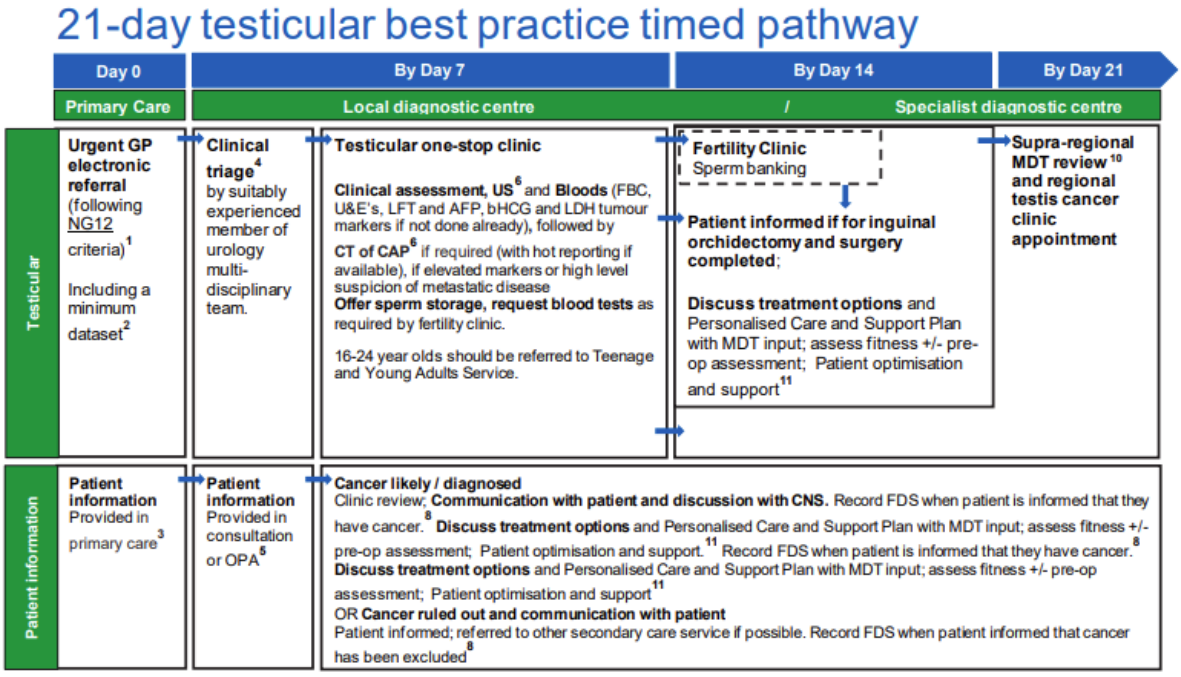


The above figures may suggest there is a higher proportion of younger patients utilising the self-referral pathway rather than the traditional urgent suspected cancer route. However, it is unclear if this is a result of the inclusion criteria for the service which excludes those under 18 and over 50, or a preference for self-referral.

Performance

- **FDS performance** (28-day performance target is 75%. Revised target for from March 2026 is 80%)
  - Baseline sample: 90%
  - Current sample: 80%
  - Overall self-referral sample: 94.6%
- **31-day performance** and **62-day performance** not applicable as no patients in the cohort were diagnosed with cancer.

Figure 13. below is the testicular best practice timed pathway. This has been utilised to benchmark pathway milestone targets in days from clock start to support pathway analysis. This has allowed an objective comparison of pathways between baseline, current and pilot samples.



Source: 'Implementing timed urology cancer diagnostic pathway – bladder, penile, renal and testicular' 2024, page 6.

Figure 14. pathway milestone summary: baseline sample

Milestone	Median Day	Target Day	Diff from target	Mean	Min	Max
USS Requested	0	3	-3	0	-21	18
USS Performed	14	14	0	14	-6	35
USS Reported	14	14	0	14	-6	35
OPA	16	14	+2	17	7	35
Diagnosis	15	28	-13	17	0	41
28-day FDS Performance	16	28	-12	18	0	41

Median day = middle value of days from clock start
Target day = best practice timed pathway target milestone in days from clock start
Diff = Median day minus target day
= meeting or below target (days)
= not meeting or above target (days)
Mean = average day from clock start
Min = lowest value from clock start
Max = Highest value from clock start

Please note this is a sample of 30 patients referred between May and July 2024 (prior to the pilot going live) on an urgent suspected testicular cancer pathway. There were no diagnoses of cancer within this sample to allow a like-for-like comparison against the self-referral sample.

Figure 15. pathway milestone summary: current sample (standard USC pathway)

Milestone	Median Day	Target Day	Diff from target	Mean	Min	Max

USS Requested	0	3	-3	0	0	0
USS Performed	18	14	+4	17	-4	35
USS Reported	18	14	+4	17	-4	35
OPA	15	14	+1	15	3	22
Diagnosis	18	28	-10	20	3	49
28-day FDS Performance	18	28	-10	20	3	51

Please note this is a sample of 30 patients referred between October and December 2024 (post the pilot going live) on an urgent suspected testicular cancer pathway. There were no diagnoses of cancer within this sample to allow like-for-like comparison against the self-referral sample.

Figure 16. pathway milestone summary: self-referral sample (12-months)

Milestone	Median Day	Target Day	Diff from target	Mean	Min	Max
USS Requested	0	3	-3	0	0	0
USS Performed	11	14	-3	12	2	36
USS Reported	11	14	-3	12	2	36
OPA	12	14	-2	12	2	36
Diagnosis	13	28	-15	16	2	36
28-day FDS Performance	13	28	-15	16	2	36

Please note this is a sample of all patients who self-referred from July 2024 and August 2025. There were no diagnoses of cancer within this sample.

Conclusions from pathway analysis

- There was a higher proportion of patients from BAME groups within the self-referral sample when compared to the baseline and current samples.
- The majority of patients in the self-referral and current sample were >39, with no patients >50 in the self-referral sample. Whereas in the baseline sample, the majority were >40.
- The median days from clock start for all milestones for the self-referral sample were within target.
- Patients from current and self-referral samples were more likely to have USS and OPA the same day (one-stop) when compared to the baseline sample.
- 28-day performance for the current sample wasn't impacted by the self-referral sample; all samples met the 75% performance target and 80% target expected March 2026.
- The median days between diagnosis and 28-day FDS was one day later for the baseline sample when compared to the self-referral sample.

COLLEAGUE FEEDBACK

Primary Care Staff Feedback

Primary care clinicians and clerical colleagues from the 27 practices participating in the pilot service were asked to provide feedback through a short survey to understand what the impact of the service had been in practices.

Clinical Colleagues
The below provides summary headline outcomes from the survey responses from 6 clinicians:

- 66.6% of primary care clinicians felt that they were unsure if the service reduced their workload
- 16.6% felt the service reduced their workload
- 16.6% felt the service did not reduce their workload
- 83.3% felt the service should continue
- 17.7% were unsure if the service should continue
- 17.7% of clinicians received comments or feedback about the service, and all cited these as having been positive
- 67% were aware their site was participating in the pilot
- 33% were not aware their site was participating in the pilot

Clerical Colleagues
The below provides summary headline outcomes from the survey responses from 4 clerical colleagues:

- 75% of primary care clerical colleagues felt the service should continue
- 25% were unsure if the service should continue
- Clerical colleagues had not received any feedback from patients
- 75% were aware their site was participating in the pilot
- 25% were not aware their site was participating in the pilot

Urology Clinicians Feedback

Consultant Urologists from UHS were asked to provide feedback through a short survey to understand what the impact of the service had been in the Urology Centre. 3 responses from urologists were received.

- 33% of Urologists felt the service should continue
- 67% of Urologists were unsure if the service should continue
- 33% of Urologists had received positive feedback from patients
- 33% of Urologists had received negative feedback from patients
- 33% had not received feedback from patients
- 100% were aware their site was participating in the pilot

Radiology Clinicians Feedback

Sonographers conducting the ultrasound scans at UHS were asked to provide feedback through a short survey to understand what the impact of the service had been on Radiology. 3 responses from sonographers were received.

- 100% of sonographers were unsure if the service should continue
- 100% of sonographers had not received feedback from patients
- 100% of sonographers were aware their site was participating in the pilot

Secondary Care Clerical Colleagues Feedback

Clerical colleagues at UHS were asked to provide feedback through a short survey to understand what the impact of the service had been on administration. 5 responses from clerical colleagues were received.

- 100% of clerical colleagues felt the service should continue
- 60% of clerical colleagues had received positive feedback from patients
- 20% of clerical colleagues were unsure if they'd received positive feedback from patients and 20% selected 'other'
- 100% were aware their site was participating in the pilot

Overall Summary of Feedback

Feedback has been collated from all staff groups and collated into four groups and outlined below.

Pilot Awareness

- 70% were aware their site was participating in the pilot
- 30% were not aware their site was participating in the pilot

Patient Feedback

- 22.2% had received positive feedback from patients
- 5.6% were unsure if they'd received feedback from patients
- 72.2% had not received feedback from patients

Workload

- 16.7% felt the service decreased their workload
- 16.7% felt the service increased their workload
- 66.7% felt unsure if the service impacted their workload

Service Continuity

- 72.2% felt the service should continue
- 0% felt the service should not continue
- 27.8% felt unsure whether the service should continue

Overall, the majority of colleagues were aware of the pilot and felt that the service should continue. Some colleagues felt there was a notable reduction in workload with fewer patients needing to be seen or virtually seen by primary care prior to referral. Of those colleagues that had received patient feedback, this was mostly positive.

Recommendations

There were some comments provided as suggestions for improvement or development of the service which were:

- To develop a digital solution to facilitate self-referrals in addition to the existing phone lines
- More awareness and communication to ensure colleagues within services are aware of the pilot
- To roll out the pilot to further practices across the area
- To review the eligibility criteria for self-referral as it was felt that some patients may be more appropriately managed on another pathway

Roll Out and Engagement

If the pilot was extended beyond Southampton city practices, the following would be considered to ensure effective roll out:

- To share comprehensive information and engage with the public and practices to promote the service and increase knowledge and awareness.
- To ensure as part of any wider roll out that all practice staff are aware of service so they can signpost patients to the bespoke animation to ensure they have the appropriate information to perform self-examination and make an informed decision about whether they would like to self-refer.

PATIENT FEEDBACK

Patient Feedback

The testicular self-referral pilot service worked with the Wessex Cancer Alliance's Inclusion and Involvement lead, to ensure robust patient feedback was collated and evaluated. A semi structured telephone interview was designed to tease out information from people about their experiences of using and views of the testicular self-referral service and offered to those contacting the service.

Please see below the headline findings and recommendations which are directly taken from the report:

Headline findings

- *Everyone was positive about their experience of the pilot service and went away reassured*
- *Self-referral was unanimously supported for its convenience and because it shortened the time to getting results*
- *The service video was useful and easy to understand, with only a couple of suggested amendments*
- *The service was easy to access, and patients had a good experience of staff throughout the pathway*

People did however identify some areas for improvement. Some of these are relating to not having a same day ultrasound scan and outpatient appointment with a Urologist. Others relate to the signage at Southampton General and others relate to the Urology reception welcome. These are outlined in the recommendations.

Overall feedback

Everyone said that they had a positive overall experience of the service: how they could access it, how they were treated, the speed at which they were seen, and the reassurance they were given. They would recommend it to others who needed a similar service.

Accessing the service

Everyone found accessing the service by phone easy. Even where calls were not answered immediately and interviewees had to leave a message, they said the call back time was acceptable. Some specifically mentioned the speed at which they were issued a letter with their appointments after the call as a positive. One did, however, say

that it would have been nice to have been able to check the appointment times being offered on the phone call as he was not able to make the first appointment. He had to find another time, so his first and second appointments were not on the same day**.**

Explanation of the service

Most people said that the explanation about the service was clear and thought the nurse doing the calls was very good. However, two people were not clear about the steps in the pathway.

"Overall brilliant and the woman on the phone was very nice but I was left a bit confused about whether I would see the consultant and have the scan on the same day – but the email after answered the questions. I was not perhaps taking everything in as I was quite worried."

Explanation of next steps

Most people said that the explanation about the service was clear and thought the call handler was very good. However, two people were not clear about the steps in the pathway.

"Overall brilliant and the woman on the phone was very nice but I was left a bit confused about whether I would see the consultant and have the scan on the same day – but the email after answered the questions. I was not perhaps taking everything in as I was quite worried."

Ultrasound scan appointment

Interviewees said the wait time between the phone call to access the service and having the scan was fine. One person mentioned it was good to be asked if they wanted a male physician and that was beyond their expectations. A couple of people mentioned that it was not easy to find the right pace to go for the scan, or to find the Urology department. They were confused by hospital signage so the directions in letters needs to reflect this accurately.

"I was not sure where the appointment was. I had the hospital name but when I got there it was not easy to find radiology in the hospital. It could have been x-ray but I was confused by the signage. I went to one area but they said they didn't have me on the list, so I had to go to another area. I can't remember receiving the letter with more details."

Experience of same day appointment

Two people said that they did not have a particularly positive experience at the Urology reception area. One said the receptionist did not know why he was there, and the other was not sure whether they should just sit and wait to be called or to report to reception. Most people said the time with the consultant was helpful and reassuring.

Written Summary

Nine out of 10 men had received their written summary. Everyone said again that this was clear, and they could not suggest any improvements to be made.

Summary

The patient feedback demonstrates that all people interviewed found the service efficient, reassuring, easy to access and would recommend it to others.

The clear areas identified for improvement for the service centred around raising awareness of the service and ensuring information shared with patients is clear and that they understand any potential next steps. Also, to review the animation to improve accessibility to contact details for the service and to consider providing further detail around the size and consistency of lumps when self-examining.

The wider recommendations out of scope of the pilot are around improving hospital signage to support patients navigating Southampton General Hospital, improving the welcome at Urology reception and aspiring to offer all patients one-stop appointments.

SERVICE BENEFITS & ISSUES

Benefits

- The service provides a new self-referral access route for people increasing choice and access.
- The service facilitates rapid turnaround from the point of self-referral to referral to Urology clinic where clinically indicated.
- The service provides a single point of contact line to maximise patient support and deliver a positive patient experience.
- The service has received feedback from people using the service which shows it to be reassuring and anxiety reducing with self-referral routes being unanimously supported by patients.
- Some patients felt the service allowed them to be seen quicker and more easily and it also shortened the journey to an answer.
- The service is preventing some people from being seen, where not clinically indicated, in both secondary and primary care.
- The service has supported with evidencing the success of alternative referral modalities for people with testicular lumps on an urgent suspected cancer pathway.
- The service does not require a review from a clinician to accept a self-referral due to agreed, clear screening questions. This means a non-medical referral can be made by administrative colleagues on to an urgent suspected cancer pathway.
- The service does not require a significant amount of administrative support due to small referral volumes and therefore, may not require additional workforce to manage the workload. This may support expansion of the pilot more widely and may be easily replicated in other providers.
- The service has demonstrated variability in the demographics of people accessing self-referral when compared to the current urgent suspected cancer pathway in terms of age and ethnicity. This supports the NHS long term plan in reducing health inequalities and improving access through additional referral modalities.
- Some colleagues felt the service reduced their workload.
- The service model and outcomes of the pilot align with objectives outlined in the Faster Diagnosis Framework surrounding pathway innovations and improvements, including streamlining of the pathway and supporting more efficient use of clinic capacity:
    - Straight to test and triage-led models to streamline the front end of the pathway.
    - Co-ordinated testing: the majority of patients are seen in a ‘one-stop’ clinic where capacity allows.
    - Processes to ensure optimal and appropriate referrals: patients are screened prior to onward referral to ensure suitability for the pathway or if another pathway is more appropriate.

Issues

- The service is not suitable for people presenting with a painful testicular lump which may be indicative of testicular torsion or another acute problem, which requires immediate medical attention. This means if a patient is incorrectly signposted to the service this may cause some minor delays in accessing medical services.

- The future commissioning of the RIS facilitating self-referral is undetermined, meaning the future of the pilot is uncertain. This needs to be considered for future planning for retaining and expanding the service.
- Some GP surgeries batch messaged their male, patient population aged 18-50 to promote the service. This initially generated higher than usual referral volumes when the pilot went live leading to patient who were not eligible for the service presenting via self-referral. The scope of the pilot is clear and is not a screening service so in future, care consideration around communications with primary care must be considered in future.
- There was an instance where a person attended for their ultrasound scan appointment and left without attending their urology outpatient appointment as part of a one-stop service. This was reviewed and the patient was unaware they were expected to also see a urologist. A review of patient information must be considered before expansion of the service.
- Due to the small number of referrals received from a small population sample, approximately 0.6% of the Southampton city male population aged 18-50, consideration needs to be given to develop a safe, sustainable, and robust workforce model to enable wider adoption of self-referral.
- There have been no cancers identified in the duration of the pilot due to the small number of referrals. A conversion rate of around 6% is expected based on a previous audit at the Trust (see appendix 2). This must be carefully considered before embedding the pathway as business as usual and any potential extension of the service as inclusion criteria may need to be reviewed to ensure the right people are being referred on the right pathway.
- Non-cancer incidental findings were discovered in 74% of the self-referral sample. This increases demand on urgent or other pathways and services responsible for the onward management of these patients which must be considered.
- Colleague feedback suggests more referrals need to be received to further evaluate the pilot before considering permanent adoption of the service.
- Some colleagues felt the service increased their workload so there must be careful consideration of demand and capacity modelling to prevent overwhelming services, supporting sustainability.
- Some primary care colleagues were not aware their practice was participating in the pilot and therefore were unaware the pathway was available to eligible patients and didn't signpost to the service.

RECOMMENDATIONS

Service Model

Service Recommendations

Recommendations for service development and considerations to enable wider roll out of self-referral:

1. To refine screening questions to clarify time scale of 'new' lump to reduce further the number of people seen in secondary care that could have been managed in primary care to maximise positive impact on secondary care.
2. To be clearer with the screening question around whether patients have been seen within the last 12 months about a testicular concern to prevent patients using the self-referral service that may be more appropriately suited to an alternative management pathway.
3. To continue to promote access to the service e.g. via GP e-consults, as well as posters targeted at eligible men

4. To consider how to make the service contact number more accessible, and to provide further details about size and consistency of lumps to look out for in the service animation
5. To use 'Teachback' and 'Chunk and Check' techniques to ensure patients have understood the service steps during the first phone call
6. To consider how appointments could be agreed by phone rather than letter
7. To review existing Urology patient information
8. To consider an online self-referral form
9. To review the sequencing of the animation so that the contact number is more accessible and to consider giving a more detailed description of the size and consistency of lumps when performing self-examination
10. The service could be expanded to include a digital solution to facilitate self-referral to enable wider access.

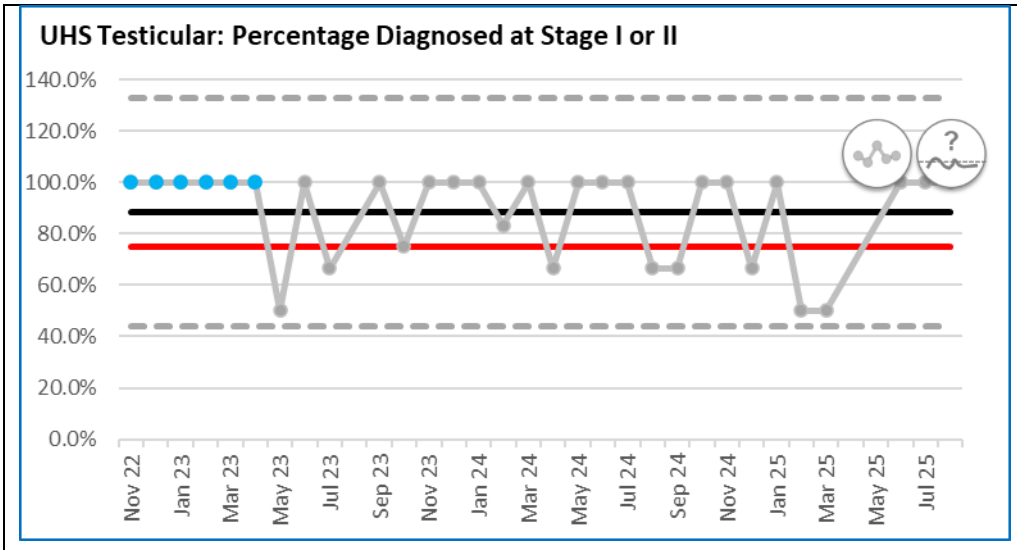
Wider Recommendations- outside of project scope

11. To strive to ensure all patients have same day 'one stop' appointments for both the scan and results by the consultant
12. To improve signage and directions to the hospital departments
13. To make sure patient letters reflect this, including whether or not patients should be told to report to Urology Reception
14. To provide further briefings to the Urology Reception staff about this clinic to improve the patient 'welcome'
15. To review patient experience at Urology Reception using a 'mystery shopper/ observer' approach.

Roll Out and Engagement

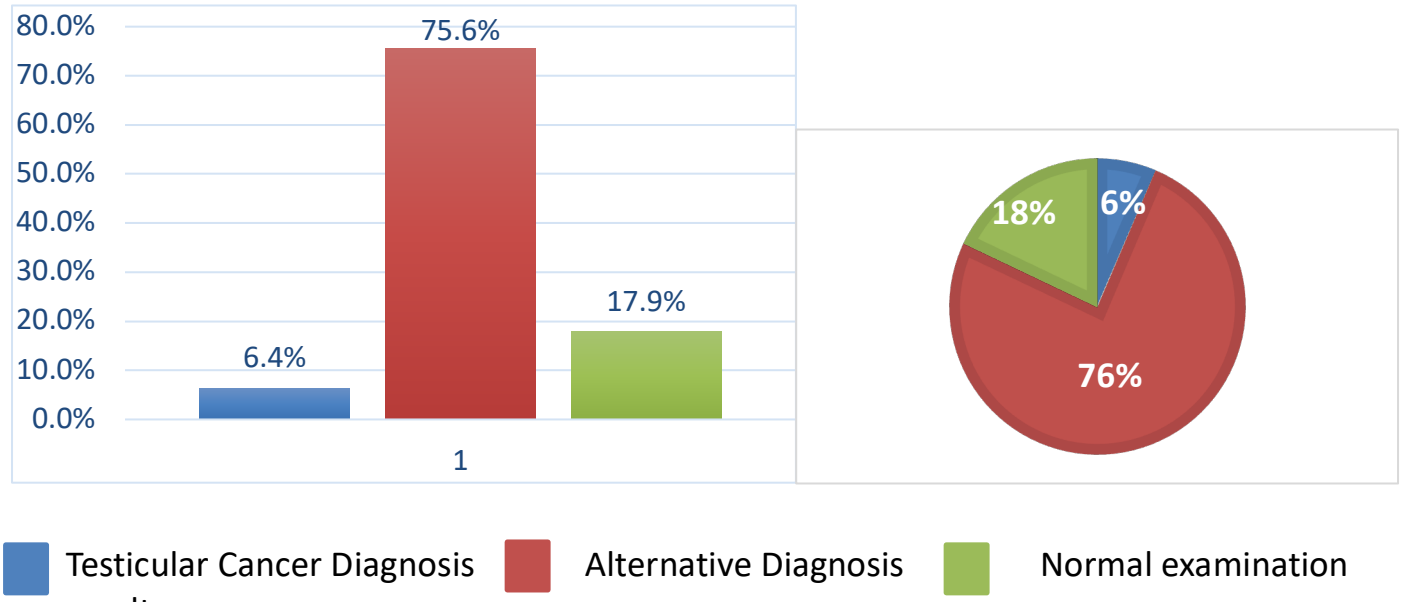
16. To ensure as part of any wider roll out that practices are aware of and able to provide the link to patients for the animation when they are signposted to the service. The leaflet is essential to ensuring patients have the appropriate information to perform a self-examination before self-referring.
17. For any wider roll out to plan and implementation to undertake robust public information giving and engagement with practices and other community health settings to promote the service and increase knowledge and awareness.

APPENDICES
Appendix 1. UHS testicular: percentage diagnosed at stage I or II



Appendix 1 above highlights the percentage of patients diagnosed at stage I or II with testicular cancer at UHS met the 75.0% target when last reported (100%; August 2025). Performance is not significantly changing and is not likely to consistently hit or miss the target. This supports the notion that demand on urology services through testicular referrals (refer to figure 4) has not significantly increased and therefore not impacted earlier diagnosis.

Appendix 2. UHS Audit of Testicular Urgent Suspected Cancer referrals between January and April 2023.



Appendix 2 above highlights the findings from an audit conducted internally at UHS of approximately 80 urgent suspected cancer referrals received between January to April 2023 broken down by a testicular cancer diagnosis, an alternative diagnosis and those with a normal examination result.