

SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No:	1653
Service	Complex Gynaecology/ Female Urology: Genito-Urinary Tract Fistulae (Girls and Women aged 16 and above)
Commissioner Lead	<i>For local completion</i>
Provider Lead	<i>For local completion</i>

1. Scope

1.1 Prescribed Specialised Service

This service specification covers the provision of a safe and effective care pathway including surgical repair, for women with a genito-urinary tract (GUT) fistula where the fistula does not heal spontaneously. A fistula repair is the treatment which takes place following the surgery or intervention which caused or precipitated the fistula– and is referred to as post precipitating surgery. A fistula is where urinary fluid leaks or flows out of the vagina and can occur following surgery (such as a caesarean section or colorectal, urological or gynaecological surgery such as a hysterectomy); or an intervention for cancer such as radiotherapy.

1.2 Description

A fistula is an abnormal connection or passage between the female genital tract and the bladder, urethra, or ureters, which if it does not heal naturally, must be corrected by carrying out a surgical repair.

1.3 How the Service is Differentiated from Services Falling within the Responsibilities of Other Commissioners

The service is accessible to all patients of the English NHS with a vesico-vaginal fistula (VVF) or urethro-vaginal fistula (UVF). The accepting specialised centres must have an automatic acceptance policy where patients meet the acceptance criteria.

2. Care Pathway and Clinical Dependencies

2.1 Care Pathway

The service will ensure the provision of specialist assessment, care and treatment for women and adolescent girls aged 16 and above with a VVF or UVF. Patients under the age of 16 are unlikely to require this intervention, but if there is concern that a patient under the age of 16 has VVF or UVF, they should be referred to paediatric services and paediatric surgery/urology and a request for advice sent to one of the national centres for this service.

Access to treatment will be guided by any applicable NHS England national clinical commissioning policies.

Referrals: The service will accept referrals for patients who are experiencing any fistula (fistulous tract) involving the bladder, urethra or genital tract. Referrals can be made by General Practitioners (GPs); secondary care clinicians (such as gynaecology, urology and colorectal clinicians); specialist health care practitioners or specialist staff from other providers. Referrals may be made by letter, email or telephone and followed up by a formal letter of referral.

Presentations will be considered to be acute where the referral is made within three weeks of the date of the precipitating surgery and non-acute where the referral is made later or if the fistula arises after radiotherapy or other none surgical treatment.

Patients will be seen depending on the individual circumstances of their fistula as follows:

- where an individual is referred 'early', usually less than three weeks following the surgery which resulted in the fistula, (known as the precipitating surgery), it is the aim that the referral will first be reviewed by the MDT, the patient will then be seen as an urgent case and the repair carried out before the tissues become unsuitable for repair;
- where the referral is made more than three weeks after the precipitating surgery, the abnormal healing tissues will be unsuitable to attempt urgent repair and the repair surgery must be delayed for a minimum of three months (range three to six months) to optimise the condition of the tissues and the outcome of the repair. In such cases, the patient will be seen in clinic following multi-disciplinary team (MDT) review and a delayed (after three months) repair will be planned.

Investigations: Prior to referral to the service, patients will be pre-investigated locally using computerised tomography urogram (CTU) and/or magnetic resonance imaging (MRI) of pelvis to assist the service in planning the route for surgery and other investigations such as cystoscopy and in some cases examination under anaesthetic (EUA) and cystoscopy/ methylene blue instillation may be undertaken. In a small number of cases, if these investigations are not available locally, they will be undertaken by the service, preferably in advance of the first clinic appointment so that the results are available for review by the service's consultant prior to the patient being seen in clinic for the first time. The referring unit should also send details of the pre-operative anaesthetic investigations which were undertaken prior to the precipitating surgery: Echocardiograms (ECHOs), electrocardiograms (ECGs), pulmonary function test (PFTs), and baseline bloods as these will enable the national centres to perform a more comprehensive anaesthetic pre-operative assessment at their one stop clinic. The service will undertake the following investigations appropriate to need:

1. Endoscopy:	
1.1	Cysto-Urethroscopy (M45.1);
2. Functional assessment:	
2.1	Urodynamics (M47.4),
2.2	Videourodynamics (M47.4)
3. Imaging:	
3.1	CTU (U3.2),
3.2	MRI (U085, U09.3),
3.3	Retrograde pyelography (M30.1)(performed at time of Cysto Urethroscopy)
4. Initial drainage procedures:	
4.1	Urethral or Suprapubic Catheterisation of Bladder (M47.8, M38.2)
4.2	Retrograde Ureteric Stenting (M27.4),

Outpatient clinic appointments:

First appointment (One Stop):

- The first clinic appointment will be a 'One-stop' clinic, with the patient first being assessed by the medical team who will then provide counselling on treatment options including the best surgical approach to suit their condition. Options will be (a) vaginal or b) abdominal approach or a c) urinary diversion (either an ileal conduit or a neobladder)) depending on the characteristics of the fistula. The clinicians and patient will then agree a treatment plan.
- The patient will then see the Clinical Nurse Specialist (CNS) or Clinical Nurse Practitioner (CNP) (who will have a special interest in this condition) and will provide advice on skin care; methods for bladder drainage; coping with urinary incontinence and information leaflets on the treatment options that the medical team discussed with the patient and provide any further counselling and support.
- On the day an anaesthetic assessment will then take place.
- If the imaging provided with the referral did not enable a clinical decision to be made (was 'unhelpful') the patient will be offered a date for a cysto-urethrogram or cystoscopy and EUA to assess their fistula. If such assessment is not deemed necessary, the patient will either be asked to consent to surgery in clinic and confirm this on the day of the operation or agree a date in one month for a telephone appointment to formally confirm consent for the surgery and address any additional questions.
- They will be offered a date for definitive surgery and agree the date in one month for a telephone appointment to formally confirm consent for their surgery and address any additional questions.
- Following their medical consultation, the patient will be given a detailed treatment plan in writing in advance of surgery.

On referral and following review in clinic, each patient's case including the results of all investigations will be discussed at the Fistulae Monthly MDT meeting and the outcome documented in the patient's notes. The outcome will also be sent to the patient as part of a formal letter and discussed by the consultant/medical team with the patient during their follow-up teleconference consultation. The service's MDT will produce guidelines for catheter care by local services following repair surgery. Please see Appendix One for an example of these.

Treatment strategy: The patient will be admitted for their definitive surgery on the day of surgery and the procedure will be performed by a surgeon who is an expert in the treatment of fistulae. On a case by case and subject to the provider's policy, if a patient has to travel more than two hours to the centre, they will be accommodated in the provider's patient hotel the night before surgery. Post-operative care will take place on a ward staffed by nurses experienced in the post-operative care requirements of patients with a fistula. When the patient is comfortable following the repair surgery, they will be discharged home with a urinary catheter in place. This will generally be between two to five days after surgery for those who have had a vaginal repair; between five to ten days for those patients who have had an abdominal repair, (with the longer stays related to complexity), and between seven to 14 days for those who have had a urinary diversion. Other than for urinary diversions, inpatient stays of more than ten days are not anticipated and will require exception reporting. Prior to discharge, ward nursing staff will request District Nursing and GP Practice Nurse support to be available for the patient locally once home and share discharge documentation with these staff to ensure that their surgical wound is reviewed in a timely and appropriate manner and the patient is supported with catheter care for the appropriate length of time. A copy of this guidance will be given to the patient so that they will know what local support to expect once they return home. At discharge, the patient will be provided with contact details for the service's CNS to call for advice in the event of any clinical concerns.

A formal cystogram or methyl blue test will take place between one and three weeks after surgery for fistula repair patients, whereas none ileal conduit (neobladder) urinary diversion patients will have a formal cystogram six weeks post-surgery. If healing following fistula repair is demonstrated on a cystogram/methylene blue test, the indwelling catheter will be removed and the patient will

have a trial of void. If healing following none ileal conduit urinary diversion is demonstrated at the six weeks cystogram, they will be admitted for a formal trial of intermittent self-catheterisation, (ISC).

Repair Surgery: will include the following procedures as appropriate. The main diagnostic codes for this service are ICD10, N360, N820 and N821; operative codes are OPCS4, P251 and P252 plus approach code of first revisional surgery (Y71.3), or second revisional surgery (Y71.6) or third or more revisional surgery (Y71.7).

1. Diagnostic	
1.1	Cysto Urethroscopy (rigid cystoscopy) (M45.5) (rigid cystoscopy)(In some cases, this will be part of a planning EUA)
2. Approach	
2.1	Vaginal Repair of Vesicovaginal Fistula (P25.1); (Y50.3)
2.2	Vaginal Repair of Urethrovaginal Fistula) (P25.2); (M73.3)
2.3	Abdominal Transvesical Repair of Vesicovaginal Fistula (P25.1); (Y50.8);
2.4	Vaginal Transperitoneal Repair of Vesicovaginal Fistula (P25.1); (P25.2); (Y50.3)
2.5	Laparoscopic approach code (Y75.1)
3 Type of Reconstructive surgery	
3.1	Urethral Reconstruction (M73.4)
3.2	Martius Labial Fat Pad Flap (Y69.8); (Z44.3); (P05.9); (S25.2)
3.3	Colpocleisis (M18.1, M18.2)
3.4	Ileal Conduit (M19.1); (M19.2) Must be in combination with N36.0 or N82.0
3.5	Clam Cystoplasty (M36.1-M36.3) Must be in combination with N36.0 or N82.0
3.6	Continent Diversion and Mitrofanoff (M19.8); (M36.4-M36.9) Must be in combination N36.0 or N82.0)
4. Number of this surgery following the precipitating surgery	
4.1	1st Revisional Surgery (Y71.3),
4.2	2nd Revisional Surgery (Y71.6),
4.3	3rd or More Revisional Surgery (Y71.7).
5. Post-operative assessment:	
5.1	Cystogram (Y97.8)

Follow-Up:

UVF/VVF: The service's CNS/CNP will telephone patients to follow them up one week after discharge and then in the outpatient clinic between one to three weeks following repair, the CNS/CNP will undertake a review following their cystogram and/ or perform a methylene blue test to establish whether the repair wound has healed appropriately. If it has, the CNS/CNP will take the catheter out. If it has not, the catheter will be left in for another one to two weeks after which the patient will have repeat imaging/methylene blue and will be reviewed in the outpatient clinic by the CNS/CNP again. Unless there are problems, patients will then be reviewed routinely in the Consultant outpatient clinic (or by telephone if the patient prefers) between three and four months after surgery to assess short-term outcomes. If all is well, the patient will have a face or telephone review with the Consultant for the final time at 12 months post-surgery and will then be discharged to their GP for routine follow up. Over and above the psychological support that the medical team and the CNS/CNP will provide, the team will ask the GP to make an onward referral to local services for any additional psychological support as appropriate.

Ileal conduit: If the procedure was an ileal conduit, a form of urinary diversion, the patient will have a renogram in an outpatient setting twelve weeks after surgery which will be reviewed when they attend outpatients for review by the Consultant and the Stoma Nurse, ideally but not necessarily on the same day as the renogram is performed.

Neobladder: If the procedure was a neobladder (a form of urinary diversion), a cystogram will be performed in an outpatient setting and the patient will then be seen six weeks after surgery by both the Consultant and the Urinary Diversion CNS for removal of catheter and formal initiation of intermittent self-catheterisation, (ISC).

For all procedures, if the repair has healed appropriately, the CNS will take the catheter out, if it has not healed, the catheter will be left in for a further period, then reviewed again following a repeat cystogram one to two weeks later. Unless there are problems with healing, the patient will be reviewed routinely in the Consultant outpatient clinic three to four months after surgery to assess short-term outcomes. If all is well, then a patient who has had an ileal conduit or neobladder will have a telephone review with the Consultant for the final time at 12 months after surgery and will then be discharged for life-long follow up with their local urology team.

Exclusions: Vesicovaginal and urethrovaginal fistula that are the result of active new or recurrent cancer requiring further cancer treatment; patients with intestinal tract fistulae involving the bowel, whose care is covered by the NHS England specification A08/S/a Intestinal Failure; ongoing psychological support needs are outside the scope of this specification and will be met via the service asking the patient's GP to make an onward referral to local care providers; uretero vaginal fistulae, of which there are approximately four cases per year and are managed by urologists surgically through the abdomen or robotically by reimplanting the ureter and draining the kidney into the bladder, are outside the remit of this specification.

Multidisciplinary Team (MDT) Core membership:

Consultant Urologist or Urogynaecologist (MDT Lead) with training & expertise in fistula management;

Consultant Urogynaecologist (if Urologist above) or **Urologist** (if Urogynaecologist above);

Clinical Nurse Specialists (CNS)/Clinical Nurse Practitioners (CNP) with an interest in fistula management (if appropriately trained/experienced can also carry out the duties of the Specialist Continence Nurse or Practitioner (SCN/SCP), the Stoma Nurse or Urinary Diversion Nurse,

Stoma Nurse (unless the CNS/CNP has this experience and training);

Urinary Diversion Nurse (unless the CNS/CNP has this experience and training);

Specialist Continence Nurses (SCN) / Specialist Continence Practitioners (SCP);

Healthcare Assistants (HCA);

Radiology for interpretation of pre-operative imaging and post-operative cystogram (lead named person);

Access to: Physiotherapy (named person and available as required);

Coloproctology (named person and available as required);

Nutrition support (dietetics), where bowel fistulae are managed in addition;

Psychology (as required).

2.2 Interdependence with other Services

Co-located services: Urology, Urogynaecology, Coloproctology, Nursing, Nutrition, Physiotherapy, Radiology (Consultant).

Interdependent services: The service will also work with patient support groups, including involving them in guideline production and in the production of literature for patients.

For Public Consultation

Genito-Urinary Tract Patient Pathway

Diagnosis of Vaginal or Urethro fistula (Secondary >> Primary Care) (N=300)

GP or secondary care specialists makes referral to national centre (N=200) (with the remainder presumed not referred due to limited life expectancy, lack of fitness for surgery or patient's wish)

< 3 Weeks following the surgery/injury that resulted in the fistula, (Precipitating Surgery) (N=10); Catheterise and urgent Referral via Telephone ± Email, Follow-Up Referral Letter.

> 3 Weeks post-surgery/injury that caused the fistula (N=140) Routine Referral Letter.

Decline referral if patient unfit for UVF or VVF surgery. (n=40)

If unfit for UVF or VVF repair but decision is made to undertake urinary diversion, this should be offered at the specialist centre in order to avoid unnecessary delay in the patient journey. (N=10).

Additional Investigations as appropriate (N=160); CTU/MRI Pelvis (Locally unless unavailable or scan of poor quality then at national centre), Community or Local Secondary Care Specialist Continence Nurse to review Management of Urine Leakage locally.

MDT review of referral letter and investigations (n=160), including anaesthetic.

Outpatient review at Centre (N=160): for

- i) Counselling;
- ii) Provision of/discussion on Patient Information Leaflet;
- iii) Take consent for treatment;
- iv) Give date for Definitive Repair surgery (N=150) of which a) 105 vaginal approach (70%), b) 45 abdominal approach if not suitable for fistula repair (30%), ± Preliminary Separate Cystoscopy/EUA in rare cases if Indicated;
- v) Or give date for Urinary Diversion (around 10) (5 ileal conduit and 5 neobladder)
- vi) CNS/CNP will review patient's management of urine leakage;
- vii) Patient Group ± Psychological Support Offered;
- viii) Date given for pre-operative assessment clinic (or may be same day as the clinic)

Patient admitted on day of surgery for Vaginal Repair or Abdominal Repair (laparoscopic/robotic or open) only if Vaginal Repair is NOT possible or if there is an absolute indication for Abdominal Repair

Telephone follow-up at one week

Outpatient clinic CNS review, including cystogram/methyl blue at three weeks after Surgery and Trial of Void if fistula has healed

Outpatient telephone clinic with Consultant and CNS/HCA at four months, Consultant telephone follow up at 12 months and unless problems, discharge back to GP if all is well.

3. Population Covered and Population Needs

3.1 Population Covered By This Specification

Women and adolescent girls aged 16 and above with a genito-urinary tract fistula. Patients under the age of 16 are unlikely to require this intervention, but if there is concern that a patient under the age of 16 has VVF or UVF they should be referred to commissioned specialised Congenital Gynaecological Abnormalities or paediatric surgery/urology service providers for review.

The service outlined in this specification is for patients ordinarily resident in England* or otherwise the commissioning responsibility of the NHS in England (as defined in Who Pays?: Establishing the responsible commissioner and other Department of Health guidance relating to patients entitled to NHS care or exempt from charges).

* Note: for the purposes of commissioning health services, this EXCLUDES patients who, whilst resident in England, are registered with a GP Practice in Wales, but INCLUDES patients resident in Wales who are registered with a GP Practice in England.

3.2 Population Needs

A total of approximately 140 surgical interventions are now coded each year in England for a vesico-vaginal fistula or urethra vaginal fistula including a) surgical repairs (either an abdominal or vaginal approach), or b) a more invasive urinary diversion procedure.

3.3 Expected Significant Future Demographic Changes

No growth is expected in the total number of patients referred apart from that due to improved coding and identification of patients.

3.4 Evidence Base

The specification is based on the following clinical evidence: Review of Hospital Episode Statistics HES data: In 2014-2015 there were 97 surgical repairs (for 84 Vesico-Vaginal Fistula (VVF) and 13 Urethro-Vaginal Fistula (UVF) including abdominal and vaginal approaches. Urinary diversion procedures were in addition to this number.

In multiple providers, the default position is to undertake the more invasive urinary diversion procedure (289/1194 = 24%, Cromwell et al 2013), rather than the primary VVF repair even though a urinary diversion has greater morbidity and significant adverse long term impacts on the patient's quality of life, Cromwell, D., Hilton, P., 2013.

There is correlation in the likelihood of the more invasive abdominal VVF repair surgery being performed in low volume centres and such centres have a median of eight days length of stay, Cromwell, D., Hilton, P. 2013.

There is correlation between the likelihood of the less invasive vaginal (VVF) repair being undertaken in centres with higher volumes due to the surgeons there being more experienced in this procedure, Cromwell D, Hilton, P 2013.

There is evidence that high volume VVF centres have half the failure rate of lower volume centres and are far more likely to repair a fistula successfully than perform a urinary diversion such as an ileal conduit or other form of urinary diversion, Cromwell D, Hilton 2013. Five per cent of women with VVF will have associated upper tract problems such as ureteric obstruction or uretero-vaginal fistula, Goodwin, W.E, Scardino, P.T 1980, Akman, R.Y, Sargin, S, Ozdemir, G. et al 1999.

A review of fistula surgery and outcomes in the UK from 2000 to 2009 (Cromwell D, Hilton 2013) showed that only three surgical teams in England were performing more than three fistula repairs

annually, and that the revision rates for failure in these 'larger' volume units are half those in other units.

The aetiology and incidence of urogenital tract fistulas vary geographically. In the United States and other developed countries, these are uncommon, are most often the result of gynaecological surgery and less often as a result of obstetric injury, severe pelvic pathology or radiation therapy Tancer ML 1992.

In developed countries, patients with successfully repaired bladder and ureteral fistulas usually have no residual problems.

4. Outcomes and Applicable Quality Standards

4.1 Quality Statement – Aim of Service

The aim of the service is to provide high quality assessment, diagnostics, care planning and surgical intervention where appropriate for women with a genito-urinary tract fistula. The service will provide continuity of expert care across the care pathway and will involve other specialists identified in this specification as appropriate.

NHS Outcomes Framework Domains

Domain 1	Preventing people from dying prematurely	N
Domain 2	Enhancing quality of life for people with long-term conditions	N
Domain 3	Helping people to recover from episodes of ill-health or following injury	Y
Domain 4	Ensuring people have a positive experience of care	Y
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	Y

4.2 Indicators Include:

Number	Indicator	Data Source	Outcome Framework Domain	CQC Key question
Clinical Outcomes				
101	Number of new patient referrals	Provider submitted	3	effective
102	% patients having vaginal repair	Provider submitted	3	effective
103	% of patients having a vaginal repair discharged within five days.	Provider submitted	3	effective

104	% of patients having a abdominal surgery discharged within ten days.	Provider submitted	3	effective
105	% patients that return to theatre within 30 days	Provider submitted	3	effective
106	% patients having urinary diversion surgery	Provider submitted	3	effective
107	% patients with anatomical closure at 1 year post surgery (none radiotherapy (RT))	Provider submitted	3	effective
108	% patients with anatomical closure and continence at 3 years post-surgery (none RT)	Provider submitted	3	effective
109	% patients with RT related fistula with anatomical closure at 1 year post surgery	Provider submitted	3	effective
110	% patients with RT related fistual with anatomical closure and continence at 3 years post- surgery	Provider submitted	3	effective
111	% patients discussed at MDT	Provider submitted	3	effective
Patient Experience				
201	There is information for patients and carers	self -declaration	3,4	caring responsive
202	The service is collecting patient reported outcomes	Self- declaration	3,4	caring responsive
203	The service is collecting feedback from patients	self -declaration	3,4	caring responsive
Structure and Process				
001	There is a specialist team	Self- declaration	3,5,	effective, safe
002	There are monthly MDT treatment planning meetings	Self- declaration	3,5	effective, safe
003	Patients are seen in a one stop clinic	Self- declaration	3,5	effective, safe
004	There are patient pathways in place	Self -declaration	3, 4 ,5	effective, safe
005	There are clinical guidelines in place	Self- declaration	3,5	effective, safe

Please see Appendix 3 for full description of these metrics. See also Schedule 6 of the NHS Standard contract.

4.3 Commissioned providers are required to participate in annual quality assurance and collect and submit data to support the assessment of compliance with the service specification as set out in Schedule 4A-C

There is a requirement to hold national audit meetings involving all specialist centres meeting together on an annual basis. Audit meetings should address: clinical performance and outcomes including surgical and non-surgical outcomes; process-related indicators, such as efficiency of the assessment process; prescribing policy, bed provision and occupancy, outpatient follow-up; stakeholder satisfaction, including feedback.

4.4 Applicable CQUIN goals are set out in Schedule 4D

5. Applicable Service Standards

5.1 Applicable Obligatory National Standards

There are no applicable obligatory national standards.

5.2 Other Applicable National Standards to be met by Commissioned Providers

Maintenance of skill requires regular and consistent involvement in the management of a range of gynaecological and urological conditions, with a minimum of three and optimally 10 cases of lower urinary tract fistula per year. Hilary CJ et al 2016.

British Association of Urological Surgeons (BAUS) information leaflets are available for providers to share with patients:

https://www.baus.org.uk/_userfiles/pages/files/Patients/Leaflets/Vaginal%20fistula%20abdominal.pdf

https://www.baus.org.uk/_userfiles/pages/files/Patients/Leaflets/Vaginal%20fistula%20vaginal.pdf

5.3 Other Applicable Local Standards

The service's specialist centres must ensure they are fully integrated into their Trust's corporate and clinical governance arrangements and comply fully with clinical negligence scheme for trusts (CNST) and Care Quality Commission (CQC) requirements in terms of quality and governance.

6. Designated Providers (if applicable)

7. Abbreviation and Acronyms Explained

The following abbreviations and acronyms have been used in this document:

CNS/CNP	Clinical Nurse Specialist/Clinical Nurse Practitioner
CTU	Computerised Tomography Urogram
Cystogram	Also known as cysto-urethrogram.
Cystoscopy	A cystoscope is a thin tube with a camera and light on the end. During a cystoscopy , a doctor inserts this tube through the urethra (the tube that carries urine out of your bladder) and into the bladder so they can visualize the inside of the bladder
ECG	Electrocardiogram
ECHO	Echocardiogram
EUA	Examination under anaesthetic
Fistula	An abnormal or surgically made passage between an organ and the body surface, or between two organs. (Plural – fistulae)
GP	General Practitioner
GUT	Genito-Urinary Tract
HCA	Healthcare Assistant
HES	Hospital Episode Statistics

IIQ7	Incontinence impact questionnaire
Ileal conduit	A type of urinary diversion procedure
ISC	Intermittent self-catheterisation
MDT	Multi-Disciplinary Team
MRI	Magnetic Resonance Imaging
Neobladder	A type of urinary diversion procedure
PISQ12	Pelvic organ prolapse/urinary Incontinence Sexual function Questionnaire
PFT	Pulmonary Function Tests
Post precipitating surgery	The precipitating surgery is the original surgery or treatment which caused the fistulae. After this,(post) the repair surgery will take place if there is potential benefit to the patient
SCN/SCP	Specialist Continence Nurse or Specialist Continence Practitioner
UDI6	Urogenital distress inventory 6
UVF	Urethro-vaginal fistula
VVF	Vesico-vaginal fistula

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Appendix 1: Guidance on post-surgical catheter management split by National and Local providers and primary care (Suggestion)

Catheter care following vesico-vaginal fistula repair instructions: What to Expect Post Surgery Vesico-Vaginal and Urethro-Vaginal Fistula Repair

1. X (the national centre which performed your repair surgery) will arrange for a telephone follow-up appointment for you with the Health Care Assistant (HCA) [name] one to two weeks after your discharge from hospital.
2. You will receive an appointment three to four weeks post discharge in Imaging (X-Ray) for a Cysto-Urethrogram. Your catheter will be removed if all is healed and you will be asked to pass urine normally before you leave the department. If all is not yet fully healed, your catheter will be left in and a repeat Cysto-Urethrogram booked for one to two weeks later.
3. You should ring the HealthCare Assistant (HCA), [name] following this appointment and leave them a message letting them know whether your catheter was removed or not, and the date of your next Cysto-Urethrogram (if required), as arranged by the x-ray team. The HCA will arrange to review you in the Outpatient clinic the same day or later that week. We will also arrange a telephone follow-up appointment with one of the unit Doctors six to eight weeks following discharge from hospital to check on your progress.
4. We will book a formal face to face outpatient appointment at x (the national centre) four months following discharge. You should come prepared to perform a flow rate test and let the nursing staff in outpatients know this is what you are expecting upon your arrival. A maximum urinary flow rate test measures how fast you pass urine and will involve you passing urine into a special toilet immediately before you see your urologist or Specialist Nurse to discuss the results of your X-rays and/or ultrasound scans. To do the test, please try to come to this clinic appointment with your bladder comfortably full, as at least 150ml of urine (quarter of a pint) is needed to be passed for a satisfactory test result. If you have difficulty in keeping a full bladder, please inform the staff as soon as you arrive so that they can help provide you with sufficient fluid to fill up your bladder.
5. Our HCA [name] or Clinical Nurse Specialist/Practitioner (CNS/CNP) [name] will ask you to fill out some outcome questionnaires (patient satisfaction, urinary, bowel and sexual function) as you wait for your appointment.
6. Following this face to face appointment you will have a telephone appointment with one of our medical team 12 months following your operation.

7. If you have any worries/queries related to your procedure you should ring our HCA [name] or CNS/CNP [name] on the numbers listed below. Please leave a message if they are busy and cannot answer and they will get back to you.
8. If you would like to rearrange your appointment you should contact our outpatient bookings department on the number listed below. Can you please also let one of our Patient Pathway Co-ordinators (PPC) know your new appointment date on the numbers listed below.
9. If you feel you have a problem that needs urgent and/or immediate attention you should go to the Accident and Emergency department (A&E) of the national centre for immediate assessment (or the nearest A&E department if you are some distance away). The A&E department is best placed to carry out immediate assessment, investigation and treatment of urgent problems. They will contact us if they feel your problem is related to your surgery and needs our attention.

Contact Numbers:

HCA [name and number]; CNP [name and number]; PPC [name and number];
 PPC [name and number]; Outpatient Appointment Bookings [number]

Catheter patient passport: You have a catheter (tube) draining urine from your urinary bladder either via your water pipe (urethra) or through a small hole in your belly (supra pubic). This passport should be kept with you & in a safe place when you get home as it carries the details of your catheter and your planned care. This passport should be read in conjunction with the 'catheter care' booklet and is in addition to the advice you should have received from the hospital staff.

Patient details	
Name	
Date of birth	
Address	
GP details	
Name	
Address	
Telephone number	
Catheter details	
Date of insertion:	
Reason for catheter insertion:	
Type of catheter:	
<ul style="list-style-type: none"> • Supra Pubic • Urethral • Short term • Long term 	
Size:	
Batch number:	
Urinary Drainage system	
Long tube	
Short tube	
Catheter valve	
Night time drainage	
Catheter securement	
Supplies provided, please list (including replacement catheter)	

Management plan	
Trial without catheter - Date/time:	
Appointment given	
Management plan	
Catheter change	
(i) national centre only Date/time:	
(ii) Hospital (routine) Date/time:	
(iii) Community Date/time	
Appointment given	
Referral to district nurses	
YES NO	
Reason for referral	
District Nursing Contact number	

Appendix 2: Guidelines for local providers in undertaking first MRI/CTU locally prior to referral to the national service so that image quality will be sufficient for use by the service. (Suggestion)

RI URO-FISTULA	
INDICATION	Uro-Vaginal or Uro-rectal fistula.
PROTOCOL	<p>Full bladder. Administer buscopan.</p> <p>3-plane TSE T2 SFOV [200] bladder and rectum (3 mm) - cover the bladder and rectum down to the perineum. May need to do 2 contiguous blocks. Should be a 3-4 slice overlap.</p> <p>Axial and sagittal STIR SFOV [200] (3mm) - same coverage as above.</p> <p>Coronal T2 BLADE LFOV kidneys down to pelvis - i.e. above the area scanned earlier. FOV to cover abdominal contents. May need to do 2 contiguous blocks. Should be a 3-4 slice overlap.</p> <p>Axial T1 TSE PELVIS 4mm</p>
NOTES	

Appendix 3: Detailed metrics

Number	Indicator	Detail		Data Source	Alert	O.F Domain	CQC Key question
		Descriptor	Notes	Evidence documents			
Clinical Outcomes - quantitative data							
101	Number of new patient referrals			Provider submitted	>20	3	effective
102	% patients having vaginal repair	Denominator = total number of patients having a repair Numerator = number of patients having a vaginal repair		Provider submitted	>70%	3	effective
103	% of patients having a vaginal repair discharged within five days.			Provider submitted	> 80%	3	effective
104	% of patients having a abdominal surgery discharged within ten days.			Provider submitted		3	effective
105	% patients that return to theatre within 30days			Provider submitted	<5%	3	effective
106	% patients having urinary diversion surgery			Provider submitted	<5%	3	effective
107	% patients with anatomical closure at 1 year post surgery (none RT)			Provider submitted	<80%	3	effective
108	% patients with anatomical closure and continence at 3 years post surgery (none RT)			Provider submitted	<90%	3	effective

109	% patients with RT related fistula with anatomical closure at 1 year post surgery				Provider submitted		3	effective
110	% patients with RT related fistula with anatomical closure and continence at 3 years post surgery				Provider submitted		3	effective
111	% patients discussed at MDT				Provider submitted	<100%	3	effective
Patient Experience								
201	There is information for patients and carers	The service must provide information to patients and carers which should cover: - the service including functions/roles of the team members - description of the patient pathway - the planned treatment and other treatment options - information about local and national patient and carer involvement groups and patient self-help groups if relevant - information about the services offering psychological, social and spiritual/cultural support - name and contact details for their clinical nurse specialist - other relevant contact points including emergency contact and contact for catheter advice/support if required.	The information should be age appropriate and available in languages and formats understandable by patients and carers including local ethnic minorities and people with disabilities. This may necessitate the provision of visual and audio material.	Operational policy	self - declaration	N	3,4	caring responsive

202	The service is collecting patient reported outcomes	The service should collect patient reported outcomes including : - sexual function - bowel function - urinary function		Operational policy	self - declaration	N	3,4	caring responsive
203	The service is collecting feedback from patients	The service should undertake an exercise to obtain feedback on patients' experience of the services offered. The exercise and any actions taken as a result should be presented and discussed within the service and management team.		Annual report	self - declaration	N	3,4	caring responsive
Structure and Process - infrastructure requirements, staffing, facilities etc								
001	There is a specialist team	There should be a lead clinician who should be a urologist or urogynaecologist with agreed responsibilities and time specified for the role The specialist team should include: - urologist with training and expertise in fistula management - urogynaecologist with training & expertise in fistula management - radiologist - clinical nurse specialists/advanced nurse practitioners providing specialist care for - continence - stoma - urinary diversion In addition to the specialist team there should be the following named contacts - coloproctologist with an interest in fistula management - physiotherapy - dietitian		Operational policy	self - declaration	N	3,5,	effective, safe

		- psychological support						
002	There are monthly MDT treatment planning meetings	<p>The MDT should have monthly treatment planning meetings for discussion of patients and agreement of treatment options.</p> <p>The attendance at each individual scheduled treatment planning meeting should constitute a quorum, for 95% or more, of the meetings.</p> <p>The minimum attendance should include:</p> <ul style="list-style-type: none"> - urologist - urogynaecologist - radiologist - clinical nurse specialist <p>The outcome of the meeting will be recorded in the patients notes and discussed by the consultant with the patient who will also be given a detailed treatment plan in writing in advance of surgery.</p>		Operational Policy	Self - declaration	N	3,5	effective, safe
003	Patients are seen in a one stop clinic	<p>Patients will be seen and assessed in a single one stop clinic which will include:</p> <ul style="list-style-type: none"> - consultant surgeon - clinical nurse specialist - anaesthetic assessment 		Operational Policy	Self-declaration	N	3,5	effective, safe
004	There are patient pathways in place	The service should agree with the relevant service providers and relevant commissioners, patient pathways for referral, assessment, investigation, treatment, discharge and follow up, as detailed in the service specification	Pathways specify how the different hospitals and groups of professionals should interact at defined stages of the patient journey, for diagnosis,	Operational Policy	Self - declaration	N	3, 4 ,5	effective, safe

			assessment, management and follow up/repatriation, as relevant. pathways should take into account nationally and internationally agreed guidance and standards.					
005	There are clinical guidelines in place	There are clinical guidelines in place for the referral, investigation, treatment, discharge and follow up as detailed in the service specification. Where relevant these should reflect nationally and internationally agreed guidelines	Clinical guidelines cover guidelines, protocols, and 'SOPs' which describe how to manage a patient in a given clinical situation or specified point on the pathway.	Operational Policy	Self - declaration	N	3,5	effective, safe