

## SCHEDULE 2 – THE SERVICES

### Service Specifications

<b>Service Specification No.</b>	<b>E10sd</b>
<b>Service</b>	<b>Complex Gynaecology Services – Recurrent Urinary Incontinence</b>
<b>Commissioner Lead</b>	
<b>Provider Lead</b>	
<b>Period</b>	
<b>Date of Review</b>	

#### 1. Population Needs

##### National/local context and evidence base

Urinary incontinence is the unintentional passing of urine. It is a very common problem and is thought to affect millions of people worldwide. It is not clear exactly how many people are affected, but it is estimated that between three and six million people in the UK have some degree of urinary incontinence. Urinary incontinence affects about twice as many women as men and becomes more common with age.

Urinary incontinence covers a wide range of disparate conditions (page 13). Stress incontinence accounts for 17% of incontinence in women, whilst 8% have overactive bladder with urge incontinence. These different conditions have very different treatments and management algorithms. 10% of women have a mixture of stress and urge incontinence (mixed incontinence). Other less common conditions include overflow incontinence, passive incontinence and incontinence associated with neurological diseases or trauma; these can present complex and difficult management problems and require subspecialist management in specialist units from first presentation.

Complex and recurrent incontinence should be managed by specialists with the necessary expertise to deal with all the patient's underlying problems. They should be able to offer a comprehensive range of treatments and surgical procedures. This is because there is no single procedure that is appropriate for all situations. The complex nature of many of these cases mandates that patients should be managed in units that offer care delivered by subspecialist Urogynaecologists and Female, Neurological and Urodynamic Urologists (FNUU). This should be in a multi-disciplinary team (MDT) structure. This will ensure expert units will have enough patients to develop and maintain their specialist expertise.

In England and Wales over 15,000 stress incontinence surgeries are performed annually. These procedures are generally performed by Gynaecologists and Urologists. Some are generalist consultants (with practices covering a range of gynaecological or urological conditions) and some are specialists (with more focused specialist interest in incontinence and/or prolapse). These subspecialist fields are known as FNUU.

These surgeries are chiefly performed for primary stress urinary incontinence and have a success rate of about 85%. This means:

- Approximately 2,250 patients each year will have persistent/recurrent urinary incontinence and require further surgery
- Of these 2,250 approximately 75% will have successful procedures – leaving about 563 women with recurrent incontinence or severe urinary stress incontinence

It is these women with recurrent incontinence and recurrent or severe stress urinary incontinence who fall within NHS England’s direct commissioning responsibility..

There are also a large group of women with urge urinary incontinence. Generally they respond to primary medical and physical therapies. Those that do not may be managed with Intravesical Onabotulinum toxin ‘A’ injections as a second line treatment.

For those who fail both of these treatments more invasive surgeries such as ileocystoplasty are performed. The numbers for each of these procedures performed annually are difficult to define accurately due to coding difficulties but are approximately 1500 for Onabotulinum toxin A (this will include 1<sup>st</sup> time and repeat injections as this procedure needs to be repeated every 6-9 months if successful). And 105 ileocystoplasty (or other bowel cystoplasty procedures).

Clinically there is discussion as to the most efficacious and cost effective form of operative intervention for urge urinary incontinence. Primary Onabotulinum toxin injection is not a subspecialist procedure however those women failing to respond to this procedure or withdrawing from the therapy due to side-effects and requiring further intervention should be within the realm of this specification.

## 2. Outcomes

### 2.1 NHS Outcomes Framework Domains & Indicators

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

## **Outcome Measures**

Domain 3 of the NHS outcomes framework focuses on helping people to recover from ill health or following injury. This includes recovery from elective surgery including incontinence surgery. Combining indicators that monitor adverse outcomes (showing progress in reducing cases in which recovery has been interrupted by emergency admissions) with those that measure positive progress in recovery (PROM) demonstrates the NHS's contribution to minimising the adverse impact of ill health and injury upon the quality of life of those affected.

The main measures to be assessed for adverse outcome within the remit of this specification will be:

1. Emergency readmissions within 30 days of discharge from hospital following elective surgery
2. The main improvement indicator is a Patient Reported Outcome Measures (PROM)

It is expected that the management of complex and recurrent incontinence will take place in specialist units. The specialist units will utilise a national databases (such as the British Association of Urological surgeons (BAUS) or British Society of Urogynaecology (BSUG) databases) to monitor activity and ensure outcomes can be audited. Benchmarking between units will ensure that quality of care is optimised.

Domain 4 of the NHS outcomes framework seeks to Ensure patients have a positive experience of care. For the purposes of this specification, this will be measured using the Overall Patient Experience score which is the average (mean) of five domain scores:

- Access & Waiting domain
- Safe, high quality co-ordinated care domain
- Better information, more choice domain
- Building closer relationships domain and
- Clean, friendly, comfortable place to be domain

### **Service outcomes:**

1. Services will provide a tertiary service to support women requiring specialist support within a network of care and pathways
2. Eligible women will be referred using a defined referral system that can be audited for waiting times
3. There will be an agreed planned and mapped pathway of care for women whose primary procedure for urinary incontinence has failed or who has complications arising from treatment of urinary incontinence including problems arising from mesh implantation.
4. The Service will be part of a multi-disciplinary team working together, networking and linking with other healthcare services across both community and hospital settings.
5. A discharge plan will be prepared offering support and facilities required providing care at home
6. Outcome measures including relief of symptoms and satisfaction with care will be measured and audited.

7. The Provider will be expected to use evidence based approaches and to demonstrate efficiencies whenever possible.
8. Appropriate referrals to specialist colleagues will be documented and GP informed of any transfer of care
9. It is the responsibility of the Provider to recruit/provide suitable and appropriately competent and qualified personnel in the provision of this service. When advanced surgical techniques such as laparoscopic surgery are required the unit will have available clinicians who have the appropriate training in both incontinence and laparoscopic surgery. This may be provided by a network of specialist services delivered between a number of units. When there is a change in personnel, the provider must inform the commissioning body and the accrediting body (where appropriate) so that Specialist Unit status can be reconfirmed.
10. All patients should be under the care of an experienced multidisciplinary team. This should include an Urogynaecologist and an FNUU Urologist, a Specialist Nurse / Physiotherapist and Colorectal Surgeon where required.
11. Providers will enter all procedures involving implants on a national registry and organise follow up and audit of outcomes

### 3. Scope

#### 3.1 Aims and objectives of a specialist service

To provide patient centred specialist care for women with a **recurrence of symptoms of stress or stress predominant incontinence** following surgical treatment of urinary incontinence.

The primary aims are:

1. To provide safe, effective and evidence based pathways of care to women with recurrent and complex incontinence by subspecialist FNUU Urologists and Urogynaecologists practising within accredited Specialist Units
2. To perform an extended or advanced assessment of the anatomical and functional problems which will include assessment of:
  - Anatomical disruption
  - Urinary function
  - Bowel function
  - Sexual function
3. To perform appropriate investigations of lower urinary tract and gastro-intestinal tract function
4. To provide counselling about the full range of surgical and non-surgical treatment options for stress incontinence. This will include treatments outlined in current NICE clinical guidelines:
  - Conservative and lifestyle management, where appropriate
  - Mid urethral tapes such as Tension-free or transobturator vaginal tapes
  - Burch colposuspension (open or laparoscopic)
  - Injectable agents

- Autologous sling
  - Artificial Urethral Sphincter
  - Urinary Diversion, in extreme cases
5. To provide counselling about the full range of surgical and non-surgical treatment options for urge incontinence. This will include treatments outlined in current NICE clinical guidelines:
    - Medical and lifestyle management
    - Intravesical Botulinum Toxin injections
    - Augmentation cystoplasty
    - Suprapubic catheterisation
    - Urinary Diversion, in extreme cases
  6. To provide continuity of care through the whole care pathway encompassing other specialised services included within the pathway
  7. In the case of incontinence associated with neurological conditions, to provide specialist clinics and consultants with training and expertise in the management of this specific group of conditions.

### **3.2 Service description/care pathway**

The service outlined in this specification is for patients ordinarily resident in England. Specifically, this service is for women who have developed complications, including failure, of primary surgery to treat urinary incontinence. They will:

- Be referred either from primary care or secondary care through local networks to Specialist Units (as defined above)
- Assessed in the outpatient setting by a named Consultant Urogynaecologist or an appropriately trained FNUU Urologist.
- Have appropriate investigations of lower urinary tract and gastrointestinal tract function will be performed (urodynamics, anorectal studies, radiological or ultrasound imaging)
- Discuss their treatment options with a multi-disciplinary team including a sub-specialist Urogynaecologist, a FNUU Urologist, a Specialist Nurse / Physiotherapist and a Colorectal Surgeon when appropriate.
- Be counselled about all the relevant management options including non-surgical and surgical treatments.
- Have elective surgical treatment performed if requested after informing the patient about the alternative approaches to surgery including laparoscopic techniques

Services will provide the defined activities outlined below as part of a multidisciplinary team associated with interdependent services

#### **A. Management of recurrent urinary incontinence / failed primary surgical treatment**

Primary surgical treatment of urinary incontinence (approximately 15,000 FCE 2011) is performed by Gynaecologists and Urologists. Primary surgery for stress urinary incontinence is normally within the competency of a Gynaecologist or Urologist who has a special interest in female urinary incontinence. NICE (2006) recommends that these procedures should only be performed by consultants who have a caseload of at least 20 cases per year.

In a small number of cases the primary surgery fails and there is also a risk of recurrence of incontinence over time. Furthermore, other symptoms of lower urinary tract dysfunction may develop, such as urinary frequency/urgency or voiding dysfunction developing after surgery for

stress incontinence. Such cases should be referred to specialist units that are able to offer management by subspecialist FNUU Urologists or Urogynaecologists working within an MDT framework.

In the case of urge urinary incontinence, conservative and medical management are generally provided in primary care, but may also be provided by non-subspecialist gynaecologists and urologists. Where medical treatment has failed, invasive treatment with Botulinum Toxin bladder injections may be offered by appropriately trained urologists and gynaecologists with an interest in incontinence treatment. Augmentation cystoplasty should only be undertaken in specialist units by FNUU Urologists or Urogynaecologists with the necessary expertise.

In the case of stress urinary incontinence, conservative management, including supervised pelvic floor exercises, is generally provided in primary care or by non-subspecialist gynaecologists and urologists. Primary surgical treatment may be offered by appropriately trained urologists and gynaecologists with an interest in incontinence treatment who perform at least 20 surgical procedures for stress incontinence per year. Surgery for persistent or recurrent stress incontinence, and complex cases (including incontinence associated with neuropathic bladder dysfunction, trauma or voiding dysfunction) should only be provided in specialist units (as defined above).

#### **B. Management of complications of prolapse or incontinence surgery**

In addition to treatment failure, surgery for incontinence and surgery for pelvic organ prolapse may be followed by the following problems:

- Urinary fistula
- Anorectal dysfunction including incontinence
- Dyspareunia
- Mesh exposure

The investigation and management of women who develop these complications is highly complex. Their surgery can be technically challenging and alternative techniques may be required which are not within the repertoire of most gynaecologists or urologists. Such cases should be managed by specialist centres with expertise and experience of removing mesh and pelvic reconstruction. Units that accept referrals for such cases will have a caseload of at least 20 such complex cases per year.

#### **3.3 Service quality assurance for patients:**

Specialist Units:

Complex and recurrent urinary incontinence should be managed in specialist units, which provide treatment by consultants working within a MDT structure. Specialist units will provide a comprehensive range of incontinence treatments applicable to a broad spectrum of clinical scenarios (including both urge and stress incontinence), in compliance with current NICE guidelines.

In order to maintain expertise and surgical experience, specialist units will be able to demonstrate a caseload of complex and recurrent incontinence surgical procedures ideally in excess of 10 cases per year (on average, over 3 or more years). Units that perform between 5 and 10 such cases per year must have special arrangements for local clinical governance in place and must operate under the auspices of a larger regional MDT in which 10 or more complex or recurrent cases per year are performed. It is intended that, over time, a small number of specialist units will emerge and a required minimum number of complex surgical cases can be proposed based on the evidence of outcomes data. The minimum number of complex and recurrent cases is

anticipated to increase over time.

Specialist units will be able to provide the following treatments for complex and recurrent urinary incontinence:

- Conservative and lifestyle management, where appropriate
- Mid urethral tapes such as tension-free or transobturator vaginal tapes
- Burch colposuspension (open or laparoscopic)
- Injectable agents
- Autologous sling

Specialist units will be able to offer the following operative treatments, either locally or via an established referral pathway to a quaternary centre:

- Artificial Urethral Sphincter
- Suprapubic catheterisation
- Urinary Diversion, in extreme cases

MDT Team:

1. The MDT for recurrent UI must be comprised of a Urogynaecologist and an FNUU Urologist (as defined above), as well as specialist nurses, physiotherapists and a coloproctologist where appropriate. There should also be defined links to other related services (e.g. radiology, neurology, psychology), which should be co-located with them. The provider should deliver high quality services within an agreed network of providers whose population may also use this service.
2. The MDT must convene at least 12 times per year. In order to be quorate, the meeting must be attended by at least 3 members. There must be at least two consultants (urogynaecologist or FNUU Urologist) present at all meetings. A full meeting of the MDT including both FNUU Urologist and Urogynaecologist must take place at least 4 times per year. The MDT must ensure documented discussion of complex cases, review of important diagnostic tests and prospective audits of activity and outcomes. National databases, such as the British Association of Urological Surgeons (BAUS) or British Society of Urogynaecology (BSUG) databases, should be used to record activity for all cases and yearly audits of surgical outcomes should be undertaken with national benchmarking between Specialist Units. Those treating complex or recurrent incontinence will be able to demonstrate continuing medical education (CME) in incontinence and/or other relevant areas of practice. There is a progression of requirements based on this as detailed in appendix 2 below.
3. Consultant FNUU Urologists and Urogynaecologists working in a specialist unit will provide at least one specialist incontinence clinic per week, will devote at least 50% of their clinical practice to FNUU Urology or urogynaecology and will have direct involvement in the provision of urodynamics testing within their job plan.
4. Providers will put in place clear referral pathways to ensure that patients with complex and recurrent incontinence are treated in specialist incontinence clinics by subspecialist incontinence clinicians. This has been identified as a potential quality improvement scheme and Clinical Commissioning Group's may implement this separately or as part of this policy

#### Consultant training:

Many consultants currently have expertise and experience gained through traditional training schemes in Urology or Gynaecology with subsequent development of specialist practice as consultants. It is anticipated that future consultants will be able to demonstrate subspecialist training. In gynaecology, defined training schemes and curricula exist for urogynaecology, including Subspecialist Training Schemes or ATSM modules as the generic gynaecology curriculum does not cover these skills comprehensively. In urology, there is currently no curriculum for FNUU Urology as a significant proportion of the skills requirements are covered within the Urology generic training curriculum. However, new consultants wishing to practice as FNUU Urologists will be expected to demonstrate focussed training in incontinence management and surgical procedures.

Some women will require surgery employing laparoscopic techniques. It is essential that laparoscopic surgical procedures to treat incontinence be performed in units that have the appropriate expertise.

#### Accreditation of Specialist Units:

- Providers wishing to offer treatment for complex and recurrent incontinence will be required to demonstrate compliance with the training criteria. Local commissioning teams must ensure that providers wishing to function as Specialist Units provide evidence of compliance with these criteria. Accreditation of Specialist Units by professional bodies such as BSUG and BAUS will be regarded as evidence of compliance, and these bodies will ensure that accreditation standards are commensurate with those for Specialist Unit status.
- Units which are unable to provide such services or which cannot provide evidence of compliance with the required standards will need to develop tertiary referral pathways to a specialist centre and will be expected to discontinue these services locally.
- Specialist Units must provide evidence of ongoing compliance with the above criteria every 3 years, including results of relevant clinical audits. When there is a change in consultant personnel within the MDT, the provider must inform the commissioning body and the accrediting body (where appropriate) so that specialist unit status can be reconfirmed.

#### 3.4 Population covered

Included within individual conditions above.

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.

Specifically this service is for women who have had previous surgery for prolapse/incontinence and require specialist intervention as outlined within this specification.



### 3.5 Any acceptance and exclusion criteria and thresholds

- Eligible women will be referred using a defined referral system that can be audited for waiting times
- Pathways of care with auditable outcome measures will be employed.
- The service will accept referrals from other providers particularly where the referring service does not undertake the procedures the patient requires.
- The Provider will be expected to use evidence based approaches and to demonstrate efficiencies whenever possible
- A discharge plan will be prepared offering support and facilities required providing care at home.
- Appropriate referrals to specialist colleagues will be documented and GP informed of any transfer of care

**Exclusions:** Cancers these are covered in the cancer services specifications

### 3.6 Interdependencies with other services/providers

#### i) Co-located Services

Availability of the various services (Urogynaecology, FNUU Urology, Colorectal Surgery, Physiotherapy and imaging) ideally on the same campus with easy access to the MDT has several advantages. This ensures better communication, a more efficient service and lower costs for hosting of the services.

#### ii) Interdependent Services

The delivery of this service will be within the remit of an MDT working together, networking and linking with other healthcare services across both community and hospital settings. These services include urology, colorectal services, imaging, and community.

**iii) Related Services** - services either at the preceding or following stage of the patient journey. Preceding services will include the community (their engagement being essential) as well as other units, which will refer to the specialist services for management of these complex conditions.

#### iv) Data Submission

This will be through the BSUG, BAUS or equivalent national databases and will include preoperative, intraoperative and postoperative data on consecutive cases. Monitoring of caseload and benchmarking of outcome data will form part of the process of re-accreditation of specialist units.

## 4. Applicable Service Standards

### 4.1 Applicable national standards e.g. NICE

#### See Appendix 3

1. NICE (2013) 'Urinary incontinence: The management of urinary incontinence in women, NICE Clinical Guideline CG171'
2. NICE (2012) 'Urinary incontinence in neurological disease: management of lower urinary tract dysfunction in neurological disease, Clinical Guideline 148'

3. NICE (2003) 'Systematic review of the efficacy and safety of sacral nerve stimulation for urinary urge incontinence and urgency/frequency.'
4. NICE (2005) 'Insertion of extraurethral (non-circumferential) retropubic adjustable compression devices for stress urinary incontinence in women, NICE Interventional Procedures Guidelines IPG133'
5. NICE (2005) 'Intramural urethral bulking procedures for stress urinary incontinence, NICE Interventional Procedures Guidelines IPG138'
6. NICE (2006) 'Insertion of biological slings for stress urinary incontinence, NICE Interventional Procedures Guidelines IPG154'
7. NICE (2008) 'Single-incision sub-urethral short tape insertion for stress urinary incontinence in women, NICE Interventional Procedures Guidelines IPG262'
8. All surgeons carrying out lower urinary tract surgery are mandated to use the BSUG, BAUS or equivalent national databases.

#### 4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

1. Units providing services within the remit of this specification will be accredited by BSUG and BAUS. This will ensure quality standards and a reassurance that these specialist units meet all criteria required to provide these services by an independent and competent body.
2. Commissioners must ensure that providers wishing to offer treatment for complex or recurrent urinary incontinence are compliant with the criteria set out in this document. Specialist Units must provide evidence of ongoing compliance with these criteria every 3 years (including audit data and case-numbers), or whenever there is a change in subspecialist consultant personnel.

## 5 Coding

Universal coding strategies should be encouraged so that accurate workload data can be monitored across the UK for primary and recurrence incontinence. The following recommendations are designed to facilitate common practice between providers.

1. Code for the main procedure and any ancillary procedures performed
2. In the case of surgery for recurrent incontinence, the code Y71.3 is used.
3. In the case of surgery for recurrent incontinence following two previous procedures for the same clinical problem, the code Y71.6 is used
4. In the case of surgery for recurrent incontinence following three or more previous procedures for the same clinical problem, the code Y71.7 is used. It is recommended that further codes be introduced to denote recurrence after 4 and 5 previous procedures.
5. The following **do not** constitute recurrent incontinence:
  - A second periurethral bulking agent injection (which would be considered to constitute part of the original treatment strategy)
  - Repeated applications of Botulinum toxin bladder injections (which would be

- considered to constitute part of the original treatment strategy)
- A procedure for stress incontinence after previous intervention for urge incontinence
  - A procedure for urge incontinence after previous intervention for stress incontinence
  - The second stage of a two stage procedure (eg permanent sacral neuromodulation implant after test phase, including PNE)

## Appendix One

### Quality standards specific to the service

Quality Requirement	Threshold	Method of Measurement	Consequence of breach
<b>Domain 1: Preventing people dying prematurely</b>			
Not Applicable			
<b>Domain 2: Enhancing the quality of life of people with long-term conditions</b>			
Proportion of people feeling supported to manage their condition	> 90%	Proportion of patients feeling supported assessed through questionnaires /telephone interview	Audit to evaluate causation and change in practice where feasible
Unplanned Admissions	<2%	HES data	Audit to evaluate causation and remedial action
Ability to work with this condition	>85%	Assessed through patient assessment of their condition	Audit to evaluate causation and remedial action
<b>Domain 3: Helping people to recover from episodes of ill-health or following injury</b>			
Emergency readmissions within 30 days of discharge from hospital	< 5%	HES data: Proportion of patients readmitted following surgery for their recurrent prolapse or incontinence	Audit to evaluate causation and remedial action
Patient Reported Outcome Measures (PROM) for elective procedures	>70%	Completion of pre and post-operative ICIQ, KHQ, ePAQ or other validated questionnaires	
<b>Domain 4: Ensuring that people have a positive experience of care</b>			
Measuring patient experience of outpatient care. This is across three stages of the care pathway: pre-visit; during the visit to the Outpatients department; and the transition/post-visit period	> 85%	Care Quality Commission's Outpatient survey	Audit to evaluate causation and remedial action

Quality Requirement	Threshold	Method of Measurement	Consequence of breach
Measuring patient experience of hospital inpatient care which is the average (mean) of five domain scores 1) Access & Waiting domain 2) Safe, high quality co-ordinated care domain 3) Better information, more choice domain 4) Building closer relationships domain and 5) Clean, friendly, comfortable place to be domain.	>85%	The Care Quality Commission's Adult Inpatient Survey	Audit to evaluate causation and remedial action
<b>Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm</b>			
All Patient Safety incidents reported especially Safety incidents involving severe harm or death	98%	Reduction of Incidents compared to previous years	Audit to evaluate causation and remedial action
Measurement of Incidence of hospital-related venous thromboembolism	As per national KPIs	Number of cases per year by the number of admissions for elective surgery	Audit to evaluate causation and remedial action
Measurement of Incidence of healthcare associated infection: i MRSA bacteraemia; ii C.difficile	As per national KPIs	Number of cases per year by the number of admissions for elective surgery	Audit to evaluate causation and remedial action

## Appendix 2 - Definitions:

1. Incontinence- The complaint of any involuntary leakage of urine
2. Stress urinary incontinence- The complaint of involuntary leakage on effort or exertion, or on sneezing or coughing.
3. Urgency- The complaint of a sudden compelling desire to pass urine that is difficult to defer.
4. Urge urinary incontinence- The complaint of involuntary leakage accompanied by or immediately preceded by urgency
5. Overactive bladder syndrome- The complaint of urgency, with or without urge incontinence, usually with urinary frequency and nocturia
6. Mixed Incontinence- The co-existence of symptoms of stress incontinence and urge incontinence
7. Pelvic organ prolapse- The descent of one or more of: the anterior vaginal wall, the posterior vaginal wall, and the apex of the vagina (cervix/uterus) or vault (cuff) after hysterectomy
8. Recurrent Incontinence- Urinary incontinence that persists or recurs following at least one surgical procedure intended to correct that problem. This would not include repeated administration of bladder Botulinum toxin injections or a repeat peri-urethral bulking procedure, which would be considered to be supplementary procedures forming part of the original management strategy. It also does not include the emergence or persistence or a different type of incontinence (eg the complaint of stress incontinence after the surgical treatment of urge incontinence or vice versa)
9. Complex incontinence- A spectrum of difficult and challenging conditions including overflow incontinence, passive incontinence and incontinence associated with neurological diseases, radiotherapy injury or trauma. Patients with these conditions require specialist management from first presentation
10. FNUU Urology- Female, Neurological and Urodynamic Urology

Training definitions:

1. FNUU (Functional, Female, Neuro-urology and Urodynamic Urology) is defined by the British Association of Urological Surgeons as the sub-specialty of urology that covers the investigation and treatment of benign conditions of the lower urinary tract. It also encompasses related problems within the female genital tract. The particular focus of the sub-specialty is on disorders of function and on inflammatory conditions affecting these systems. A major component of the subspecialty is neurological urology, which covers the management of patients with neurological conditions that have an impact on urinary tract and sexual function. See Appendix 3 for full details of FNUU urology including job plan
2. Urogynaecology  
Urogynaecology is a sub-speciality of gynaecology that deals with benign disorders of the lower urinary and genital tract, principally urinary incontinence and genital prolapse. A Urogynaecologist is defined by British Society of Urogynaecology (BSUG) as a Gynaecologist who fulfils the following criteria:
  - Has a dedicated Urogynaecology clinic or equivalent per week including secondary and tertiary referrals, as part of a MDT service.
  - Has trained in a unit that provides the full range of investigations and treatments required for training.
  - Has urodynamics experience and has a regular urodynamics session (minimum of 1 per month)
  - Provides 3 clinical sessions of Urogynaecology per week and at least one major Urogynaecology procedure associated with pelvic floor dysfunction per working week per year.
  - Regularly audits their practice eg BSUG database
  - Proportion of continuing medical education (CME) in Urogynaecology or equivalent
  - For consultants gaining accreditation after 2010 this would require successful completion of either an advanced training skills module (ATSM) in Urogynaecology or subspecialty training

Urologist with an Interest in FNUU has the following job plan:

- Dedicated FNUU Clinic or equivalent per week including secondary and tertiary referrals, as part of a multidisciplinary service.
- Evidence of training in a Unit, which provides the full range of investigations and treatments required for training.
- Urodynamics experience e.g. Special Skills Training
- Regular Urodynamic sessions (minimum of one per month) either personally or in a supervisory capacity
- Provide two clinical FNUU urology sessions per week
- Surgery: One FNUU procedure associated with pelvic floor dysfunction i.e. incontinence and prolapse per working week per year.
- Audit e.g. BAUS/BSUG surgical audit
- CME review: proportion of CME in FNUU urology

Services delivered:

- Close liaison with primary care colleagues regarding the development of local FNUU services.
- Multidisciplinary team working with urogynaecologists, coloproctologists, specialist nurses and specialist therapist.
- Coordination of urodynamic services and personal, active participation in urodynamic assessment.
- Overactive bladder/detrusor overactivity – investigation, conservative management and Botulinum toxin service.
- Female stress incontinence – investigation, conservative management and surgical treatment.
- Bladder outflow obstruction – investigation and treatment of the complex case.
- Bladder pain – investigation and conservative management.
- Other pelvic and genital pain – investigation and conservative management.
- Pelvic floor prolapse – assessment and management or assessment and referral for treatment.
- Investigation and treatment of the neuropathic lower urinary tract, genital tract and bowel. To include MS, Parkinson's disease, stroke and spinal pathology.
- Management of complex urinary tract infection.

Urologist with a Specialist FNUU Practice has the following job plan/definition:

- A consultant with a regional or supra-regional practice that includes a significant volume of tertiary referral or highly specialised work.
- 50% of working week devoted to FNUU urology
- Dedicated FNUU Clinic or equivalent per week including secondary and tertiary referrals, as part of a multidisciplinary service.
- Evidence of training in a Unit, which provides the full range of investigations and treatments required for training.
- Urodynamics experience e.g. Special Skills Training
- Regular Urodynamic sessions (minimum of one per month) either personally or in a supervisory capacity
- Provide three clinical FNUU urology sessions per week
- Surgery: One major FNUU procedure associated with pelvic floor dysfunction i.e. incontinence and prolapse per working week per year.
- Audit e.g. BAUS/BSUG surgical audit
- CME review: proportion of CME in FNUU urology

Services delivered:

- Provision of advanced urodynamic assessment.
- Recurrent urge urinary incontinence/detrusor overactivity – investigation, conservative management, Botulinum toxin service, Sacral Neuromodulation service, Clam Ileocystoplasty.
- Recurrent female stress incontinence – investigation, conservative management and surgical treatment including intra-urethral bulking agents, mid-urethral tapes, mid-

urethral and bladder neck slings, open and laparoscopic techniques of colposuspension and bladder neck artificial urinary sphincter.

- Recurrent POP – investigation, conservative management and surgical treatment including open and laparoscopic sacrocolpopexy.
- Recurrent urge urinary incontinence- – investigation, conservative management and surgical treatment including pTNS, Botulinum toxin injections, Sacral neuromodulation, clamcystoplasty
- Management of intractable frequency/urgency syndrome patients.
- Management of intractable bladder pain.
- Continent urinary diversion and orthotopic bladder replacement surgery.
- Neurourology in relation to spinal cord injury and spina bifida. .
- Complex reconstructive surgery such as post irradiation pelvic pathology.
- Vesico-vaginal fistula, mesh and tape complications and other rare lower urinary tract conditions

DRAFT FOR PUBLIC CONSULTATION



### Appendix 3 - Criteria for unit approval by year 2015-19

Year	Database	Protocols	MDT	Job planning	Complex / recurrent caseload
2015-16	Registered using a database	Unit protocols	MDT to include Urogynaecologist, FNU urologist, physio or nurse specialist, and colorectal specialist.	job plan recognising specialist area	Min 5 / year based on 3 yr average. Ideally this should be 10 and those between 5 and 10 such cases per year must have special arrangements for local clinical governance.
2016-17	>200 registered incontinence cases / year		Time in job plans for MDT	Objectives to include development needs in LUTs	As above
2017-18	audit report of cases			MDT within job plan	> 10 cases / year
2018-19	12 months of outcome data at 3-6 months	BSUG accreditation or equivalent	Audited outcomes of MDT (patient numbers)	Multidisciplinary clinics	> 20 cases / year with published outcome data

