

E10/S/d

**NHS STANDARD CONTRACT
FOR COMPLEX GYNAECOLOGY : RECURRENT PROLAPSE AND URINARY
INCONTINENCE**

**PARTICULARS, SCHEDULE 2 – THE SERVICES, A - SERVICE
SPECIFICATIONS**

Service Specification No.	E10/S/d
Service	Complex Gynaecology : Recurrent Prolapse and Urinary Incontinence
Commissioner Lead	
Provider Lead	
Period	12 months
Date of Review	

1. Population Needs

1.1 National/local context and evidence base

Patients with symptoms and signs of prolapse and/or incontinence after previous surgical treatment require the services of a specialist centre. There are about 13,000 instances of this seen nationally.

Multi-professional and multi-disciplinary input is required because the patient often has co morbidities which render the care of her gynaecological disorder especially complex e.g. uterine prolapse and wishing for further pregnancy, urinary/faecal incontinence accompanying prolapse. This is best provided by a Sub-specialist centre co-located with other specialised services.

Units that provide this service will also need defined links to other definition sets and should be co-located to the relevant services. The Provider will deliver high quality services within an agreed network of Providers whose population may also use this service.

Over 40,000 incontinence and prolapse surgeries are performed annually in England and Wales. The majority of these procedures are performed by gynaecologists with a special interest in Urogynaecology. Data from a historical data set in the US suggests that one in three women who have surgery for stress incontinence or pelvic organ prolapse will require a further surgical intervention either to treat recurrent incontinence, recurrent prolapse or prolapse in a different

area or to treat complications of the previous surgery and about half of these will require tertiary level management as described in this specification. This equate to 13,000 cases annually.

Such cases should be managed by gynaecologists who have a sub-specialty interest in Urogynaecology (sub-specialty trained or over 50% workload includes Urogynaecology). Each region requires a centre which has the multidisciplinary expertise to manage such cases and units will need a minimal caseload to develop and maintain this expertise. There are currently 16 such units in England. These caseloads are in accordance with the RCOG projections for workforce planning which aims to produce a core of 55 sub- specialist Urogynaecologists and 350 special interest Urogynaecologists.

Some women may require prolapse surgery augmented with mesh. Only units which have surgeons who have the training and expertise with a caseload of over 20 such cases per year should perform this surgery. It is expected that this type of surgery will be performed by sub-specialist Urogynaecologists.

Some women will require surgery employing laparoscopic techniques. Such techniques are not currently widely practised and currently there is no defined curriculum for training in laparoscopic prolapse in the UK. It is important that laparoscopic surgical procedures to treat prolapse are performed in units which have sub-specialist expertise in Urogynaecology and laparoscopic surgery to ensure that all the functional and anatomical issues are addressed.

The regional urogynaecology units currently established in England all have at least two subspecialist Urogynaecology surgeons working within the units who could manage the expected workload.

2. Scope

2.1 Aims and objectives of service

To provide patient centred specialist care for women with recurrence of symptoms or de novo symptoms following surgical treatment of urinary incontinence or pelvic organ prolapse.

The primary aims are:

- 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
- To perform appropriate investigations of lower urinary tract and gastro- intestinal tract function
- To provide counselling about the surgical and non-surgical treatment options

- To offer the appropriate surgical treatment (including laparoscopic) including the option of augmentation of the repair with mesh when requested.
- To provide continuity of care through the whole care pathway encompassing other specialised services included within the pathway

2.2 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 or pelvic organ prolapse:

- they will be referred either from primary care or secondary care
- they will be assessed in the outpatient setting by a named Consultant subspecialist Urogynaecologist (either by training or by devoting over 50% working week to Urogynaecology practice)
- appropriate investigations of lower urinary tract and gastrointestinal tract function will be performed (urodynamics, anorectal studies, radiological or ultrasound imaging)
- treatment options will be discussed by a multi-disciplinary team including a subspecialist Urogynaecologist, a specialist nurse, a physiotherapist and a colorectal surgeon when appropriate. A Urologist may also be involved where relevant.
- the patient will be counselled about the management options including non-surgical and surgical treatments.
- elective surgical treatment will be 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

Management of recurrent urinary incontinence / failed primary surgical treatment

Primary surgical treatment of urinary incontinence (approx 15,000 Finished Consultant Episodes 2011) is performed by gynaecologists who have a special interest in female urinary incontinence and is performed in over 50 departments in England and Wales. 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. National Institute for Health and Care Excellence NICE (2006) recommends that these procedures should only be performed by consultants who have a caseload of at least 20 cases per year.

In 10-20% cases the primary surgery fails and there is also a risk of recurrence of stress incontinence over time. Furthermore, other symptoms of lower urinary tract dysfunction may develop. The investigation and management of women whose primary surgery for stress incontinence has failed or who have complications such as mesh exposure following insertion of a tape is more complex. Their surgery can be technically challenging and alternative techniques may be required which are not within the repertoire of the majority of gynaecologists. Such cases should

be managed by centres with expertise and experience of removing mesh and reconstruction of the area concerned. Units which accept referrals for such cases will have a caseload of at least 20 cases per year.

Management of recurrent pelvic organ prolapse / failed primary surgical treatment

Primary surgery for pelvic organ prolapse is usually performed by gynaecologists who have received additional training in urogynaecology. When primary surgery fails or there is a recurrence of prolapse there is often associated bladder, bowel and sexual dysfunction. Further surgery is technically more difficult and may require techniques involving implant materials (mesh) which employ techniques which are not normally within the repertoire of gynaecologists who perform primary surgery. Techniques employing laparoscopic surgery are not practised by the majority of Gynaecologists and will only be performed by appropriately trained surgeons with expertise in prolapse surgery. Furthermore, mesh implants are associated with exposure/erosion into the vagina, bladder or rectum which can be technically difficult to manage surgically. Additional surgical expertise and experience is required to manage such cases and combined procedures with colorectal and urological surgeons may be required.

Management of complications of prolapse or incontinence surgery

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

- urinary voiding dysfunction
- urinary incontinence
- urinary fistula
- ano-rectal dysfunction including incontinence
- dyspareunia

Investigation and management may include:

- urodynamics (including the role of video and ambulatory)
- imaging of lower and upper urinary tract and bowel

Treatment may include further surgery requiring tertiary level expertise.

2.3 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.

2.4 Any acceptance and exclusion criteria

- Eligible women will be referred using a defined referral system that can be audited for waiting times
- Pathways of care with auditable outcome measures should be employed.
- 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

2.5 Interdependencies with other services

This service will interact with other specialties including, urology, colorectal, radiology and community.

3. Applicable Service Standards

3.1 Applicable national standards e.g. NICE, Royal College

- NICE (2006) 'Urinary incontinence: the management of urinary stress incontinence in women, NICE Clinical Guidelines CG40'
- NICE (2005) 'Insertion of extraurethral (non-circumferential) retropubic adjustable compression devices for stress urinary incontinence in women, NICE Interventional Procedures Guidelines IPG133'
- NICE (2005) 'Intramural urethral bulking procedures for stress urinary incontinence, NICE Interventional Procedures Guidelines IPG138'
- NICE (2006) 'Insertion of biological slings for stress urinary incontinence, NICE Interventional Procedures Guidelines IPG154'
- NICE (2008) 'Single-incision sub-urethral short tape insertion for stress urinary incontinence in women, NICE Interventional Procedures Guidelines IPG262'
- NICE (2008) 'Surgical repair of vaginal wall prolapse using mesh, NICE Interventional Procedures Guidelines IPG267'
- NICE (2009) 'Infracoccygeal sacropexy using mesh for uterine prolapse repair, NICE Interventional Procedures Guidelines IPG280'
- NICE (2009) 'Infracoccygeal sacropexy using mesh for vaginal vault prolapse repair, NICE Interventional Procedures Guidelines IPG281'

- NICE (2009) 'Insertion of mesh uterine suspension sling (including sacrohysteropexy) for
- uterine prolapse repair, NICE Interventional Procedures Guidelines IPG282'
- NICE (2009) 'Sacrococpopexy using mesh for vaginal vault prolapse repair, NICE Interventional Procedures Guidelines IPG283'
- NICE (2009) 'Sacrococpopexy with hysterectomy using mesh for uterine prolapse repair, NICE Interventional Procedures Guidelines IPG284'
- All surgeons carrying out lower urinary tract (LUT) surgery are mandated to use the Tthe British Society of Urogynaecology (BSUG) database or equivalent.
- The service will only include Gynaecologists with sub-specialty expertise. When laparoscopic techniques are required the surgeons involved will have had appropriate training in laparoscopic surgery in addition to sub-specialty expertise in Urogynaecology.
- Appropriate training is defined as a minimum of 2 years training, including evidence of theoretical training (>1 specific course), mentorship and audit outcome data (BSUG), with a minimum number PA.

4. Key Service Outcomes

- Services will provide a tertiary service to support women requiring specialist support within a network of care and pathways.
- Eligible women will be referred using a defined referral system that can be audited for waiting times.
- There will be an agreed planned and mapped pathway of care for women whose primary procedure for urinary incontinence or prolapse repair has failed or who has complications arising from treatment of urinary incontinence or prolapse including problems arising from mesh implantation.
- The Service will be part of a multidisciplinary team working together, networking and linking with other healthcare services across both community and hospital settings.
- A discharge plan will be prepared offering support and facilities required providing care at home
- Outcome measures including relief of symptoms and satisfaction with care will be measured and audited.
- The Provider will be expected to use evidence based approaches and to demonstrate efficiencies whenever possible.
- Appropriate referrals to specialist colleagues will be documented and GP informed of any transfer of care
- 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 Urogynaecology and laparoscopic surgery.
- All patient should be under the care of an experienced multidisciplinary team. This should include an Urogynaecologist, a specialist nurse, a physiotherapist and an urologist and colorectal surgeon where required.

- Providers will enter all procedures involving implants on a National Registry and organise follow up and audit of outcomes.

Interim for adoption from 01/10/13