E10/S/b

**NHS STANDARD CONTRACT
FOR COMPLEX GYNAECOLOGY : UROGENITAL AND ANORECTAL CONDITIONS**

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

Service Specification No.	E10/S/b
Service	Complex Gynaecology : Urogenital and Anorectal Conditions
Commissioner Lead	
Provider Lead	
Period	12 months
Date of Review	

1. Population Needs

1.1 National/local context and evidence base

Double incontinence (combined urinary and faecal) can be the most degrading and debilitating benign condition that any human being has to endure. The prevalence of faecal incontinence in women suffering with urinary incontinence is 9 to 26%.[1] Women with double incontinence have a significantly higher physical and psychosocial impairment compared to those with solitary urinary or faecal incontinence.[2] Each condition is normally managed by different specialities.

Double prolapse (uterine and/or vaginal prolapse combined with rectal prolapse) is also a difficult condition to treat particularly if accompanied by urinary and/or faecal incontinence. Some women develop obstructive defaecation with varying degrees of rectal intussusception associated with vaginal prolapse and/or incontinence.

Multi-professional and multi-disciplinary input is required because the functions of the lower urinary tract and the lower gastro-intestinal (GI) tract are interrelated. Therefore surgical intervention in one compartment can adversely affect function in the other compartment.

Units that provide this service 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.3 The evaluation and management of these conditions require a multidisciplinary approach to avoid

duplication of care and provide a holistic approach that focuses on quality of life. Combined evaluation and surgery has been shown to have many advantages in terms of outcome and patient satisfaction[3]

20-30% of women presenting with urinary symptoms have symptoms of anal incontinence and about 10% of women with uterine/vaginal prolapse have an anorectal problem. Most of these women will be treated conservatively and about a quarter will require surgical intervention.3 With a throughput of at least 80 to 100 patients a year, each Pelvic Floor Unit would be expected to perform at least 20 combined surgical procedures (including sacral nerve stimulation)
per year.

References

1. Kapoor D, Thakar R, Sultan AH. Combined urinary and fecal incontinence
   International Urogynaecology Journal and Pelvic Floor Dysfunction 2005;16:321-8.
2. Fialkow MF, Melville JL, Lentz GM, Miller EA, Fenner E. The functional and psychosocial impact of fecal incontinence in women with urinary incontinence. American Journal of Obstetrics & Gynecology 2003;189:127-9.
3. Kapoor D, Sultan AH, Thakar R, Abulafi MA, Swift I, Ness W. Management of complex pelvic floor disorders in a multidisciplinary pelvic floor Clinic. Colorectal Disease 2008;10:118-123

2. Scope

2.1 Aims and objectives of service

The aim of the services is to co-ordinate treatment of double incontinence (Urinary and Faecal Incontinence) and/or double prolapse (utero/vaginal and rectal prolapse) to ensure optimal outcomes.

The primary aims are:

- To provide a safe and effective care pathway for women with double incontinence and/or double prolapse.
- To provide social, economic and psychological benefits for women requiring the service
- To provide continuity of care through the whole care pathway encompassing other specialised services included within the pathway

2.2 Service description/care pathway

Management of women with combined urinary and faecal incontinence
Services will provide the defined activities outlined below as part of

a multidisciplinary team associated with interdependent services

- Women with double incontinence.
- Women with double prolapse.

When incontinence problems occur in women the co-ordinating specialist is often, but not always, a gynaecologist. The relevant anatomy, diagnoses and treatment options are markedly different in men and women, thus the organization of specialised urinary and faecal incontinence services needs to be considered separately. About 10% of women with urinary incontinence also experience anal incontinence. In addition, they may have prolapse of both the genital tract and the rectum. A multi-disciplinary approach to their management is required to prevent a sequence of duplicating investigations and procedures on adjacent parts of their pelvic anatomy

Services for the assessment and treatment of double incontinence and/or double prolapse in women

Women with anatomical derangement and dysfunction of both the genital tract and the anorectum need both the expertise of an urogynaecologist and a colorectal surgeon with a special interest in anorectal dysfunction. They also need the facilities to perform the relevant investigations of the lower urinary and lower gastrointestinal tracts.

Detailed assessment and specific characterisation of the cause(s) of urinary and of faecal incontinence should be made before any surgical intervention. Once the diagnosis has been clarified, the relevant first surgical procedure is usually undertaken by the local hospital gynaecology, urology or colorectal department.

There are services for the assessment and treatment of urinary and faecal incontinence and genital prolapse which, although not considered specialised services (because they are provided in more than 50 hospitals in England) are nevertheless not provided by every local hospital gynaecology or urology or colorectal department. These services include:

- assessment and treatment of combined urinary and faecal incontinence.
- assessment and surgical treatment of combined genital and rectal prolapse.
- incontinence combined with major prolapse e.g. grade 2 or 3 uterine descent/vault prolapse with grade 2 or 3 cystocele and/or rectocele.
- incontinence associated with voiding difficulties.
- incontinence due to a combination of significant detrusor over activity, with sphincter incompetence (Note: this condition may be treated by the local hospital gynaecology or
- urology service where the relevant expertise is available, otherwise this requires referral to a specialist).
- asesssment and treatment of surgical complications of treatments for urinary and faecal incontinence and genital prolapse e.g. 1st repeat surgery.

Urologists or gynaecologists or colorectal surgeons who are specialists in the particular areas listed below may deliver these specialised services. They will often work jointly on complex cases. The following conditions and interventions

are considered specialised services:

- Assessment and surgical treatment of vesicovaginal and rectovaginal fistula.
- Incontinence associated with neurological conditions such as paraplegia or multiple sclerosis, and / or has more than one cause simultaneously
- Intractable incontinence requiring urinary or faecal diversion procedures or sacral nerve neuromodulation
- Assessment and treatment of surgical complications of treatments for urinary and faecal Incontinence and genital prolapse e.g. 2nd or more repeat surgery, significant mesh complications.

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- Incontinence associated with neurological conditions such as paraplegia or multiple sclerosis, and / or has more than one cause simultaneously
- Intractable incontinence requiring urinary or faecal diversion procedures or sacral nerve neuromodulation
- Assessment and treatment of surgical complications of treatments for urinary and faecal
- Incontinence and genital prolapse e.g. 2nd or more repeat surgery, significant mesh complications.

Repeat surgery for urinary and faecal incontinence and genital prolapse requires more expertise because the procedures are generally more complex than the initial procedure and the potential for damaging complications is considerably increased by the consequences of previous surgery.

2.3 Population covered

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 requiring assessment and treatment of combined urinary and faecal incontinence.

2.4 Any acceptance and exclusion criteria

Acceptance criteria

(See appendix)

- Eligible women will be referred using a defined referral system that can be audited for waiting times
- 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.
- Patients with co-morbidities that would deem them unsuitable for surgery.

2.5 Interdependencies with other services

The gynaecology service will be part of a multidisciplinary team working together, networking and linking with other healthcare services across both community and hospital settings. These services include, urology and colorectal services, genetics, imaging, psychology, plastics 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 (2007) 'Faecal incontinence: the management of faecal incontinence adults, NICE Clinical Guidelines CG49'
- NICE (2005) 'Transobturator foramen procedures for stress urinary incontinence, NICE Interventional Procedures Guidelines IPG107'
- 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) 'Transabdominal artificial bowel sphincter implantation for faecal incontinence, NICE Interventional Procedures Guidelines IPG276'

4. Key Service Outcomes

- Complex Gynaecology Services will provide a tertiary service to support women requiring specialist support within a network of care and pathways.
- There will be an agreed planned and mapped pathway of care for women with a complex gynaecological problem
- The Complex Gynaecology Service will be part of a multidisciplinary team working together, networking and linking with other healthcare services across both community and hospital settings.
- The Provider will be expected to use evidence based approaches and to demonstrate efficiencies whenever possible.
- Complex Gynaecology Services will work to defined pathways of care.
- Eligible women will be referred using a defined referral system that can be audited for waiting times
- 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
- It is the responsibility of the Provider to recruit/provide suitable and appropriately competent and qualified personnel in the provision of this service.
- All patients should be under the care of an experienced multidisciplinary team

Service Pathway – Complex Gynaecology Combined urinary and faecal incontinence		
Referral Pathway type/source	Service Delivery	
	Primary GP, continence services, gynaecology clinics, urology clinics, surgical and colorectal clinics	**Secondary** Similar to primary referral source. Tertiary referrals from other hospitals
Outpatient Appointment (Detail? Assessment, MDT, Single Clinician etc)	Intergrated Continence Services - Triage Clinic, Pelvic Floor Clinic (Urogynaecologist, Colorectal Surgeon, Urologist, Colorectal/Urogynaecology	
	MDT (Urogynaecologists, Urologist, Colorectal Surgeons, Colorectal/Urogynaecology Nurse Specialist, Radiologist, Neurologist, if indicated)	
Investigations/procedures needed	Urine dipstick/MSU, Urinary diary, Bladder Ultrasound, IVU and Cystoscopy if indicated Wexner/St Mark's score, Urodynamics/Videourodynamics, Anal ultrasound, Anorectal physiology tests (Anal Manometry EMG, Anorectal sensation etc), Defaecating Proctogram,	
Treatment Strategy (please provide detail)	Outpatient	Inpatient
	Physiotherapist/Continence Nurse Advisor: Pelvic floor exercises/bladder retraining Colorectal Nurse Specialist: Bowel re-education, biofeedback Pretibial transcutaeneous nerve stimulation Injectable transurethal bulking agents	Urinary continence srugery (Injectable bulking agents, TVT, TOT, Colposuspension, Slings, Artificial Sphincter) Intravesical Botulinum Toxin, Sacral Nerve Modulation Anal Incontinence Surgery (Sphincter repair, artificial sphincter, Graciloplasty, Colosstomy, Sacral Nerve Modulation
Follow up (detail)	Combined Pelvic Floor Clinic/Urogynaecology Clinic/Colorectal Clinic/Urology Clinic/Nurse Specialist Clinic Usually 6-8 weeks unless adverse outcomes	
Further investigations/treatments required (detail)	Only if adverse outcomes	
	Urodynamics/Videourodynamics	
	Endoanal Ultrasound/Manometry	
Second treatment episode if needed (detail)	As for primary, but deferred for >3 months	

Service Pathway – Complex Gynaecology Combined genital and anorectal prolapse

Referral Pathway type/source	Service Delivery	
	Primary GP, continence services, gynaecology clinics, urology clinics, surgical and colorectal clinics	**Secondary** Similar to primary referral source. Tertiary referrals from other hospitals
Outpatient Appointment (Detail? Assessment, MDT, Single Clinician etc)	Intergrated Continence Services - Triage Clinic, Pelvic Floor Clinic (Urogynaecologist, Colorectal Surgeon, Urologist, Colorectal/Urogynaecology MDT (Urogynaecologists, Urologist, Colorectal Surgeons, Colorectal/Urogynaecology Nurse Specialist, Radiologist, Neurologist, if indicated)	
Investigations/procedures needed	Wexner/St Mark's score. Urodynamics/Videourodynamics, Anal ultrasound, Anorectal physiology tests (Anal Manometry EMG, Anorectal sensation etc), Defaecating Proctogram,	
Treatment Strategy (please provide detail)	Outpatient Physiotherapist/Continence Nurse Advisor: Pelvic floor exercises/bladder retraining Colorectal Nurse Specialist: Bowel re-education, biofeedback Vaginal Pessaries	Inpatient Vaginal hysterectomy +/- anterior repair Abdominal approach - Anterior Rectopexy, Posterior Rectopexy (sutured, mesh +/- resection) Perineal approach - Delormes Rectopexy, Stapled transanal Resection Rectoplasty (STARR)
Follow up (detail)	Combined Pelvic Floor Clinic/Urogynaecology Clinic/Colorectal Clinic/Urology Clinic/Nurse Specialist Clinic Usually 6-8 weeks unless adverse outcomes	
Further investigations/treatments required (detail)	Only if adverse outcomes Urodynamics/Videourodynamics Endoanal Ultrasound/Manometry	
Second treatment episode if needed (detail)	As for primary, but deferred for >3 months	