SCHEDULE 2 – THE SERVICES

Service Specification No:	1649
Service	Specialised Complex Surgery for Urinary Incontinence and Vaginal and Uterine Prolapse (16 years and above).
Commissioner Lead	*For local completion*
Provider Lead	*For local completion*

1. Scope

1.1 Prescribed Specialised Service

This service specification describes specialised complex surgery services for urinary incontinence and vaginal and uterine prolapse. It covers the management of women with complex primary urinary and combined urinary and faecal incontinence and uterine and/or vaginal prolapse combined with rectal prolapse where repeat and or further surgical treatment is being considered following unsuccessful prior surgical procedures.

Repeat surgery for incontinence and prolapse requires more expertise as the procedures used are generally more complex than the initial procedures and the potential for damaging complications is increased by the consequences of previous surgery.

It also describes the role of Regional Multi-Disciplinary Teams (Regional MDTs) treating women with complex pelvic floor dysfunction and mesh related problems. The Regional MDT will work with Local Multi-Disciplinary Teams (Local MDT) and the Specialised Mesh Removal MDT (Mesh MDT) within a clinical network arrangement.

This specification incorporates the previously commissioned specifications for Complex Gynaecology: Urogenital and Anorectal Conditions (E10/S/b), and Complex Gynaecology: Recurrent Prolapse and Urinary Incontinence (E10/S/d).

Specialised services for women with complications of mesh inserted for urinary incontinence and vaginal prolapse is covered by the Specialised Services for Women with Complications of Mesh Inserted for Urinary Incontinence and Prolapse service specification.

1.2 Description

Urinary incontinence is the unintentional leakage of urine. Pelvic organ prolapse is where the apex (top) of the vagina (uterus or vault), anterior (front) vaginal wall (urethra or bladder) or posterior (back) vaginal wall (rectum) protrudes towards or through the opening of the vagina. Urinary incontinence and prolapse can be associated with faecal incontinence (unintentional leakage of bowel motion) and rectal mucosal prolapse (protrusion of the lining of the rectum towards or through the anus). Incontinence and prolapse are both very common and are treated in primary and secondary care. Where surgery is to be offered, the care should always be managed by clinicians with appropriate expertise who can offer a comprehensive range of treatments and surgical procedures within a multi-disciplinary team (MDT) structure.

A small number of women with incontinence and prolapse will require complex and/or more invasive specialised surgical treatment which the majority of urogynaecology and female urology units will

not offer. Such treatments fall under specialised commissioning and are the subject of this service specification.

This includes:

- Women with recurrent stress predominant incontinence usually following prior surgical procedures or urethral bulking and who may require more surgery
- Women with combined urinary and faecal incontinence and/or combined rectal and vaginal prolapse
- Women with recurrent same compartment prolapse following the failure of previous surgery
- Vaginal mesh insertion to treat prolapse
- Some primary surgery for stress incontinence and prolapse are also specialised with only a small number of cases performed annually for example colposuspension (see surgical procedures in section 2)
- Women with urgency urinary incontinence who fail to respond to Onabotulinum toxin 'A' injections as a second line treatment or who withdraw from therapy due to side effects and still require further intervention such as sacral nerve stimulation (covered in a separate NHS England policy) or ileocystoplasty (or other bowel cystoplasty procedures).
- Women who have developed complications, including failure of previous surgery to treat pelvic organ prolapse and where further surgical treatment is being considered.
- Women who require simultaneous combined Urogynaecology/ female urology and colorectal surgery.
- Women who require specialised single compartment prolapse surgery because of the complexity of their case or associated co-morbidities for example, neurological conditions.
- Women who require specialised primary incontinence surgery because of the complexity of the case or associated comorbidities (e.g. neurological conditions, complex urinary tract reconstruction, voiding dysfunction, ano-rectal dysfunction and dyspareunia etc.)
- Simple localised excision of minor mesh exposure into the vagina following discussion and agreement with the Mesh MDT within the Specialised Mesh Removal Service (Mesh Service)

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

Clinical Commissioning Groups commission non-specialised gynaecology and female urology services and Local MDTs to provide non-surgical and surgical options for women with primary stress urinary incontinence and primary organ prolapse. Local MDTs will refer women to their Regional Specialist MDTs who can provide more complex treatment, including repeat surgery for complex urinary incontinence and vaginal and uterine prolapse.

Local MDTs work with their Regional MDTs within an established clinical network. Specialist services providing Regional MDTs are responsible for ensuring that they deliver specialised treatment as part of an established network.

The regional specialised service must ensure that the Local MDTs within its network are working to: -

- Jointly agreed guidelines and pathways
- Referral guidelines and protocols

2. Care Pathway and Clinical Dependencies

2.1 **Care Pathway**

This service specification covers the management of women with complex primary urinary and combined urinary and faecal incontinence and uterine and/or vaginal prolapse, including where this is combined with rectal prolapse. It also covers the management of women with these conditions where repeat and/or further surgical treatment is being considered following prior surgical procedures.

The service will ensure the provision of specialist assessment, care and treatment for women and adolescent girls aged 16. Patients under the age of 16 years are unlikely to require this intervention, but if there is concern that a patient under the age of 16 requires treatment, 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.

The Regional MDT is central to providing high quality care for women requiring treatment of complex prolapse and urinary incontinence conditions.

The MDT must include:

Core Members: -
A consultant sub-specialist in urogynaecology;
A consultant urologist with expertise in female urological conditions
A specialist nurse (urogynaecology, urology or continence)

Other MDT members: -
Will be determined by the complexity of the case mix and will include: -

A colorectal surgeon with expertise in pelvic floor problems
A specialist in pain management with an expertise in pelvic pain
A pelvic floor specialist physiotherapist
A psychosexual counsellor
An occupational therapist
A radiologist with expertise in pelvic floor imaging
Other specialist imaging
A neurologist
A gastroenterologist
A neurosurgeon
A plastic surgeon
Access to a member of the care of the elderly team

Support for the MDT structure is required to co-ordinate the MDT and provide data entry and to ensure all appropriate investigations are available for the MDT meetings. The outcome of the MDT ratified interventions must be documented, and a clear pathway established to communicate this information to the patient and the Local MDT.

Referral processes and source
Referrals will be accepted from General Practitioners (GPs) and Local MDTs where complex co-morbidities are identified, and specialised referral criteria are met.

Good communication between the Regional MDT and the Local MDT is essential to enable appropriate triage of referrals and advice for Local MDTs and patients about the most appropriate treatment options. The mechanism of communication will vary but can be via teleconferencing, video conferencing and face to face MDT meetings.

All referred patients and their available investigation results will be discussed at the Regional MDT. If the Regional MDT recommends further investigations these will be arranged, the patient communicated with and then re-discussed again at the Regional MDT with the results of the additional investigations.

Outpatient Appointments
All patients accepted into the specialised service will be offered an outpatient appointment to determine the diagnosis and to recommend management following on from discussions at the Regional MDT and decisions regarding management options.

Investigations
Many of the investigations will have already been performed by the Local MDT and the results should be made available to the Regional MDT prior to the initial outpatient appointment. However, further or repeat investigations may be required and these may include*:

- Urodynamics
- Videourodynamics
- Ambulatory urodynamics

- Ultrasound – pelvic floor and endoanal
- Anorectal studies
- Magnetic resonance imaging (MRI)
- Mercapto acetyl tri-glycine' scan (MAG3 scan)
- Barium or MR defecating protogram (magnetic resonance)
- Bowel motility studies

*Please note that the above is not an exhaustive list of investigations.

The investigations will allow for an extended or advanced assessment of the anatomical and functional problems which may include an assessment of:

- Anatomical disruption
- Urinary function
- Bowel function
- Sexual function

Treatment Strategy

There is no single procedure that is appropriate for all situations and treatment options should be discussed at the Regional MDT and with the patient to determine the most appropriate option for each patient.

The Regional MDT will determine which women are suitable for complex primary surgical treatment or further surgical treatment.

The Regional MDT should review all patients who have had previous failed continence or prolapse procedures and advise the patient of treatment options prior to deciding on whether to have repeat surgery.

For women who are referred for a specialist evaluation of vaginal prolapse, centres must use the Pelvic Organ Quantification System in advance of MDT discussions/decisions.

Mesh Complications

Mid urethral tape mesh is commonly used to treat stress urinary incontinence in women whilst vaginal mesh is occasionally used to treat prolapse. Both are successful treatment options, however there are known complications in relation to the use of mesh resulting in significant morbidity in some women. These complications may include:

- Vaginal exposure
- Extrusion into the urinary tract
- Extrusion into the bowel
- Infection
- Pain
- Fistulae
- Mesh shrinkage
- Organ perforation
- Nerve or vascular injury
- Sexual difficulty

All women with mesh complications must be referred to the Mesh Service's Multi-Disciplinary Team (Mesh MDT) (see Specialised Services for Women with Complications Of Mesh Inserted For Urinary Incontinence And Vaginal Prolapse Service Specification).

Vaginal mesh extrusion into adjacent organs, will almost always require removal of the mesh and members of the Mesh MDT must carry out this surgery.

For non- complex mesh complications, (lump, sinus or discharge or exposure of a small amount of mesh <1cm in the vagina in a non-critical area) mesh removal may not always be required. However, if indicated and following discussion and agreement with the Mesh MDT, simple localised excision of minor mesh exposure into the vagina may be performed by the Regional MDT.

For mesh complications with pain but with no extrusion, infection, fistula or exposure, input from the local specialist pain management service will be necessary. If mesh removal is advised a referral will need to be made to the Mesh Service.

Surgical Procedures
The following procedures when undertaken for repeat or complex primary cases are specialist surgical procedures and can only be performed in specialised centres

- Colposuspension (open and laparoscopic)
- Rectus Fascial or Fascia Lata Slings
- Artificial Urinary Sphincter
- Ileocystoplasty (or other bowel cytoplasty procedures) which should be performed by a urological surgeon with expertise in this procedure
- Sacral nerve stimulation for overactive bladder (covered by a separate NHS Clinical Commissioning Policy. https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/10/e10pb-sacrl-nrve-stimltn-bladdr.pdf)
- Laparoscopic hysteropexy
- Laparoscopic sacrocolpopexy
- Colpocleisis
- Vaginal insertion of mesh for pelvic organ prolapse
- Re-do open sacrocolpopexy
- Anterior colporrhaphy for repeat same compartment prolapse
- Posterior colporrhaphy for repeat same compartment prolapse
- Re-do apical/vault prolapse

The following procedures will be included as part of this specification **ONLY** when performed jointly by a colorectal surgeon with a urogynaecologist or urologist specialising in female urology present: -

- Laparoscopic ventral rectopexy/ DeLormes rectopexy
- Stapled Transanal Resection of the Rectum (STARR) procedure
- Sphincter repair surgery +/- perineal reconstruction
- Dynamic graciloplasty

Procedures that involve the treatment of vesicovaginal/ urinary tract and/ or rectovaginal and anoperineal fistulae should only be undertaken in centres commissioned to provide vesicovaginal/ urinary tract fistulae and rectovaginal/ anoperineal colorectal surgery as outlined in the Complex Gynaecology/ Female Urology: Genito-Urinary Tract Fistulae (Girls and Women aged 16 and above) Service Specification.

In a small number of women simultaneous surgery with a urogynaecologist or urologist and colorectal surgeon is required, including women with complex neurological conditions such as paraplegia or multiple sclerosis.

Follow-up
All patients will have a single postoperative follow up visit within six months of surgery.

In some specific cases patients will require a series of follow-up visits with the specialist nurses but generally further follow ups can take place at the patient's local unit.

Data Management, Audit and Governance

- The management of complex and recurrent incontinence and prolapse will take place in specialist units, which provide treatment by consultants working within a MDT structure operating within a clinical network arrangement.
- The MDT must convene at least once each month. The MDT is quorate if there are at least three members in attendance. There must be at least a consultant sub specialist in urogynaecology, a consultant urologist with expertise in female urological conditions, the specialist nurse or the physiotherapist from the non-core MDT.

- All procedures must be recorded on either the British Association of Urological Surgeons (BAUS) or British Society of Urogynaecology (BSUG) databases and the subsequent national database that will form part of the development of a national registry.
- Specialist units will provide complex incontinence and prolapse treatments in compliance with current NICE guidelines.
- Most specialised and non-specialised units will have BSUG accreditation. NHS England does not recognise the achievement of BSUG accreditation as an endorsement to deliver this service specification. It acknowledges that it is an indication of good working practices.
- All specialist surgeons providing treatment to patients under this service specification must be members of the appropriate sub-speciality society. All urogynaecologists must have BSUG membership. All urologists forming part of the Regional MDT must have membership of the Female, Neuro-urological and Urodynamic Urologists (FNNU) section of BAUS.
- Advanced laparoscopic surgery and advanced open surgery is not within the repertoire of most gynaecologists/ urologists specialising in female urology who perform primary surgery. These techniques should only be performed by appropriately trained surgeons with expertise in these techniques (specialist gynaecologist / specialist urologist). NHS England requires evidence from units delivering this service specification of their competency to perform these procedures.
- Repeat laparoscopic surgical procedures to treat prolapse, including primary procedures such as hysteropexy, sacrocolpopexy and paravaginal repairs should only be performed in units which have the appropriate expertise in laparoscopic urogynecologist/ female urology conditions to ensure that all the functional and anatomical issues are addressed. The recommended case load per individual surgeon is 10 cases of advanced laparoscopic prolapse or incontinence operations per year (as an individual or as part of a two-person surgery team).
- Specialised services providing advanced surgery techniques as listed above and mesh insertion services must use Trust appraisal systems to ensure that surgeons are appropriately trained and current in their practice; adhere to clinical and NICE guidance, comply with national data requirements and report complications. The use of mesh should be in line with the latest NICE guidance and professional standards
- All adverse incidents linked to mesh must be reported to the Medicines and Healthcare Products regulatory Agency (MHRA) yellow card scheme
- All additional reporting requirements for individual patients also apply (e.g. reporting to local incident systems, the National Reporting and Learning System and serious incidents to the Strategic Executive Information System (StEIS)
- Regional MDTs performing simple localised excision of minor mesh erosion, must present data and discuss outcomes at an annual clinical summit

Regional MDTs must provide patients with information on all mesh and non-mesh treatments, treatment options and risks.

The Regional MDT must always legally obtain patient consent in order to record the discussion between the clinician and patient about the treatment procedure, the alternatives, recommendations and questions/understanding.

2.2 Interdependence with other Services

It is expected that trusts delivering specialised complex surgery for prolapse and urinary incontinence conditions will be able to demonstrate competence in advanced open and advanced laparoscopic techniques and have access to the specialised equipment and theatres to support this.

Co-located services

Specialist urogynaecology and specialist urology must be co-located within the same Trust.

The following services must also be co-located or be available to the Regional MDT. -
Colorectal surgery
Pelvic floor Specialist pain management
Physiotherapy

Psychosexual counselling
Occupational therapy
Radiology and other specialist imaging
Gastroenterology
Neurosurgery
Plastic surgery
Elderly care team

3. Population Covered and Population Needs

3.1 Population Covered By This Specification

This service specification covers the management of women with complex primary urinary and combined urinary and faecal incontinence and uterine and/or vaginal prolapse combined with rectal prolapse where repeat and or further surgical treatment is being considered following unsuccessful prior surgical procedures. Repeat surgery for incontinence and prolapse requires more expertise as the procedures used are generally more complex than the initial procedures and the potential for damaging complications is increased by the consequences of previous surgery.

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

Stress urinary incontinence affects approximately 1 in 3 women older than 18 years at some point in their lives. It is estimated that a woman who is currently 18 years old has a 14% chance to undergo surgery for stress urinary incontinence during her life time.

Prolapse of the vaginal wall and uterus are common conditions affecting up to 50% of women who have given birth.

11% of women undergo a surgical repair by the age of 80 years and the socio-economic and psychological and physical impacts of stress urinary incontinence and prolapse are considerable.

In England, over 22,000 procedures for urinary stress incontinence and prolapse are performed each year by urogynaecologists and urologists.

Approximately 15% of women who have had a stress incontinence operation will have a persistent/recurrent urinary incontinence and require further surgery. Approximately 10% of women who have had surgery for prolapse, will develop symptoms and signs of recurrent prolapse in the same compartment. This is defined in the International Urogynaecological Association (IUGA)/ International Continence Society (ICS) joint report, as prolapse arising from the same site that will require specialist treatment services.

Urinary and faecal incontinence and urinary and rectal prolapse are common conditions. The prevalence of faecal incontinence in women suffering with urinary incontinence is 9% to 26%. The majority of women will be treated by non-specialised services with non-surgical interventions or appropriate single compartment surgery.

Between 2008/09 to 2016/17 194,107 patients had urogynaecological procedures of which 96,286 were for urogynaecological prolapse and 101,538 were for stress urinary incontinence.

Overall patients with reported urogynaecological procedures to treat urogynaecological prolapse or stress urinary incontinence has reduced year on year from 25,416 patients in 2008/09 to 17,349 patients in 2016/17 a reduction of 32 percent.

Tape insertion procedures for stress urinary incontinence

- Between 2008/09 to 2016/17, 100,516 patients had a reported tape insertion procedure for stress urinary incontinence.
- In 2016/17 there were 7,245 patients who had an insertion for this procedure group type, a reduction of 48% from 2008/09 when 13,990 patients were recorded.

Non-tape procedures for stress urinary incontinence

- Between 2008/09 to 2016/17, 1,195 patients had a reported non-tape procedure for stress urinary incontinence.
- In 2016/17 there were 133 patients who had this procedure group type, a reduction of 6% from 2008/09 when 141 patients were recorded.

Mesh insertion procedures for urogynaecological prolapse

- Between 2008/09 to 2016/17, 27,016 patients had a reported mesh insertion procedure for urogynaecological prolapse.
- In 2016/17 there were 2,680 patients who had an insertion for this procedure group type, a reduction of 13% from 2008/09 when 3,073 patients were recorded.

Non-mesh procedures for urogynaecological prolapse

- Between 2008/09 to 2016/17, 71,350 patients had a reported a non-mesh procedure for urogynaecological prolapse.
- In 2016/17 there were 7,334 patients who had this procedure group type, a reduction of 12% from 2008/09 when 8,338 patients were recorded.

Patients who have had removal procedures

The number of patients that have had urogynaecological procedures that relate to the removal of material associated with tape and mesh has varied. Increasing from 580 patients in 2008/09 to 679 patients in 2012/13 before decreasing to 502 patients in 2016/17 an overall reduction of 13% between 2008/09 to 2016/17.

3.3 Expected Significant Future Demographic Changes

There are no expected significant demographic changes but the use of mesh sling as a treatment for female SUI is decreasing, with a reduction by about 50% between 2008 and 2017. This highlights a change in patient choice and surgical practice, which is likely to reflect concerns about longer term complications, outcomes and risk of surgery after mesh insertion.

3.4 Evidence Base

This specification is based on the following clinical evidence:

- NICE (2019) Urinary incontinence and pelvic organ prolapse in women: management. CG123
- NICE (2015) Urinary incontinence in women: management. CG171
- NICE (2012) Urinary incontinence in neurological disease: assessment and management. CG 148
- NICE (2004) Sacral nerve stimulation for urgency incontinence and urgency frequency. IPG64.
- NICE (2017) Extra urethral (non-circumferential) retro-pubic adjustable compression devices for stress urinary incontinence in women IPG576.
- NICE (2005) Intramural urethral bulking procedures for stress urinary incontinence, NICE Interventional Procedures Guidelines IPG138.
- NICE (2016) Single-incision short sling insertion for stress urinary incontinence in women, IPG566.
- 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) Sacrocolpopexy using mesh for vaginal vault prolapse repair, NICE Interventional Procedures Guidelines IPG283.
- NICE (2017) Sacrocolpopexy with hysterectomy using mesh for uterine prolapse repair, IPG577.
- NICE (2007) Faecal incontinence: The management of faecal incontinence in adults' CG49.
- NICE (2006) Stimulated graciloplasty for faecal incontinence IPG 159.
- NICE (2004) Sacral nerve stimulation for faecal incontinence IPG 99.
- NICE (2004) Artificial anal Sphincer Implantation IPG 66.
- NICE (2010) Stapled transanal rectal resection for obstructed defaecation syndrome IPG 351.
- NICE (2003) Circular stapled haemorrhoidectomy IPG 34.
- NICE (2008) Transabdominal artificial bowel sphincter implantation for faecal incontinence IPG 276.
- NICE (2011) Endoscopic radiofrequency therapy of the anal sphincter for faecal incontinence IPG 393.
- NICE (2011) Percutaneous tibial nerve stimulation for faecal incontinence IPG 395.

4. Outcomes and Applicable Quality Standards

4.1 Quality Statement – Aim of Service

The service has the following aims:

To provide a Regional MDT service to cover the management of women with complex primary urinary and combined urinary and faecal incontinence and uterine and vaginal prolapse combined with rectal prolapse where repeat and or further surgical treatment is being considered following unsuccessful prior surgical procedures. To work with Local MDTs and the Mesh MDT within an established clinical network.

NHS Outcomes Framework Domains

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

4.2 Indicators Include:

Outcome Measures

Number	Indicator	Data Source	Outcome Framework Domain	CQC Key question
Clinical Outcomes				
101	Numbers of patients referred for complex urinary incontinence surgery	Provider	2,3,5	effective
102	Proportion of patients referred for complex urinary incontinence surgery who are accepted for treatment	Provider	2,3,5	effective
103	Proportion of complex urinary incontinence procedures being carried out laparoscopically	Provider	2,3,5	effective
104	Numbers of patients referred for complex vaginal and uterine prolapse surgery	Provider	2,3,5	effective
105	Proportion of patients referred or complex vaginal and uterine prolapse surgery who are accepted for treatment	Provider	2,3,5	effective
106	Proportion of or complex vaginal and uterine prolapse procedures being carried out laparoscopically	Provider	2,3,5	effective
107	Proportion of patients re referred into the service within 1 year for prolapse / incontinence	Provider	2,3,5	effective
108	Proportion of patients return to theatre within 30 days	Provider	2,3,5	effective
109	30-day mortality	Provider	2,3,5	effective
110	Mean length of stay in hospital for open prolapse procedure	Provider	2,3,5	effective
111	Mean length of stay in hospital for laparoscopic prolapse procedure	Provider	2,3,5	effective

112	Mean length of stay in hospital for open incontinence procedure	Provider	2,3,5	effective
113	Mean length of stay in hospital for laparoscopic incontinence procedure	Provider	2,3,5	effective
114	Number of patients treated with simple localised excision of minor mesh exposure	Provider	2,3,5	effective
Patient Experience				
201	Patients and carers are provided with information	Self-declaration	4	caring, responsive
202	Feedback from patients is reviewed and informs service development and improvements	Self-declaration	4	caring, responsive
Structure and Process				
001	There is a specialist team	Self-declaration	2,3,5	effective, safe
002	There are regional MDT treatment planning meetings	Self-declaration	2,3,5	effective, safe
003	Each surgeon undertaking laparoscopic surgery does a minimum of 10 procedures per year	Self-declaration	2,3,6	effective, safe
004	There are clinical guidelines in place	Self-declaration	2,3,5	effective, safe
005	There are patient pathways in place	Self-declaration	2,3,5	effective, safe
006	The service is submitting data to a national database	Self-declaration	2,3,5	effective, safe

Detailed definitions of indicators, setting out how they will be measured, are included in schedule 6.

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

4.4 Applicable CQUIN goals are set out in Schedule 4D

5. Applicable Service Standards

5.1 Applicable Obligatory National Standards

Providers of this service should ensure that all current NICE and professional guidance over the intervention and treatment options to treat complex urinary incontinence and/ or vaginal or uterine prolapse

5.2 Other Applicable National Standards to be met by Commissioned Providers

Not applicable

5.3 Other Applicable Local Standards

Not applicable

6. Designated Providers (if applicable)

7. Abbreviation and Acronyms Explained

MDT	Multi-disciplinary team
MRI	Magnetic resonance imaging
MAG 3	Scan Mercaptan acetyl tri-glycine scan
MR	Magnetic resonance
STARR	Stapled Transanal Resection of the Rectum
MUS	Mid uretheral sling procedures
GP	General Practitioners
BSUG	The British Society of Urogynaecology
BAUS	The British Association of Urological Surgeons
NICE	National Institute for health and care excellence
MHRA	Medicines and Healthcare Products Regulatory Agency
NRLS	The National Reporting and Learning System (NRLS)
StEIS	Serious Incidents to the Strategic Executive Information System
IUGA	International Urogynaecological Association
ICS	International Continence Society
FNNU	Female, Neuro-Urological and Urodynamic Urologists