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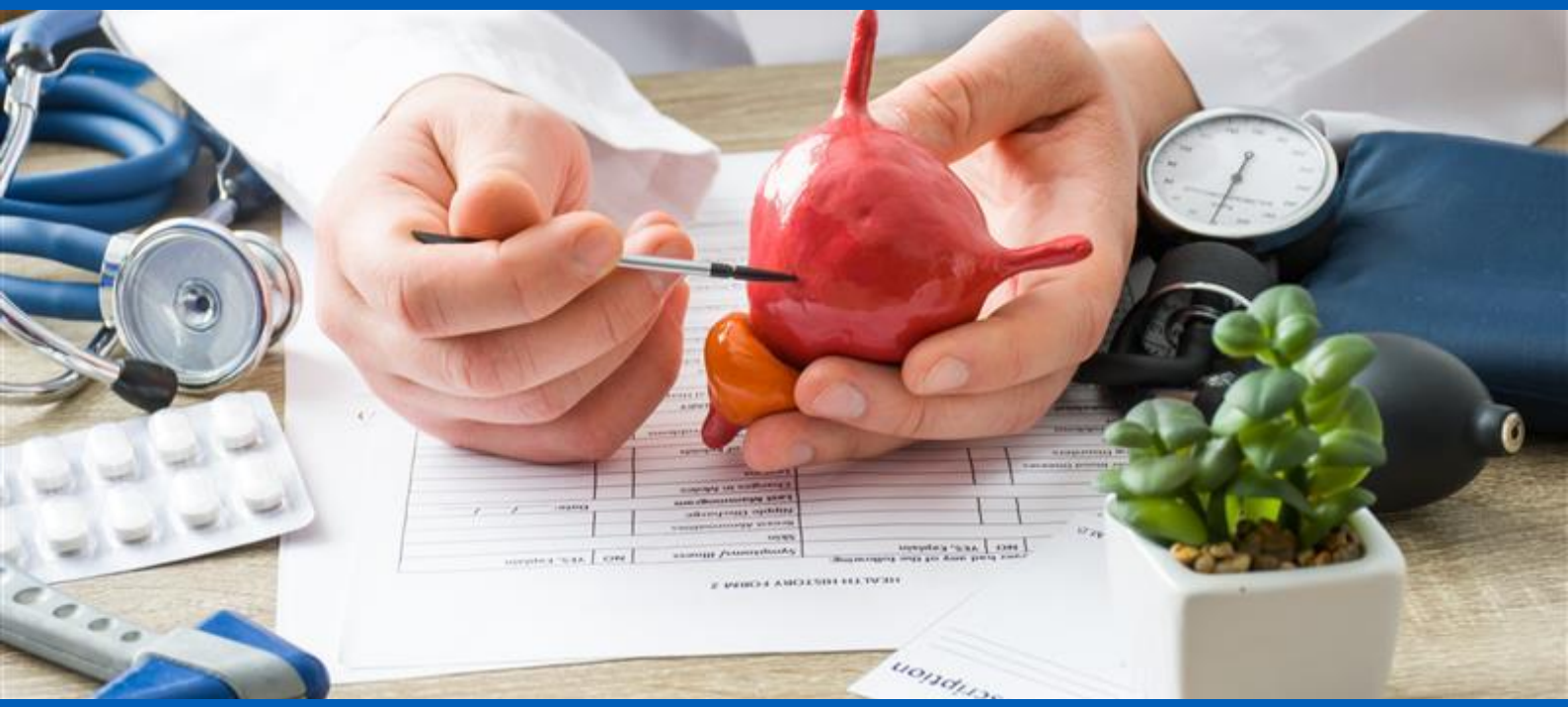
GIRFT Improving functional reconstructive urology and urogynaecology service delivery

February 2025



GIRFT is part of an aligned set of programmes within NHS England

Contents

Introduction 1

Delivery checklist 2

1. Initial referral and triage 3

2. Initial appointment 5

3. Treatment planning and delivery 6

4. Assessment and diagnostic testing 8

5. Follow up and support 10

6. Audit and continuous improvement 12

7. Education and training 13

8. Minimum service specification 15

Further information 16

Contributors 17

Introduction

The GIRFT national reports on urology and maternity and gynaecology identified variations in practice and gaps in service provision across the NHS, highlighting the need for improvement. There is a trend towards subspecialisation in both specialties, reflecting the need for expertise in functional and reconstructive urology for patients with lower urinary/genital tract disorders and neurological diseases affecting urinary function.

This GIRFT Best Practice Academy document, a collaboration between the British Association of Urological Surgeons (BAUS), the British Society of Urogynaecology (BSUG) and the British association of Urological Nursing (BAUN), aims to identify good practice on service improvement focusing on functional urological and gynaecological aspects of care. Delivering improvements in functional reconstructive urology and urogynaecology can offer significant benefits:

- Tailored, patient-centred treatments to improve patient experience and outcomes.
- More procedures delivered as outpatient or day surgery, reducing inpatient bed pressure and operation cancellations.
- Cost savings through better management of urinary symptoms and reduced medication spend.

The starting point in the quality-improvement process is the recognition that some aspects of functional urological and gynaecological care (functional bladder problems, pelvic organ prolapse and neurological conditions affecting the urinary tract) receive little attention. This can lead to long delays accessing specialist care, poor utilisation of advice and guidance, inefficient use of appointments and limited access to specialist surgical care.

Collaborative working between functional and reconstructive urology and urogynaecology has been recognised as one of the key components of multidisciplinary team working for effective management of complex pelvic floor problems.

This approach aims to support clinical staff and managers in supporting the delivery of improved and efficient care within the NHS and improve patient satisfaction.

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Delivery checklist

1. Initial referral and triage	• Ensure that each secondary care unit has clear standards for accepting and allocating appointments. • Maximise the use of advice and guidance documents for male and female Lower Urinary Tract Symptoms (LUTS), incontinence and recurrent UTI. • Advise the use of community resources and networks, e.g. pelvic health physiotherapy and continence team assessment prior to referral. • Encourage patient self-help with signposting to patient information leaflets and decision aids.
2. Initial appointment	• Offer one-stop clinics for common conditions where appropriate. • Complete and communicate a clear plan for further diagnostics and/or management. • Increase use of telephone review and PIFU and ensure appropriate rationale for follow-up appointments.
3. Treatment planning and delivery	• Ensure every centre includes a consultant with a subspecialist interest in functional and reconstructive urology and a consultant with a special interest in urogynaecology. • Provide patients access to a full range of incontinence treatment options including neuromodulation & stress incontinence surgery locally or via onward referral to centres with expertise. • Establish clear referral pathways from general to specialist units.
4. Assessment and diagnostic testing	• Implement one-stop clinics with multidisciplinary teams and point-of-care diagnostics for efficient patient assessment. • Standardise urodynamic practices with clear indications, quality control and interpretation guidelines. • Integrate patient-reported outcome measures into routine clinical practice for improved decision-making and service evaluation.
5. Follow up and support	• Establish integrated care pathways across community, secondary, and tertiary settings. • Implement patient empowerment strategies with education and self-management tools. • Develop condition-specific follow-up protocols with patient-initiated follow ups (PIFU) where possible.
6. Audit and continuous improvement	• Collaborate with clinical coding to ensure accurate data recording for both inpatient and outpatient services. • Use Model Health and National Consultant Information Programme (NCIP) dashboards for service and personal reflective practice. • Submit relevant data to national registry and specialist associations.
7. Education and training	• Offer Trainees 3 – 6 months experience working in a centre with functional and reconstructive urology and specialist urogynaecology, to provide an opportunity to develop a sub-specialty interest. • Provide training in management of pessaries for pelvic organ prolapse for primary care providers such as GP trainees and allied health professionals. • Establish cross-specialty Clinical Fellowships in NHS regions and area networks, with support from trust management, on pelvic floor conditions to develop a more joined-up approach and improve patient outcomes. • Promote innovation and research in the sub-specialty including the training of future functional and reconstructive urologists and specialist urogynaecology surgeons.
8. Minimum service specification	• Ensure minimum staffing includes 2 consultants with a specialist interest in female and functional bladder disorders, Clinical Nurse Specialists (CNS), a specialist postgraduate trained pelvic health physiotherapist and clinical scientists in specialist urodynamic centres. • Ensure MDT and collaborative work is included in clinicians' job planning. • Provide the equipment and theatre time necessary for the service.

1. Initial referral and triage

Key quality actions:

- Ensure that each secondary care unit has clear standards for accepting and allocating appointments.
- Maximise the use of advice and guidance documents for male and female Lower Urinary Tract Symptoms (LUTS), incontinence and recurrent UTI.
- Advise the use of community resources and networks, e.g. pelvic health physiotherapy and continence team assessment prior to referral.
- Encourage patient self-help with signposting to patient information leaflets and decision aids.

The NHS long term plan articulates the ambition within service reconfiguration to reduce outpatient visits by a third. The GIRFT documents 'Urology outpatient transformation' and 'Maternity and Gynaecology GIRFT Programme National Specialty Report' describe a plan to streamline care to enable earlier interventions and better-informed referrals.

Many patients who are referred for assessment of their functional bladder conditions are naïve of any management or treatment in primary care. Hence there is much to be gained by seeking specialist advice and guidance, which may if properly implemented avoid secondary referral. Provision of community continence and access to pelvic health physiotherapy is varied but should work alongside a network in primary and secondary care. This should ensure patients can receive as much care as possible in the community setting.

Specialist advice and guidance can empower GPs to provide optimal urology and urogynaecology support. Resources for clinicians and patients include:

- Advice & Guidance templates that can be individualised by secondary care clinicians. Trusts are encouraged to display these on their websites where not already available.
- Patient decision aids from BAUS, BSUG, NICE and NHS England.
- Patient information leaflets from BAUS and BSUG.

Patients then requiring a specialist opinion will be best placed to receive their clinical assessment, investigation and management as part of a one-stop clinic.

General principles

Prior to initial clinic (where applicable):

- Patients offered an initial clinic appointment will already have tried and failed on conservative +/- medical treatment (i.e. GP/referring clinician has already followed pre-set management pathways prior to referral).
- Ensure referral and supporting information (including imaging) is available and that the patient is booked into the appropriate clinic, for the initial consultation.
- Ensure pre-clinic assessment and investigations completed (arranged at triaging or primary care stage). For example:
    - Flow rate, post-void residual measurement and questionnaires (ICIQ UI/IPSS) if indicated for LUTS referral (or arrive 20 mins early to clinic to have recorded)
    - Urine dipstick and post void residual
    - Bladder diary and relevant questionnaires
    - Imaging completed, reported and available (ultrasound urinary tract and post void residual or other imaging such as CT if history of stones)
    - Renal function blood test for neuropathic patients
    - Any relevant medical history or treatment. If history of cancer, details of treatments and prognosis

Types of clinic appointments available according to triage:

- Face to face – male LUTS, clinical problems requiring examination by clinicians, e.g. pelvic organ prolapse.
- Telephone or video consultation – conditions not requiring examination by a clinician or will involve additional investigation and opportunity for assessment (i.e. Botox follow up; BPS follow up after bladder instillations).
- Patient not present (PNP) – convert to face to face as required.
- Nurse-led clinic – long-term follow-up patients, for example stable neurourology patients.

2. Initial appointment

Key quality actions:
- Offer one-stop clinics for common conditions where appropriate.
- Complete and communicate a clear plan for further diagnostics and/or management.
- Increase use of telephone review and PIFU, and ensure appropriate rationale for follow-up appointments.

Ensure that pre-clinic assessments and investigations have been completed (see page 3), and the patient is booked into the clinic with appropriate expertise.

Types of clinic:

- **General:** One-stop clinics for conditions such as assessment of LUTS, urinary incontinence and pelvic organ prolapse.
- **Subspecialist:** Multidisciplinary clinic: examples include pelvic floor clinic for complex recurrent incontinence, mesh complications in dedicated mesh centres, patient requiring urinary tract reconstruction (i.e. urology, urogynaecology and colorectal clinicians and associated nurse practitioners as appropriate).

Initial clinic visit should include:

- Full assessment of patient and initial investigations (flow rate, post void residual, urine dipstick).
- Relevant questionnaires.
- Abdominal, perineal, vaginal and neurology examination guided by patient presentation.
- Arrange imaging and diagnostic procedures if indicated.
- Referral to sub-specialist and diagnostic procedures if indicated.
- Referral to sub-specialist and/or pelvic floor MDT for relevant patients.
- Risk assessment – safe for discharge to GP versus requirement for additional follow up.
- Provide patient information leaflets and patient decision tools on condition and treatment options.
- Document, set and manage patient expectations with clear and timely communication to patient, GP and other professionals.

Ensure a clear plan is made following clinical assessment:

- Discharge – no further action needed/definitive treatment provided.
- Discharge with advice for GP/primary care management.
- Investigation and further assessment.
- Referral onto sub-specialist.
- Referral to other specialties such as pain team or psychology.
- Referral onto pelvic floor MDT.
- Book surgery/definitive management.

3. Treatment planning and delivery

Key quality actions:

- Ensure every centre includes a consultant with a subspecialist interest in functional and reconstructive urology and a consultant with a special interest in urogynaecology.
- Provide patients access to a full range of incontinence treatment options including neuromodulation & stress incontinence surgery locally or via onward referral to centres with expertise.
- Establish clear referral pathways from general to specialist units.

Patients with conditions that are covered by the subspecialty are best served in units where there is a consultant taking a lead role in functional and reconstructive urology and a consultant with a special interest in urogynaecology.

A tertiary referral practice should be available on a regional basis through area networks. This includes urologists and a subspecialist urogynaecologist with practice in a highly specialised field, for example, spinal cord injury, complex recurrent prolapse, incontinence and complex urinary tract reconstruction.

Suggested patterns of service are outlined in Figure 1 on page 7.

Example specialised tertiary centre

Cambridge University Hospital is a specialised tertiary centre and BSUG Accredited centre for complex Urogynaecology and also commissioned by NHS England as a Mesh Complications centre.

The centre has a well-established pelvic floor MDT and mesh MDT and joint pelvic floor clinic with Urogynaecology / Urology / Colorectal and Radiology with input from other specialist i.e. plastics, pain team, psychologist and specialist nurses.

The management of complex cases of recurrent incontinence or prolapse, and mesh complications, take place with joint operating sessions between Urogynaecology/Urology and Colorectal.

CUH is also a laparoscopic and robotic-assisted surgery centre and most complex surgeries are performed with minimal access.

Example of MDT development at Stockport >

Figure 1 Patterns of service

General service

Unit with consultant urologist with an interest in functional and reconstructive urology or urogynaecology, who works within a hospital pelvic floor MDT or networks with subspecialists and MDT regionally. The unit will have clear referral pathways to a specialist functional and reconstructive urology or urogynaecology service.

- Close liaison with primary care colleagues regarding the development of local functional and reconstructive urology/urogynaecology services.
- Local MDTs to ensure comprehensive patient-centred care, as suggested by the NICE guidelines on incontinence.
- Standardised protocols and pathways based on evidence-based guidelines (e.g. NICE guidelines) to ensure consistency and quality in patient care.
- Management of incontinence
  - Overactive bladder– investigation, pharmacotherapy, an intravesical botulinum toxin service, with ability to provide or refer for provision of neuromodulation or urinary tract reconstruction.
  - Female stress incontinence – investigation, pelvic floor physiotherapy and a full range of surgical options (e.g. urethral bulking, autologous fascial sling, colposuspension).
- Bladder outflow obstruction – investigation and treatment of the complex case.
- Investigation and treatment of the neuropathic lower genitourinary tract. To include patients with urinary issues related to multiple sclerosis (MS), Parkinson's disease (PD), stroke and spinal pathology.
- Management of benign bladder pain syndromes– investigation and initial management.
- Management of pelvic floor prolapse assessment and management, or assessment and referral for treatment.
- Assessment and management of recurrent complicated urinary tract infection.
- Assessment and management of benign urethral pathology.

Specialist functional and reconstructive urology / urogynaecology service

A unit with one or more consultant urologists with regional or supra-regional specialist functional and reconstructive urology/urogynaecology practice. Such a practice would include a significant volume of tertiary referral or highly specialised work. One or more such units would likely exist in each area networks and would provide services which might include one or more of the following.

- Regional MDTs to facilitate the referral of complex cases from general functional and reconstructive urology/urogynaecology services to specialist ones. These regional MDTs ensure that patients with complex needs are reviewed by a team of experts, providing a higher level of care and more accurate treatment planning.
- Management of intractable LUTS e.g. patients with ketamine bladder, persistent OAB, neurogenic bladder, refractory bladder pain syndrome.
- Complex neurourology (e.g. spinal cord injury, spina bifida) and / or complex congenital urology.
- Prosthetic implants – artificial urinary sphincter (female and male), neuromodulation.
- Benign complex reconstructive surgery e.g. ureteric reconstruction, urinary diversion and bladder replacement surgery.
- Complex recurrent prolapse.
- Vescio-vaginal fistula and other rare lower urinary tract conditions.

By implementing these structured services and ensuring robust referral pathways, the quality of care for patients with functional reconstructive urological and urogynaecological conditions can be significantly enhanced.

NHS Specialised commissioning services

- Synthetic mesh removal and post-removal reconstructive surgery.

4. Assessment and diagnostic testing

Key quality actions:

- Implement one-stop clinics with multidisciplinary teams and point-of-care diagnostics for efficient patient assessment.
- Standardise urodynamic practices with clear indications, quality control and interpretation guidelines.
- Integrate patient-reported outcome measures into routine clinical practice for improved decision-making and service evaluation.

Accurate, efficient assessment and diagnostic testing are crucial in functional reconstructive urology and urogynaecology. This section outlines key strategies and best practices for comprehensive evaluation, emphasising the importance of streamlined processes, evidence-based techniques, and patient-centred approaches. By implementing these recommendations, clinicians can enhance diagnostic accuracy, improve patient experience, and optimise treatment planning.

One-stop clinics

- Pathways suitable for one-stop clinics include:
  - Recurrent UTI;
  - LUTS including urinary incontinence;
  - Pelvic organ prolapse (POP).
- Design principles: Layout optimisation to minimise patient movement and maximise efficiency; ensure privacy and dignity.
- Staff and equipment requirements: Multidisciplinary team including urologists, urogynaecologists, radiologists, clinical scientists, clinical nurse specialists, physiotherapists, phlebotomists; essential equipment such as uroflowmeters, bladder scanners and ultrasound machines, urodynamic equipment. Provision to carry out local anaesthetic day-case procedures where appropriate (flexible cystoscopy, bladder instillations, catheter insertion, intermittent self-catheterisation training). Provision for outpatient management of pelvic organ prolapse e.g. pessaries and measuring tools for POP-Q.
- Patient flow optimisation: Implement appointment scheduling systems that account for varying case complexities; use of patient navigators to guide patients through multiple assessments. Referral screening to allow patients to complete information pre-visit, for example bladder diary, MSU, PROMs (ICIQ-UI, ICIQ-OAB, ICIQ-MLUTS, ICIQ-FLUTS, ICIQ-LUTSQoL).
- Pad testing: Standardised protocols for 1-hour and 24-hour tests to quantify urine loss severity.

Presentation	Diagnostic needed prior to consultation
Recurrent UTI	USS & PVR, urine culture results
Female LUTS & UI	Urine & PVR, urine dipstick/culture - UTI excluded
Male LUTS & UI	Urine & PVR, urine dipstick/culture - UTI excluded
CPPS/BPS	USS & PVR, urine dipstick/culture – UTI/NVH excluded

Urodynamic Studies

- To be performed by appropriately trained clinicians – nurses, clinical scientists, doctors.
- Potential for incorporation into 'one-stop' visit.
- Departments to aspire to IQIPS accreditation.

Advanced Imaging and Specialised Assessments

- Refer patients who need specialist assessment (complex bladder, bowel and vaginal symptoms) to a regional centre where specialist clinics are offered, for example: Pelvic floor and endoanal ultrasound, dynamic MRI and defecating proctography and anal physiology, joint specialty review and joint speciality treatment if required.

Diagnostic Algorithms

- EAU guidelines for non-neurogenic female LUTS.
- EAU guidelines on neuro-urology.
- NICE Urinary incontinence and pelvic organ prolapse in women [NG123].
- Evidence-based pathways: Develop clear, step-by-step algorithms for common presentations such as urinary incontinence, overactive bladder, LUTS related to BPE, and recurrent UTIs.
- Decision support tools: Available for stress urinary incontinence. Implement electronic systems that guide clinicians through diagnostic algorithms, ensuring consistency and reducing variability in care.

5. Follow up and support

Key quality actions:

- Establish integrated care pathways across community, secondary, and tertiary settings.
- Implement patient empowerment strategies with education and self-management tools.
- Develop condition-specific follow-up protocols with patient-initiated follow ups (PIFU) where possible.

Effective follow up and support are crucial for patients with functional reconstructive urological and urogynaecological conditions. This section outlines a comprehensive approach to ensure continuity of care, patient empowerment, and optimal outcomes.

Integrated Care Pathways

Community-based Support

- Primary care involvement: GPs should be equipped with clear guidelines (example guidelines from South East London) for managing common functional reconstructive urological and urogynaecological conditions and recognising when to refer to secondary care.
- Community continence services: Establish clinics in primary care to provide holistic continence assessments, education on self-management, access to support for pelvic health physiotherapy, catheter care, pad assessments, routine pessary changes with appropriate onward referral as needed.
- Telemedicine and remote monitoring: Implement secure platforms for virtual consultations and remote symptom tracking.

Secondary and tertiary care follow up

- Outpatient and nurse-led clinics: Patient-initiated follow ups (PIFU) with urologists or urogynaecologists should be encouraged.
- Pelvic health physiotherapy services: Integrate dedicated pelvic floor physiotherapists into the care pathway.
- Specialist clinics: Establish dedicated clinics staffed by subspecialist urologists and urogynaecologists with expertise in complex functional reconstructive urology and urogynaecology.

Patient Empowerment and Self-Management

- Education and resources: Develop comprehensive educational materials including leaflets, videos, and interactive online resources. Leaflets are available for urgency and frequency and prolapse management.
- Self-management tools: Provide patients with paper/digital tools such as bladder diaries, pelvic floor exercise regimens, and fluid intake trackers. Teach patients how to use these effectively for ongoing self-monitoring. This could include validated digital health applications for symptom tracking, treatment adherence, and communication with healthcare providers.
- Patient support groups and support for carers and family members: Facilitate the formation of local and online support groups. Collaborate with existing patient organisations and charities to provide peer support networks and share experiences.
- Quality of life assessments: Regularly administer validated quality of life questionnaires and Patient-Reported Outcome Measures (PROMs).

Comprehensive Support Services and Continuity of Care

- Establish clear referral pathways to psychological services.
- Establish a protocol for regular long-term monitoring and ensure entry into relevant registries where required.
- Transition of care: Develop structured handover processes for patients transitioning from paediatric to adult services. This should include joint clinics, comprehensive medical summaries, and patient education tailored to young adults.

6. Audit and continuous improvement

Key quality actions:

- Collaborate with clinical coding to ensure accurate data recording for both inpatient and outpatient services.
- Use Model Health and National Consultant Information Programme (NCIP) dashboards for service and personal reflective practice.
- Submit relevant data to national registry and specialist associations.

Benchmarking can be difficult due to the variation in ratio of conversion of clinic attendance to surgical treatments and the precise coding of surgical procedures. Correct coding and recording of procedures is vital, and good relationships with clinical coders should be encouraged to ensure accurate data collection.

It is essential for clinicians to review the surgical outcomes of these patients using PROMS, and local audit of results should be encouraged.

A key recommendation of the Cumberlege review in the response to concerns regarding use of vaginal mesh, is that data regarding stress incontinence procedures be submitted to the Pelvic Floor Registry. Trusts should support compliance with and submission of this data to the registry when it becomes available.

Clinicians and their clinical leads should be encouraged to review the practice and results of their own institutions and compare with others working within the local MDT. Routine review of Model health and NCIP dashboards should be incorporated into appraisal and reflective practice for benchmarking against national results. They can be used as a tool to help develop practice and pathway design. An example would be review of day case rates for GIRFT identified index procedures such as TURP or Anterior colporrhaphy, comparing local practice to BADS (British Association of Day Surgery) suggested rates.

Regular validation of patients on outpatient waiting lists is recommended in the GIRFT Urology outpatient guidance.

Clinicians should be encouraged to participate in national review of practice such as in BAUS snapshot audits and information from the BSUG database. They should review and act upon the information provided back to them to inform their practice and use any identified shortfall as a driver of change.

There is significant unwarranted variability regarding which treatment options are currently available to patients based on the expertise available locally. As part of continuous improvement all clinicians should be encouraged to refer to services regionally where not locally available.

7. Education and training

Key quality actions:

- Offer Trainees 3 – 6 months experience working in a centre with functional and reconstructive urology and specialist urogynaecology, to provide an opportunity to develop a sub-specialty interest.
- Provide training in management of pessaries for pelvic organ prolapse for primary care providers such as GP trainees and allied health professionals.
- Establish cross-specialty Clinical Fellowships in NHS regions and area networks, with support from trust management, on pelvic floor conditions to develop a more joined-up approach and improve patient outcomes.
- Promote innovation and research in the sub-specialty including the training of future functional and reconstructive urologists and specialist urogynaecology surgeons.

Experience at an earlier stage of training

The urology surgical curriculum requires that trainees should have rotated through and had experience in functional reconstructive urology. In practice, trainees experience of functional and reconstructive urology and urogynaecology is often limited relative to the other sub-specialties, especially in terms of practical clinical experience. Where trainees have not had experience of functional reconstructive urology and urogynaecology at an early stage, this influences their choice of areas of interest towards other sub-specialties. These interests tend to persist throughout their training, as it becomes harder to change at a later stage once they have already started down the route of another sub-specialty.

Trainees should have sufficient experience of functional reconstructive urology and urogynaecology at an early enough stage of their training to ensure an opportunity to develop a sub-specialty interest. This opportunity is best offered through a dedicated period of around 3 to 6 months of training at a tertiary centre offering functional reconstructive urology.

In the core curriculum of Obstetrics and Gynaecology training, exposure to urogynaecology is incorporated from an early stage. The Royal College of Obstetricians and Gynaecologists (RCOG) have introduced a new curriculum where ST5 trainees can undertake urogynaecology as a special interest module.

Cross-specialty pelvic floor fellowships

Pelvic floor issues are often cross-specialty, involving urology, urogynaecology and colorectal expertise. A holistic expertise in pelvic floor anatomy, rather than a specialty approach, can deliver better outcomes for patients. Such an approach is more common internationally through Clinical Fellowships in pelvic floor conditions. These fellowships should also be adopted in the NHS. Trust management should utilise the existing sub-specialty urogynaecology training

programmes. In some cases an area network approach might be taken to offering fellowships, or other less formal arrangements. Programme directors should support trainees undertaking a specialist interest module to travel between NHS regions that can facilitate their training needs.

Surgical innovation

There are significant opportunities for innovation in the field of functional reconstructive urology and urogynaecology, many of which are relatively unexplored when compared to areas that have seen greater research focus such as cancer. Examples include the adoption of robotically-assisted surgery, provision of and access to cadaver training, simulation training with virtual trainers, and machine learning. This need for innovation must be factored into the education and hands on training of future surgeons in the NHS.

8. Minimum service specification

Key quality actions:

- Ensure minimum staffing includes 2 consultants with a specialist interest in female and functional bladder disorders, Clinical Nurse Specialists (CNS), a specialist postgraduate trained pelvic health physiotherapist and clinical scientists in specialist urodynamic centres.
- Ensure MDT and collaborative work is included in clinicians' job planning.
- Provide the equipment and theatre time necessary for the service.

Staffing

The unit should comprise:

- Minimum of 2 consultants with a specialist interest in functional reconstructive urology and urogynaecology disorders, including urologists and urogynaecologists. Clinicians should be members of the functional and reconstructive urology (FRU) Section of BAUS or BSUG.
- Adequate Clinical Nurse Specialist support to work alongside the clinicians as well as being able to work independently to provide:
    - Patient Assessment/follow up
    - Tuition of ISC
    - Urodynamics
    - Procedures such as flexible cystoscopy and Botox injection
    - Pessary changes
- Specialist postgraduate trained pelvic health physiotherapists.
- In specialist centres, there should be clinical scientists in addition to the above, to support this work.
- Clinicians should work within a pelvic floor MDT as per NICE guidelines (See other sections and case studies).
- There should be adequate time in job plans to incorporate MDT work and patient validation work.

Pathways

- Optimisation of procedures to outpatient or day case activity (using right procedure, right place principles) for example, outpatient local anaesthetic flexible cystoscopy, paraurethral bulking and botox injection.
- There should be clear and agreed pathways within area networks to refer to named subspecialist clinicians for more complex conditions if not offered by local expertise, which may include discussion with specialist MDTs.

Facilities and equipment

- Appropriate facilities with maintained and updated equipment to provide quality standard urodynamics. If more advanced investigations such as video or ambulatory urodynamics

are not available locally there should be clear agreed referral pathways to units who can provide quality studies.

- Units should aspire to IQIPS, UKCS or BSUG accreditation.
- There should be equitable provision of theatre time for functional and urogynaecology patients that is not compromised by other urological or gynaecological conditions.

Further information

Recommended document	Author	Overview
GIRFT national report on urology GIRFT national report on maternity and gynaecology	GIRFT	GIRFT national specialty reports on urology and maternity and gynaecology.
Urology: Specialty 'Advice and Guidance' (A&G) toolkit	GIRFT, BAUS, BAUN	This toolkit provides tips on making optimal use of Advice and Guidance (A&G) and template responses that can be adapted for use when responding to A&G requests.
Urinary incontinence and pelvic organ prolapse in women: management [NG123]	NICE	NICE Guideline on management of pelvic organ prolapse in women.
Clinical Knowledge Summary on urinary incontinence in women	NICE	NICE Clinical Knowledge Summary covering managing stress incontinence, urgency incontinence, mixed urinary incontinence, overflow urinary incontinence and urogenital fistula.
Clinical Knowledge Summary on urinary tract infection (lower) in women	NICE	NICE Clinical Knowledge Summary covering acute and recurrent UTIs, with or without haematuria, or in pregnancy, and catheter associated UTIs.
Guidelines on non-neurogenic female LUTS Guidelines on Neuro-urology	EAU	European Association of Urology (EAU) guidelines, offering practical evidence-based guidance on the clinical problems associated with female LUTS, neuro-urology.
South East London Urology Adult Primary Care Guidelines	South East London Integrated Care System	Guide to assist primary care colleagues in decision making, produced by clinical and non-clinical staff across the South East London (SEL) Urology Network.
Patient decision aid: Surgery for stress urinary incontinence	NICE, BAUS, RCOG, BSUG	Patient decision aid outlining surgical options for stress urinary incontinence (SUI) when non-surgical treatments fail.
Patient information leaflets	BSUG	Patient information leaflets covering general pelvic floor health, prolapse, incontinence and urogynaecology recovery.
Patient information booklet on Management of Urinary Frequency, Urgency and Urge Incontinence	POGP	Patient information booklets developed by POGP.
Pelvic organ prolapse		
The pelvic floor muscles		

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