Royal College of Obstetricians & Gynaecologists

Mesh Complications Management Training Pathway

Guidance for Established Practitioners

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Contents

Introduction

This guidance is to help doctors who are applying for accreditation in Mesh Complications Management needed to manage patients presenting with a wide range of mesh implant complications originally inserted for urinary incontinence (UI), pelvic organ prolapse (POP) and rectal prolapse.

It does not include management of patients with complications of mesh inserted for other reasons including abdominal wall hernia or for complications following non-mesh surgery for UI, POP or rectal prolapse. You will also need to read the Mesh Complications Management Training Pathway .

You can contact us via training@rcog.org.uk and ask to speak to the Education team for advice before you apply.

Applicants need to demonstrate that they have achieved the learning outcomes required for the totality of the Mesh Complications Management Training Pathway.

Training Pathway framework

The Mesh Complications Management Training Pathway entails 4 high-level learning outcomes, known as Capabilities in Practice (CiP). Each CiP is supported by several key skills and subsequent descriptors, which are expected to be demonstrated by the applicant. The CiPs are outlined below and the key skills for each of these are outlined in this guide.

Further details of the descriptors can be found in the Mesh Complications Management Training Pathway.

Mesh Complications Management Training Pathway
• CiP 1 – The doctor has the knowledge, skills and attitudes required for clinical assessment of patients presenting with suspected mesh-implant complications • CiP 2 – The doctor is able to investigate mesh complications, and interpret the results of test, appropriately • CiP 3 – The doctor is competent in non-surgical management of mesh complications • CiP 4 – The doctor is competent to undertake mesh removal surgery as part of a multidisciplinary team

Submitting your evidence

Your evidence **must** be accurate and may be verified at source. All evidence submitted will be cross checked against the rest of your application and documents.

Anonymising your evidence

It is important that you anonymise your evidence before you submit it to us. You must remove:

- All patient identifying details
- Details of patients' relatives

This includes:

- Names (first and last)
- Addresses
- Contact details such as phone numbers or email addresses
- NHS numbers
- Other individual patient numbers
- GMC numbers

The following details don't need to be anonymised:

- Gender
- Date of birth

It is your responsibility to make sure that your evidence has been anonymised. Evidence which has not been anonymised will be returned to you.

How much evidence to submit and what to submit

It is up to you as the applicant to provide the assessment panel with sufficient evidence for the panel to be able to assess and confirm that you have met all curriculum requirements. This document provides guidance on what that evidence may include, but it remains the responsibility of the applicant to submit enough evidence demonstrating entrustability level 5, for all curriculum items.

The guidance provides some **indicative numbers of certain documents** that you are **strongly recommended to provide**. We have also listed other suggested evidence that you may wish to consider. This guidance on documents to supply is not exhaustive and you may also have alternative evidence. If you choose to submit alternative evidence, it must sufficiently demonstrate your development and acquisition of the relevant key skills. The emphasis should be on the quality of evidence, not quantity.

You do not necessarily have to supply every type of evidence listed, but you must submit sufficient evidence to address each of the required learning outcomes and the associated capabilities. Your evidence **must** cover the knowledge, skills and qualifications to demonstrate the required learning outcomes and capabilities in all areas of the Mesh Complications Management Training Pathway. If evidence is missing from any area of the curriculum, then the application may fail.

If you have a piece of evidence that is relevant to more than one area, do not include multiple copies in your evidence. Instead, include one copy and list it in your application under each relevant area, stating that the document is located elsewhere and you would like to cross-reference it.

It will help us to deal with your application more quickly if you make sure that you send us only evidence that is directly relevant.

Evidence of your competence should be recent. Evidence of skills or experience more than five years old should not be submitted as it will not be reviewed.

Our guidance on compiling your evidence will help you to decide what is relevant and what is not. We recommend that you read it carefully.

Organising your evidence

Your evidence must cover the knowledge, skills and qualifications required to demonstrate the high-level learning outcomes of the 4 CiPs in all areas of the Mesh Complications Management Training Pathway. We strongly recommend that you closely match your experiences against the current pathway and provide evidence of equivalence across all areas.

Missing evidence for a CiP will result in your application being unsuccessful and further evidence being requested.

The amount of evidence needed for each CiP will vary, according to the documentation required to cover each capability.

Unsuccessful applications or poor evidence

A message from the RCOG / RCS

It is our experience that applications from doctors are often submitted with inadequate or poor evidence in the following areas:

- **CiPs –** evidence of completion of the current Mesh Complications Management Training Pathway of the individual CiPs must be provided
- **Clinical evidence** – recent clinical evidence should be provided from the last five years, demonstrating ongoing, independent competence in all surgical procedures
- **Communication** – evidence of two-way communication and collaboration over the management of patients must be provided
- **Courses –** completion of all relevant courses listed must be evidenced from the last five years, or relevant practical experience will be considered, where stated

Evidence of employment in posts and duties (including training posts)

Employment letters and contracts of employment	The information in these letters and contracts **must** match your CV. They will confirm the following: • dates you were in post • post title, grade, training • type of employment: permanent, fixed term, or part time (including percentage of whole time equivalent)
Job descriptions	These **must** match the information in your CV. They will confirm the following: • your position within the structure of your department • your post title • your clinical and non-clinical commitment
Departmental annual caseload statistics	• Confirmation that you work in a specialist commissioned mesh centre

How your evidence can be used to demonstrate key skills

This evidence can be submitted to directly address the relevant key skills of your choosing.

Clinical Documentation	• Anonymised examples of operation notes, clinic letter, documentation showing practice in relevant CiP. • Anonymised operative logs / clinic logs • Anonymised Photographs / videos performing procedures
Meetings	• Attendance, or teaching at, relevant courses and international meetings

Case histories
 	
Medical reports
	• **Five** examples of case histories / medical reports covering the pathway from **the last three years**, using your own hospital template for medical reports, as if written for publication
	• Case histories / medical reports can be based on areas of clinical practice of your own choosing, and can be spread across the application to address the relevant key skills
	• This evidence should consist of a detailed description of the case including:
	  ○ Dates
	  ○ Diagnosis and patient background
	  ○ Nature of your involvement in the management of the case (including discussion on the patient management plan, the rationale for this management, the nature of your involvement and your own reflections on the case)
	• This evidence will demonstrate the types and complexity of cases you're involved in

CiP 1: The doctor has the knowledge, skills and attitudes required for clinical assessment of patients presenting with suspected mesh-implant complications

Key skills

- Takes and presents a medical history, including pelvic floor symptoms, chronic pain and impact of condition on quality of life, in patients with suspected mesh complications
- Uses standardised assessment tools when assessing patients
- Performs a general pelvic floor and/or neurological examination to clinically assess for mesh complications
- Works with specialists within the multidisciplinary team to assess and manage mesh complications

Recommended evidence

- Evidence of the following:
    - Reflective practice
    - Assessment and management of mesh patients in an out-patient setting
    - Attendance and case presentation at Mesh MDT meetings
    - Personal study
    - Tailored clinical experience
    - Sequential annual appraisal along with a personal development plan
    - Attendance at appropriate courses and meetings, as delegate or trainer

- Logs of experience in clinical assessment of patients presenting with suspected mesh-implant complications. Logbooks must include a breakdown of all related procedures and contain the following:
    - Only procedures you were involved in
    - Age (of patient)
    - Date and full name of procedure
    - Your role in the procedure
    - Critical incidents
    - Name of hospital / institution where procedure was performed
    - Audits / presentation of outcome / publication of work
    - Logbook of clinical work : MDT attendance, clinics, theatre lists

Your logbooks must demonstrate your **ongoing progression** and **maintenance of skill and competency**

- Annual caseload statistics for the total numbers of each **clinical assessment** you've performed over the **last five years**
    - Your role in the procedures must be clear – e.g. total of procedures completed independently, supervised, assisted, etc.
    - Statistics generated by hospital software/data teams are preferable

Further suggested evidence

- Medical reports and/or case histories – evidence can be spread across the application and used to directly address the relevant key skills/CiPs of your choosing

See page 8 of the guidance for further details on these

CiP 2: The doctor is able to investigate mesh complications and interpret the results of tests appropriately

Key skills

- Performs, understands and interprets appropriate investigation for assessment of suspected mesh-related complications

Recommended evidence

- Evidence of the following:
  - Reflective practice
  - Investigation, counselling and management of mesh patients in an out-patient setting
  - Attendance and case presentation at Mesh MDT meetings
  - Personal study
  - Tailored clinical experience
  - Attendance at appropriate courses and meetings, as delegate or trainer

- Logs of experience in investigating mesh complications and interpret the results of tests from the **last five years**. Logbooks must include a breakdown of all investigations and contain the following:
    - Only procedures you were involved in
    - Age (of patient)
    - Date and full name of procedure
    - Your role in the procedure
    - Critical incidents
    - Name of hospital / institution where procedure was performed
    - Audits / presentation of outcome / publication of work
    - Logbook of clinical work: MDT attendance, clinics, theatre lists

Your logbooks must demonstrate your **ongoing progression** and **maintenance of skill and competency** from the last five years of your practice

- Annual caseload statistics for the total numbers of each **investigation and interpretation** you've performed over the **last five years**
    - Your role in the procedures must be clear – e.g. total of procedures completed independently, supervised, assisted, etc.
    - Statistics generated by hospital software/data teams are preferable

Further suggested evidence

- Medical reports and/or case histories – evidence can be spread across the application and used to directly address the relevant key skills/CiPs of your choosing

See page 8 of the guidance for further details on these

CiP 3: The doctor is competent in non-surgical management of mesh complications

Key skills

- Demonstrates conservative management of mesh complications

Recommended evidence

- Evidence of the following:
  - Reflective practice
  - Referral and investigation of mesh patients in both, out-patient and in-patient (day care) setting
  - Attendance and case presentation at Mesh MDT meetings
  - Personal study
  - Tailored clinical experience
  - Attendance at appropriate courses and meetings, as delegate or trainer

Further suggested evidence

- Audits / presentation of outcome / publication of work
- Logbook of clinical work: MDT attendance, clinics, theatre lists
- Medical reports and/or case histories – evidence can be spread across the application and used to directly address the relevant key skills/CiPs of your choosing

See page 8 of the guidance for further details on these

CiP 4: The doctor is competent to undertake mesh removal surgery as part of a multidisciplinary team

Key skills

- Counsels patients wishing surgical management of mesh complications
- Performs safe surgical practice
- Diagnoses and manages intra- and post-operative complications
- Discusses and counsels patients regarding benefits and risks of partial and full mesh removal
- Actively participates in clinical audit and national registries
- Performs mesh removal surgery and manages complications
- Works with specialists within the multidisciplinary team to support patients in the pre- and post-operative period

Recommended evidence

- Evidence of the following:
- Shared decision making and patient counselling
- Reflective practice
- Surgical case load confirming practice in partial AND total mesh removal, as appropriate to their role within the multi-disciplinary surgical team, such as:
- Complete vaginal removal
- Retropubic removal (open +/or laparoscopic/robot assisted)
- Abdominal removal (open +/or laparoscopic/robot assisted)
- Groin removal
- Sacrospinous ligament (pararectal/buttock) removal)
- Performing repair of visceral injury/mesh-related fistula
- Attendance at joint operating lists with other specialties
- Case-based discussions: including reflections and cases of joint operating with other surgical disciplines
- Operative audit into practice
- Tailored clinical experience

- Explanted mesh
- Adherence to local mesh explanation protocols for specimen management
- Medico-legal aspect of mesh care

Candidates must demonstrate they have the required entrustability level for the procedures laid out for their sub-speciality (Table 1) to complete accreditation, however candidates can also choose to submit evidence for additional procedures for assessment if they wish to include these procedures in their clinical practice

- Logs of experience in mesh removal surgery from the **last five years**. Logbooks must include a breakdown of all mesh removal procedures and contain the following:
    - Only procedures you were involved in
    - Age (of patient)
    - Date and full name of procedure
    - Your role in the procedure
    - Critical incidents
    - Audits / presentation of outcome / publication of work
    - Logbook of clinical work: MDT attendance, clinics, theatre lists

Your logbooks must demonstrate your **ongoing progression** and **maintenance of skill and competency** from the last five years of your practice

- Annual caseload statistics for the total numbers of each **mesh removal surgery** you've performed over the **last five years**
    - Your role in the procedures must be clear – e.g. total of procedures completed independently, supervised, assisted, etc.
    - Statistics generated by hospital software/data teams are preferable

Further suggested evidence

- Medical reports and/or case histories – evidence can be spread across the application and used to directly address the relevant key skills/CiPs of your choosing

See page 8 of the guidance for further details on these

Table 1

Mesh Complications Management Training Pathway Procedure List

Table listing the ***mandatory*** surgical procedural requirements for each specialty.

These are the minimum procedures surgeons in that speciality must be able to perform, ***working as part of a MDT***, in a dedicated mesh Centre. Individual surgeons must submit evidence of practice in these procedures, as indicated for their specialty

Surgeons may also demonstrate additional practice in the other procedures **(*optional*).**

Continence Mesh

M – Mandatory

O - Optional

Procedure	Colorectal	Urogynaecology	Urology
Mesh revision: Either no mesh, or a small edge of mesh is removed such that the structural integrity of the implant is left intact.	O	M	M
Partial vaginal mesh excision: A segment/component of the mesh is removed or transected, such that the structural integrity of the implant is altered.	O	M	M
Complete vaginal excision: The entirety of the mesh that is in contact with the vagina is excised	O	M	M
Extra vaginal mesh excision: Retropubic removal of mesh (open or lap)	O	M	M
Extra vaginal mesh excision: Removal of mesh from groin – groin dissection and exploration	O	M	O

Extra vaginal mesh excision: Removal of mini-sling / other types of continence sling attachments +/- groin dissection	O	M	M
Cystoscopic laser therapy of mesh from Bladder or urethra	O	O	M
Removal of mesh from urinary tract vaginal, open or lap, extra peritoneal or trans peritoneal approach and subsequent reconstruction	O	O	M
Removal of mesh from bowel: transvaginal, open or lap, transanal approach and subsequent repair (including resection and loop or end stoma formation)	M	O	O
Total mesh excision: The surgical goal is the removal of 100% of the implant • Retropubic tape • Transobturator tape • Mini-slings and subsequent management of any bowel / urinary tract complication	O	M	M

Trans-Vaginal Prolapses Mesh

Procedure	Colorectal	Urogynaecology	Urology
Anterior compartment mesh revision: Either no mesh, or a small edge of mesh is removed such that the structural integrity of the implant is left intact.	O	M	O
Posterior compartment mesh revision: Either no mesh, or a small	O	M	O

edge of mesh is removed such that the structural integrity of the implant is left intact.			
Anterior compartment partial vagina mesh excision: A segment/component of the mesh is removed or transected, such that the structural integrity of the implant is altered.	O	M	O
Posterior compartment partial vagina mesh excision: A segment/component of the mesh is removed or transected, such that the structural integrity of the implant is altered.	O	M	O
Anterior compartment complete vaginal excision: The entirety of the mesh that is in contact with the vagina is excised	O	M	O
Posterior compartment complete vaginal excision: The entirety of the mesh that is in contact with the vagina is excised	O	M	O
Anterior compartment extra vaginal mesh excision: Removal of mesh from groin – groin dissection and exploration	O	O	O
Posterior compartment extra vaginal mesh excision: Removal of mesh from sacrospinous ligament and Ischiorectal fossa - sacrospinous ligament & Ischiorectal fossa dissection and exploration	O	O	O

Cystoscopic laser therapy of mesh from Bladder or urethra	O	O	M
Removal of mesh from urinary tract: vaginal, open or lap, extra peritoneal or trans peritoneal approach and subsequent repair -	O	O	M
Removal of mesh from bowel: transvaginal, open or lap, transanal approach and subsequent repair (including resection and loop or end stoma formation)	M	O	O
Total mesh excision – Anterior Compartment: The surgical goal is the removal of 100% of the implant - open or lap approach and subsequent management of any bowel / urinary tract complication	O	O	O
Total mesh excision – Posterior Compartment: The surgical goal is the removal of 100% of the implant management or any bowel / urinary tract complication	O	O	O

Abdominal Mesh

Procedure	Colorectal	Urogynaecology	Urology
Partial vaginal mesh excision: A segment/component of the mesh is removed or divided, such that the structural integrity of the implant is altered.	M	M	M
Complete vaginal mesh excision: The entirety of the mesh that is in contact	M	M	O

with the vagina is excised – vaginal, open or laparoscopic approach			
Partial removal of mesh from urinary tract: A segment/component of the mesh is removed from the urinary tract, such that the structural integrity of the implant is altered, - vaginal, open or lap, extra peritoneal or trans peritoneal approach and subsequent reconstruction	O	O	M
Complete removal of mesh from urinary tract: The entirety of the mesh that is in contact with the urinary tract is excised - vaginal, open or lap, extra peritoneal or trans peritoneal approach and subsequent reconstruction	O	O	M
Cystoscopic laser removal of mesh from Bladder or urethra	O	O	M
Partial removal of mesh from bowel: A segment/component of the mesh is removed or transected, such that the structural integrity of the implant is altered - transvaginal, open or lap, transanal approach and subsequent repair (including resection and loop or end stoma formation)	M	O	O
Complete removal of mesh from bowel: transvaginal, open or lap, transanal approach and subsequent repair (including resection and loop or end stoma formation)	M	O	O
Partial abdominal sacrocolpopexy mesh excision: a segment/component of the abdominal mesh is removed or	O	M	O

transected, such that the structural integrity of the implant is altered.			
Partial abdominal rectopexy mesh excision: a segment/component of the abdominal mesh is removed or transected, such that the structural integrity of the implant is altered.	M	O	O
Removal of sacral anchoring devices: exploration and removal of sutures/protac from sacrum	M	M	O
Complete removal of sacrocolpopexy mesh: The surgical goal is the removal of 100% of the implant - open or lap approach and subsequent management of any bowel / urinary tract complication	O	M	O
Complete removal of rectopexy mesh: The surgical goal is the removal of 100% of the implant - open or lap approach and subsequent management of any bowel / urinary tract complication (including bowel resection and loop or end stoma formation)	M	O	O