EAUN24: Comprehensive report on key sessions

Advances in prostate cancer care, sexual health, and updated EAUN Guidelines

By Mr. Phil Reynolds (GB), Ms. Jeannette Verkerk-Geelhoed (NL) and Mr. Tiago Santos (PT)

The 24th International EAUN Meeting (EAUN24) took place in Paris from 6 - 8 April and was well-attended with 327 delegates from 32 countries, including participants from Australia and New Zealand. The three-day meeting showcased important advances in urological care, and the positive impact made when nurses gather from all over the world to share their research and practical experience. The flexible cystoscopy hands-on training session was also well-received. This report summarises some highlights from sessions on prostate cancer, sexual health, and the updated guidelines for intermittent catheterisation.

Prostate Cancer SIG: Improving sexual health before and after prostate cancer treatment

The large attendance at the PCa SIG thematic session on improving sexual health before and after treatment was testament alone to the importance of the topic, and it is hoped that those that did attend found it interesting and useful and were able to take home some practice changing strategies. The session kicked off with a lecture from EAUN chair Ms. Corinne Tillier (NL), who spoke about the research from her PhD topic on non-surgical predictive factors of erectile function recovery after robotic assisted radical prostatectomy (RARP). Erectile dysfunction in the general population was found to increase with age, co-morbidity, smoking and alcohol consumption and may be the result of certain medications. Her presentation highlighted that erectile function after RARP is multi-factorial and depends on several factors such as age, function prior to the procedure and the surgical technique, for example, if nerve spare was performed. Ms. Tillier's research showed that erectile function recovery after RARP could be a lengthy process taking up to three years, and physical activity more than once a week was an independent predictor of erectile function recovery one year post RARP. Therefore, physical activity programmes can aid in the recovery of erectile function after RARP.

Following this, physiotherapist and PhD student Ms. Malene Blumenau Pedersen (DK) discussed the principles behind surgical prehabilitation for sexual health and presented her own experience of sexual health interventions for patients about to undergo a prostatectomy by trying to enhance function prior to surgery and so improve outcomes and reduce complications. Most prehabilitation studies tend to focus on single interventions whilst Ms. Blumenau Pedersen's project examined if a multi-modal four-week prehabilitation programme was feasible, consisting of five interventions: physical exercise, pelvic floor exercises, sexual health (having a video consultation with a clinic sexologist), nutritional advice, and stress management.

The preliminary results have shown that there are variations in patient experiences regarding the importance of sexual health interventions and that an individualised, patient-centred holistic approach is crucial to understanding the diverse needs and preferences of the patient. Further research is required to understand the full impact of prehabilitation for sexual health prior to prostatectomy.

The principles behind prehabilitation for sexual health presented by Ms. Blumeau Pedersen

Therapeutic radiographer Mr. Phil Reynolds (GB) presented on the topic of "loss of libido due to prostate cancer treatment and how this can be managed". His talked outlined how a cancer diagnosis can cause psychological problems such as a loss in confidence, a fear of rejection and feeling like less of a "man". He highlighted that a lot of the focus is on treating the erectile dysfunction with little done about libido itself despite patient reported outcomes defining it as a big problem. Although libido can be difficult to treat, it is important to focus on bother over function and ensure that partners are included in any discussions. It is essential to listen to their needs, but most importantly, make sure that expectations are managed and not unrealistic. The presentation also emphasised that it is important to take the focus off orgasm and to find non-sexual ways of staying close but also to try sensate focused exercises to increase the awareness of both the patient's and partner's body. The presentation included resources such as referring patients to www.lifeonADT.com, which is an educational programme for patients and partners to learn about the side effects of ADT and how best to manage them.

Lastly, urologist Dr. Findlay MacAskill (GB) spoke about supporting gay and bisexual men (GBM) with prostate cancer. The presentation highlighted that the effects of treatment of erectile tissues in heterosexuals is well documented but there is limited information for sexual minorities and that sexuality should not be a barrier to sexual support. Clinicians seem to think that there is no problem, and they treat everyone the same with open discussions, but evidence suggests that there is a mismatch in doctor/patient views with many GBM not being asked about their sexuality and that erectile function questionnaires are validated on heterosexual couples. Hopefully this is changing with the development by the University of Minnesota of a new PROM: The Sexual Minority and Prostate Cancer Scale (SMACS) created with 401 GBM, which can be used by clinicians to comprehensively measure sexual functioning in sexual minority men in conjunction with existing scales. Ultimately, the only way change is going to happen and the take home message from the presentation, is to ensure you ASK about sexuality, so the conversation is appropriate to the patient.

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The session attracted a full room of specialised nurses

Sexual Health SIG: How to break the taboo of discussing sexuality?

A lot of nurses and doctors find it difficult to start the talk on sexuality with their patients, although, this is a problem that occurs frequently in urological diseases and treatments. In this session, Assoc. Prof. Marieke Dewitte (NL) gave a very inspiring lecture on how to break the taboo of discussing sexuality. 'To have sex with your partner, communication is key' was the first subject she pointed out. It is difficult to talk about sex and what gives you pleasure when you have sex. Even with your own partner it can be difficult, due to the culture you grew up in, having the idea that sex is dangerous or prohibited.

Healthcare workers experience often a lack of knowledge, what makes it difficult to bring up the subject with their patients. Assoc. Prof. Dewitte suggested that sexual knowledge should be a mandatory aspect of the basic healthcare training. She makes clear that men and women experience sexuality in very different ways with experiencing the orgasm differently. Sex is about pleasure, so talk about pleasure! Women need stimulation of the clitoris to get arousal and reward during sexual intercourse. Men most of the time are focused on penetration to get that reward. Sex is more than penetration, fore play is the most important part of sex, penetration is the dessert. You can start the conversation by bringing up the subject, depersonalised, by telling your patient that similar patients experience sexual problems also. This will give the patient the opportunity to bring up his situation whenever he is ready. You can refer your patient to a specialist if necessary.

Ms. Helen Attard-Basson (BT) addressed the topic of erectile dysfunction (ED) in men in relation to disease or comorbidity. She gave an overview of causes of ED including vascular diseases, hypogonadism, surgeries, and drug induced/drug abuse. Risk factors like smoking, obesity, and alcohol abuse were mentioned. The management of sexual dysfunction starts with diagnostic evaluation, including medical, psychosexual history, lab control and physical examination. Management of ED includes lifestyle management, education & counselling and pharmaceutical management. The first line treatment of ED is with PDE5i like Sildenafil or Tadalafil. Failure of medication is often due to miss expectation or side effects. Second line treatment contains vacuum erection devices, intra urethral suppositories or intra cavernous self-injections with vasodilator erection stimulating medication. Side effects and contra indication were mentioned, as well as the last line of treatment, which is surgical.

Assoc. Prof. Dewitte shared practical tips and useful information on discussing sexuality

Finally, Ms. Rebecca Martin (GB) spoke about sexuality in women in relation to bladder cancer and cystectomy, which gets little attention within urology. Symptoms of sexual dysfunction in female patients presents as loss of libido, vaginal dryness, difficulty in achieving orgasm and dyspareunia. Causes of dysfunction is menopause (forced or early), medication (i.e. SSRI), blood supply, neurological diseases like MS, psychological. Research indicates that this is a multifocal problem with psychological and physical aspects like loss of desire, difficult intromission, dyspareunia, reduced clitoral sensation and orgasmic disorders. It is often seen in bladder cancer patients due to treatment in the urology practice.

Healthcare workers are not that good at talking about sexual dysfunction, especially in women. In men, treating ED has more options than treating sexual dysfunction in female patients. Especially when patients have had a cystectomy. There is only vaginal moisturising or dilators. In medical therapy topical oestrogen creams or oral mediation can be prescribed. The Plissit model was presented, where permission is the first step. The healthcare worker is the one starting the discussing on sexual dysfunction by asking the right question.
Ms. Martin's take-home message stressed the need to talk about the subject of sexuality with patients. Every healthcare professional can start the conversation on sex when a treatment leads to sexual dysfunction or whenever the healthcare worker has the feeling sexuality may be an issue to the patient. You can refer your patient to a specialised professional if you are not comfortable or able to help your patient further.

Decisional regret on prostate cancer

On day two of EAUN24 there were two presentations on the theme of "Decisional regret in prostate cancer". From the urologist perspective, Prof. Henk Van Der Poel (NL) presented about "Patient reported outcomes following treatment of localised prostate cancer and decisional regret". From the nursing perspective, there was a presentation on the "Role of RNs and NPs in the shared decision-making process" made by Ms. Corinne Tillier (NL).

Prof. Van Der Poel began by contextualising the significance of decisional regret as negative emotions and dissatisfaction experienced after a decision has been made. He emphasised the importance of not overloading patients with general information and stressed the need for individualised approaches. He shared four questions he wanted to answer about decisional regret: How to measure? Is it frequent? How does QoL affects it? How to avoid?

Prof. Van Der Poel stated that the most widely used tool to measure regret is the Decisional Regret Scale. Based on this tool, in a 2017 study published on World Journal of Surgery, it was identified that prostate cancer patients are more likely to regret their choice of treatment (24%) following by breast cancer patients (14%), sarcoma (20%), testis (10%) and non-oncology patients (6-14%).

When examining the reasons for decision regret in prostate cancer patients, Prof. Van Der Poel highlighted several factors. These patients are often asymptomatic, have numerous treatment options to choose from, may experience effects on masculinity due to treatments, have a long-life expectancy which allows more time for regret, and there is a high prevalence of prostate cancer in men.
Regarding the comparison of symptoms after prostate cancer treatments, patients tend to express more regret about sexual problems compared to urinary problems. When considering the active involvement of the patient in the choice of treatment, Prof. Van Der Poel presented findings from two studies, one conducted in Germany and the other in the UK, which reached the same conclusion: patients are less likely to regret their treatment choice if they actively participate in the decision-making process.

Furthermore, Prof. Van Der Poel highlighted that decision regret regarding prostate cancer treatment choice is not limited to the immediate post-treatment period. Several studies have shown that even 16 years after treatment, patients still experience regret, particularly those with poor quality of life and an increased fear of PSA recurrence. In his concluding remarks, Prof. Van Der Poel summarised that younger men, those who do not actively participate in treatment choice, and those lacking social support, are more likely to regret their choices.

Ms. Tillier speaking about the nursing role in preventing decisional regret

Ms. Tillier shared the nursing perspective in her presentation and noted that today, patients are increasingly seeking individualised information about potential treatment side effects, before making their choices. However, in clinical practice, it is often observed that most information about the side effects of prostate cancer treatments is delivered in a standardised manner. In such cases, patients may therefore have a misperception of the consequences of treatments which can ultimately lead to decisional regret. She also illustrated in her presentation how certain tools can aid in clinical practice, citing the existence of several individualised risk calculators for predicting urinary incontinence and ED after robot-assisted radical prostatectomy. However, despite their availability, external validation is still required.

Ms. Tillier also emphasised that to individualise the information it is imperative to consider the patient's health literacy and adapt the interventions accordingly. By taking this into account, we can ensure greater equity in nursing care and promote better patient compliance.

In her closing remarks, she stressed the importance of good communication between nurses and patients in shared decision-making. She advocated for a shift towards a clinical setting where standardised information is replaced by individualised approaches.

The meeting was great for networking and presenting your work with a poster

EAUN Guideline Intermittent Catheterisation receives new update

By Dr. Susanne Vahr Lauridsen (DK), Chair and Ms. Veronika Geng (DE), Vice Chair, EAUN Guidelines on Intermittent Catheterisation.

The revised guidelines for intermittent catheterisation including urethral dilatation were presented at EAUN24. The guideline from 2013 was revised and due to the large time span, a lot of literature had to be reviewed. Hence, those responsible have agreed to do an update in 2-3 years next time. A working group of care specialists in practice and science and a urologist spent 2,5 years working on the update. 1,433 abstracts were read, and after reviewing these, 273 studies were processed in full text, of which 49 new studies were included in the guidelines. A second literature search yielded a further 533 abstracts, of which 30 were read as full texts and 17 were added to the guidelines.

There is still little high evidence on the practical aspects of catheter placement, choice of catheter, troubleshooting and documentation. More high-quality evidence is available when it comes to preventing urinary tract infections and improving quality of life in people doing intermittent catheterisation. Many recommendations are still based on empirical knowledge - the weakest level of evidence in evidence-based guidelines, which is 4C. The working group aims to develop guidelines where we integrate the latest, highest level scientific research into the daily nursing practice, with regard to theoretical knowledge, nursing experience and the patient perspective. Fortunately, where high level literature is missing, this gap is filled with empirical evidence from experienced urology nurses, and this experience forms the basis of these 4C recommendations.

Some highlights of the revised guidelines:
In the updated guidelines, the indications, contraindications, as well as benefits and risks of the different types of catheters have been revised. The definitions for urinary tract infections have been clarified. Further definitions such as urethral stenosis or urethral meatus stenosis, as well as the terms dilatation, urinary retention or residual urine have been added.

The choice of catheter and catheter materials of the most common catheter companies have been presented and illustrated in a table making it easy to see different properties of the products. Unfortunately, some of the aids (help devices) for intermittent catheterisation had to be removed due to a lack of availability. Special attention was paid to the prevention, identification, and management of catheter-related complications. The information on training, support and empowerment of patients and caregivers was extended. New studies on quality of life in connection with intermittent catheterisation have been included in the guideline. The patient perspective has been added as a new chapter. This chapter highlights what nurses should consider regarding the patient perspective and what barriers and facilitators catheter users experience when they need to incorporate catheterisation into their daily lives and activities.

In the appendices, nurses, patients and caregivers can find support on how to perform the procedures. The micturition and drinking diary has been renewed and a new appendix deals with tools for evaluating intermittent catheterisation or self-catheterisation. These include a satisfaction questionnaire, acceptance questionnaire, quality of life, adherence scale and difficulties questionnaire.

The EAUN24 session featuring these revised guidelines began with a voting tool for feedback from participants on their own practice. They were asked if on-going support for catheterisation would be important beyond discharge. This question,

Dr. Vahr Lauridsen presenting the changes and new topics in the guidelines update

Chair and nursing members of the IC guidelines panel

which is also a recommendation in the guideline, was described as important by 100%. In response to the second question about the situation in daily practice, i.e. whether resources (time and manpower), were available, only 70% were of the opinion that this would be the case. This also showed the discrepancy between evidence-based recommendations and daily practice, to take just one example. There is still a lot to do in this respect!

The working group, under the leadership of Dr. Vahr Lauridsen with the following members: S. Chagani (PK), A. Daniels (IE), T. Kelly (IE), H. Lurvink (NL), I. Pearce (GB), M. Popiński (PL), B. Thoft Jensen (DK), G. Villa (IT), S. Wildeman (NL), V. Geng (DE), agreed on the text and recommendations in the end. We have learned a lot; by reading new studies, discussing them with each other and receiving the responses of the reviewers. We hope that this updated guideline will achieve the goal of being implemented into the clinical practice for intermittent catheterisation and urethral dilatation, considering country or region-specific regulations and the individual situation of the patients.

You can download the updated **EAUN Guideline Intermittent Catheterisation here**.

Marking a special jubilee edition, the 25th International Meeting of the European Association of Urology Nurses (EAUN25) will take place in Madrid on 22-24 March next year. We look forward to seeing you there!

EAUN24: Travel grant reports

Thought-provoking lectures and constructive discussions

Ms. Helle K. Jacobsen
Dept. of Urology
Zealand University Hospital
Roskilde (DK)

For the third time, I participated at the Annual EAUN Meeting. This experience once again lived up to my expectations of being an excellent and well-planned three-day programme. I went home feeling I had been part of a forum with many enthusiastic and skilled nursing colleagues. It has been a great educational experience to have the opportunity to listen, learn, speak and discuss all aspects of urological nursing.

This year, I think more emphasis was placed on presentations that focused on sexuality. In several of the sessions, it was emphasised from studies how important it is for patients and relatives to be well informed about surgical procedures and treatment, particularly, the implications on life afterwards, and the risk of sexual dysfunction. Talking about quality of life (QoL), several lectures reported studies of how important and crucial it is for the nurse to know what the treatment means for the individual patient and the relative(s). Concerning sexual challenges, the nurse needs to know what is essential to couples. For many nurses, it is a bit challenging to start a conversation about sexuality and perhaps to a particular extent if it concerns a homosexual man or couple. Studies show that it is necessary to talk about sexuality. Typically, anal sex requires a strong erection, which after prostate cancer surgery can be difficult to achieve. There is a need, and the recommendation is to ask the patient what is important to them and their partner. They will be very happy to answer.

The lecture by Ms. Susan Mullerworth (NL): "The impact of a cystectomy in a patient's life", made a big impression on me. She told us that she had not realised how many consequences her cancer and surgery had on her life. She recommended to inform patients about what other organs are likely to be removed and the impact this had on their body, soul, sexuality, work, relationship with spouse/cohabitant, children, sports activities, holidays, excursions, etc. She would have found it beneficial if someone had told her that she would not look and feel like she used to and what considerations arise from this, such as: "What clothes can I wear?", "How many diapers/bags should I bring?", "How should I store it"? Susan started by saying to herself: "First the cancer must be removed - then live". She told us that it is not enough to say that sex does not matter. *Because it does.*

The key message I gained from EAUN24 is that patients need much more information. We need to organise much more time for that, but we also need to discuss how we do it, when our workdays are as busy as they are.

SIG Chair Ms. Verkerk and Ms. Attard Bason in the Thematic session on Sexual health

Ms. Anna Cecilie K. Jørgensen
Dept. of Urology
Herlev and Gentofte Hospital
Herlev (DK)

As a nurse and sexologist, I was looking very much forward to the EAUN24 scientific programme full of topics regarding sexology, sexual health, and andrology. The content of this year's programme was a sign that patient sexual health is now getting more attention, and that we as nurses are aware that this issue is of big importance to the patient and their partner. This is an area where nurses have a big role to play. This is about quality of life, communication, information and pre- and rehabilitation. And we are good at that! We can be even better by research, guidelines and sharing our knowledge. That is what collaborating at the Annual EAUN Meeting is all about.

I have been attending for a few years now, and I have always done a mix between the nursing programme, and the doctors programme (EAU24). This year I found the nurses programme so interesting that I stayed in the little green EAUN-corner of the very big venue during all three days. On day one, I attended the thematic session "Improving sexual health before and after prostate cancer treatment". I learned a lot from this session. All four presenters were focused on how to best counsel and communicate with the patient, so that he ends up at the best possible place independent of treatment outcome.

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Regarding erectile recovery following radical prostatectomy, research showed us, that exercise is important. I have often been asked by men "what can I myself do to better my erection"? Now I know how to answer that question.

The speaker also said something that I strongly agree with - As I remember: "I don't care about what treatment the patient is offered and how it is done. I care about what it does to the patient, and how we can help him cope with that".

Another presentation examined if a 4-week prehabilitation programme was feasible for men who are underwent nerve-sparing prostatectomy. There is no best-practice evidence regarding prehabilitation, but it was suggested that programmes should focus on holistic person-centred care – one size doesn't fit all. Involvement of a partner can be important and sexual health should be the primary outcome.

Also featured were two subjects that I myself sometimes find difficult but important to focus on in daily practice: libido in men undergoing either localised or advanced prostate cancer treatment, and supporting gay and bisexual men with prostate cancer. I had a lot of new knowledge and in-put on how to counsel and communicate. Don't be afraid to ask about your patients sexual practices, but explain why you ask. You need the information in order to give relevant and individualised counselling.

All in all, EAUN24 was a great conference. I talked to other nurses, and I got information on who to contact regarding special topics and where to find more information. And then there was all the socialising going on outside the venue in spring-time Paris too!

Ms. Marguerite Duggan
Urology Clinical Nurse Manager/ CNS
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Galway (IE)

I was delighted to be able to attend EAUN24 with the help of travel funding provided by the EAUN. This event brought together urological nursing specialists and professionals for insightful discussions and presentations in the beautiful setting of Paris.

Prior to the meeting, the EAUN hosted a nurse's dinner, which was an excellent opportunity for colleagues from around the world to connect. EAUN24 covered a diverse range of topics, including sexual health, prostate cancer screening, gender disparities in bladder cancer, and the impact of cystectomy on quality of life (QoL).

Prostate cancer remains a significant concern and generated many topics of discussion over the weekend. I have a particular interest in this topic due to the work I have done in the past in relation to patients undergoing RARP and patients that I currently provide care for. Experts discussed the care of patients before and after prostate cancer treatment. Sexual health for these patients is paramount, emphasising early rehabilitation, patient education, and addressing sexual dysfunction. Partners' involvement in discussions was recommended and to ask the question regarding sexual preferences. Partners' involvement ensures a holistic approach, considering not only the patient's needs but also the impact on their support system. Overall, it was suggested that pre surgery interventions can improve post treatment outcomes. There were also interesting debates regarding prostate cancer screening and the need for a more formalised pathway for this screening and the importance of stopping 'opportunistic screening'.

On day two there was further discussions regarding patient reported outcomes from a patient's perspective, discussing decisional regret and unmet expectations following prostate cancer treatment. These discussions highlighted the importance of good pre treatment education and discussions with patients and partners and also the importance of providing patients with information about their condition, treatment options, and what to expect during treatment. This not only helps patients make informed decisions and actively participate in their care but also if they understand their treatment plan, they are more likely to adhere to it. Also, discussing treatment goals, potential side effects, and realistic expectations helps patients mentally prepare for the journey ahead.

During the meeting, attendees engaged in interactive panel discussions and Q&A sessions with urology and continence experts. This provided a valuable platform for urology nurses to share innovative ideas, standardise practices, and enhance the quality of urology care through collaboration and knowledge exchange. It was also a great opportunity for networking and advancing my own practice. Having this platform to engage and ask questions to experts is invaluable and one of the many reasons why I love attending these meetings.

Many thanks again to the EAUN for making it possible for me to attend EAUN24, and I look forward to hopefully being able to attend in Madrid, 2025.

Ms. Storebo presenting on the importance of pelvic floor exercises after prostatectomy

Strengthening urological nursing

Reflecting on my time as EAUN Chair

Ms. Paula Allchorne, MBA
Past Chair, EAUN
London (GB)

At the last Annual EAUN Meeting (EAUN24), I handed over the position of EAUN chair to my valued colleague Ms. Corinne Tillier (NL). After three great years as chair and over seven years on the EAUN Board as treasurer and membership secretary (when I first joined the board), I can now look back and reflect on what we have managed to achieve.

The Covid epidemic was terrible, but it showed us the advantages of sharing knowledge between like-minded countries, and it taught us to respond to challenges in healthcare by making clinical improvements quicker than ever before. But it also exposed some organisational weaknesses, and I recognised quickly the EAUN needed a more resilient and sustainable structure and strategy. The clinical landscape made us more acutely aware of the needs of our members and the board needed to look at what we were delivering to our members and how this could support urology care across Europe, and internationally.

I have said in many of my speeches, the EAUN is a platform for national societies to share, learn and support each other. It encourages and provides collaboration and is in prime position (perhaps the only organisation with 3,000 members in urology nursing) to provide a platform worldwide.

So, we canvassed our members, we listened to your comments and then reviewed the long-term strategy and completed a SWOT analysis to identify our strengths, weaknesses, opportunities and challenges. Using this information, we restructured and enhanced the overall governance for the EAUN Board to deliver your individual countries' and members' needs. We also adapted the **Board's skill mix**, with many more board members having PhDs, which has enhanced the development of the EAUN. This better supported our key focus on education and allowed us to deliver learning opportunities in a more modern and efficient way with more webinars, ESUN (European School of Urology Nursing) courses, guidelines and new initiatives - like podcasts!

Two or three members of the board now work in conjunction with **key subgroups** – for example:

Special Interest Groups
We now have five active SIGs (bladder cancer, endourology, prostate cancer, sexual health, and continence) – each SIG has a chair and a co-chair. Each chair has devised a two-year plan on what they want to do and achieve. They have all increased their group memberships substantially. For example, the bladder SIG now has >25 nurses/allied professionals.

Accreditation & endorsement
Mr. Jason Alcorn led on the accreditation and endorsement allowing us to launch our collaboration with the EU-ACME/ACNE for accreditation of the CME/CNE programme in urology nursing. With its own independent board, this ensures that there is no bias when reviewing accreditation requests, which have steadily been increasing year on year.

Guidelines
We are now working in collaboration with the EAU Guidelines Office to develop and update our guidelines with a better structure in place and support from the EAU, to ensure these are now completed within a timely timeframe. There is a plan to update the intravesical guidelines by mid-2025.

Social media
We were slow off the mark in this rapidly growing area. Taking advantage of a younger generation of board members, we now have LinkedIn, Instagram and X, as well as an increase in Facebook followers. Please join us online!

Educational Framework of Urological Nursing (EFUN)
Over the last five years, the EAUN has been collaborating with BAUN (British Association of Urological Nurses) and ANZUNS (Australian and New Zealand Urological Nurses Society) to devise an Educational Framework for urology nurses. This framework could be applicable worldwide, and I have contacted the nursing associations of 29 countries whom all want to be a part of the EFUN work. Stage two of the project will be rolled out (1st paper; Marley, Taylor, Brocksom et al, 2020) once a national agreement with the framework between the three societies/associations has been reached.

EFUN will allow the EAUN to reach (and help) countries that need this structure and support to improve urological nursing care. This demonstrates what the EAUN can offer to help standardise urological nursing care internationally.

During my time as the chair of the EAUN I have also pursued strong collaborations with BAUN and ANZUNS. A programme was recently devised between the BAUN president Ms. Sarah Hillery, the EAUN, and the President of the RSM (Royal Society of Medicine) to promote excellence in multidisciplinary working, culminating in a one-day meeting at the Royal Society of Medicine in London to showcase the work of inspirational urology nurses in the UK and how important it is to work as a multidisciplinary team.

Ms. Allchorne, Prof. James Green and Ms. Sarah Hillery (GB)

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Signing of the EAUN-BAUN-ANZUNS Memorandum of Understanding

During the same period as being the EAUN Chair, I also managed to collaborate with ANZUNS and sign a 'Memorandum of Understanding' underpinning our future collaboration with guidelines and projects. I hope that we continue with other international collaborative opportunities like this and share practice on the EAUN platform.

Before I became EAUN chair, I undertook an MBA in Health Service Management. I encourage others to do so, as it has given me the skills to advance the EAUN and critically examine what is needed to advance urological nursing care across Europe. To further this endeavour, the Board have constructed a proposal and we have had meetings with the EAU Executive Board to outline the improvements we have already made and to be clear about the further collaborative support and resources that are needed to take the EAUN and urological care forward into the next decade.

I feel the EAUN now is in a better place to take on new challenges and deliver the long-term strategy to our members. I would like to thank our members for supporting me in my role as the Chair of the EAUN and am extremely proud to hand over the reins to Ms. Corinne Tillier who will steer the EAUN to the next level. She will be a great chair and continue this valuable work to benefit staff, carers and patients.

Past EAUN Chair Ms. Paula Allchorne

New EAUN Chair Ms. Corinne Tiller