

Royal College
of OBSTETRICIANS
and GYNAECOLOGISTS



Standards for Gynaecology

Report of a Working Party

SUPER ARDUA

June 2008

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GYNAECOLOGISTS

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First published 2008

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ISBN 978-1-904752-62-2

Published by RCOG Press at the Royal College of Obstetricians and Gynaecologists
27 Sussex Place, Regent's Park
London NW1 4RG

Registered Charity No. 213280

RCOG Press Editor: Jane Moody
Design & typesetting: Karl Harrington (FiSH Books, London)
Printed in the UK by Hobbs the Printers Ltd, Brunel Road, Totton, Hampshire, SO40 3WX

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THE WORKING PARTY

Dr TA Mahmood FRCOG (Chair)

Mr JP Calvert FRCOG

Mr I Currie FRCOG

Mrs C Dhillon (Director of Standards)

Ms S Eardley (Healthcare Commission)

Ms A Marr (NHS Confederation)

Ms H Moffatt (Chief Executive)

Professor PMS O'Brien FRCOG (Immediate Past Vice President Standards)

Mrs A Spalton (Member of the Consumers' Forum)

Mr RC Warren FRCOG (Honorary Secretary)

ACKNOWLEDGEMENTS

The Working Party members are extremely grateful to the lead developers who produced the first draft standard in their particular subspecialty or special interest area and to the peer reviewers for their input. We would also like to thank everybody who contributed through the open peer review process.

Lead developers of individual standards

Dr I Banerjee MRCPI

Mr S Banerjee MRCOG

Ms T Belfield

Dr MA Bigrigg FRCOG

Dr CJM Black MRCOG

Miss ME Connor FRCOG

Miss GP Downey FRCOG

Dr LC Edozien FRCOG

Mr RG Farquharson FRCOG

Mr RM Freeman FRCOG

Dr MPR Hamilton FRCOG

Mr TC Hillard FRCOG

Miss SE Jones FRCOG

Dr AP Kasliwal MRCOG

Mr KA Louden FRCOG

Professor DM Luesley FRCOG

Dr LA Massey

Dr KF McAllister MRCOG

Mr AK Monga MRCOG

Dr N Price MRCOG

Mr CWE Redman FRCOG

Professor L Regan FRCOG

Mr MI Shafi FRCOG

Dr DR Urquhart FRCOG

Professional societies

British Association for Sexual Health and HIV

British Fertility Society

British Gynaecological Cancer Society

British Menopause Society

British Society for Colposcopy and Cervical Pathology

British Society for Gynaecological Endoscopy

British Society of Urogynaecology

Invited reviewers

Professor R Anderson MRCOG
Mrs G Bigglestone
Dr ST Cameron MRCOG
Dr L Cassidy FRCOG
Dr P Chien FRCOG
Dr M Cruickshank FRCOG
Dr LM Dolan MRCOG
Mr D Churchill FRCOG
Ms R Cocker
Dr DIM Farquharson
Dr GMM Flett FRCOG
Dr PP Fogarty FRCOG
Dr K Guthrie FRCOG
Mr HKS Hinshaw FRCOG
Miss MR Howells FRCOG
Dr V Kay FRCOG

Ms G Kumar MRCOG
Mr J Latimer FRCOG
Mr S Leeson FRCOG
Mr BH Lim FRCOG
Professor MA Lumsden FRCOG
Mr G MacNab FRCOG
Dr SC Monaghan MRCOG
Mr MS Obhrai FRCOG
Mrs C Overton FRCOG
Ms J Preston MRCOG
Mr J Price FRCOG
Mrs L Read
Dr N Siddiqui FRCOG
Ms J Townsend
Mr SK Vyas FRCOG
Professor F Wojnarowska

ABBREVIATIONS

BSCCP	British Society for Colposcopy and Cervical Pathology
DNA	did not attend
EPAU	early pregnancy assessment unit
GP	general practitioner
hCG	human chorionic gonadotrophin
HFEA	Human Fertility and Embryology Authority
HRT	hormone replacement therapy
IVF	<i>in vitro</i> fertilisation
LNG-IUS	levonorgestrel-releasing intrauterine system
NICE	National Institute for Health and Clinical Excellence
NHS	National Health Service
PID	pelvic inflammatory disease
RCOG	Royal College of Obstetricians and Gynaecologists
MUI	mixed urinary incontinence
NHSCSP	National Health Service Cervical Screening Programme
ST1	specialty training year 1
STI	sexually transmitted infection
PID	pelvic inflammatory disease
SUI	stress urinary incontinence
UAE	uterine artery embolisation
UUI	urge urinary incontinence

FOREWORD

There is a plethora of clinical and organisational recommendations from various sources, such as the Department of Health, National Service Frameworks, the National Institute for Health and Clinical Excellence, Royal Colleges and professional societies. The area of gynaecology is no different.

From the feedback on our 2002 document, *Clinical Standards: Advice on Planning the Service in Obstetrics and Gynaecology*, we are aware that providers, commissioners and, of course, women and their families, benefit from a single and comprehensive set of standards to cover all the areas of a particular service.

This working party has worked with the professional societies to agree these standards which are applicable to gynaecological services everywhere and which we believe will facilitate development of equitable, safe and high-quality services.

A handwritten signature in black ink, appearing to read 'S. Arulkumar', with a long horizontal flourish underneath.

Professor Sabaratnam Arulkumaran
President

BACKGROUND

Over the past decade in particular, there has been an unprecedented emphasis on enhancing clinical quality. In England and Wales, national agencies such as the Healthcare Commission and the National Patient Safety Agency were set up to improve standards of care and patient safety. In Scotland, such responsibilities are overseen by NHS Quality Improvement Scotland. This demonstrates commitment at the highest level to improve environments for the delivery of clinical services.

The Royal College of Obstetricians and Gynaecologists' key objective is to set standards to improve women's health. It has been producing guidelines and standards in various formats, together with other national bodies such as the National Institute for Health and Clinical Excellence (NICE) and the Scottish Intercollegiate Guidelines Network. Its current portfolio includes over 40 clinical guidelines and many working party reports, such as the *Safer Childbirth* document published in 2007.¹

The key focus of the College's past work has been on clinical standards. However, it was recognised that it was important for the College to provide guidance on the organisation of services and a document entitled *Clinical Standards: Advice on Planning the Service in Obstetrics and Gynaecology* was published in 2002.² The feedback from all the stakeholders was very positive, as it was found to be helpful in discussions between clinical teams and managers, as well as between providers and purchasers of services. In 2005, the RCOG Council established a working party to update the 2002 report. The working party membership included clinicians and representatives from the NHS Confederation, Healthcare Commission and consumers. After detailed discussions with the key stakeholders, it was agreed that two separate documents should be produced to cover gynaecology and maternity. This would enable detailed guidance to be produced in all aspects of each service.

This document covers standards in gynaecological care. The relevant professional societies have made a huge contribution to the detailed standards in 20 key areas. The document also went through an extensive peer review process.

It is expected that the standards will be used not only by healthcare professionals but also by commissioners, managers and providers. The ultimate objective is to provide an equitable and safe service with best possible outcomes for women seeking gynaecological care.

This document should be used in conjunction with other College publications, such as *Standards for Maternity Care*.³ There is some replication in this publication to achieve coverage of the entire gynaecological service.

1. Generic standards for the provision of gynaecology services

Rationale

A good doctor must fulfil his or her role in the doctor–patient partnership by being polite, considerate and honest, treating patients with dignity, treating each patient as an individual, respecting patients’ privacy and right to confidentiality, supporting patients in caring for themselves to improve and maintain their health, encouraging patients who have knowledge about their condition to use this when they are making decisions about their care.⁴

Standards

1.1 Patient focus

Communication

- 1.1.1 Appointment letters must be appropriately worded and should include the name of consultant, contact name, telephone number, clinic times and directions.
- 1.1.2 For women attending a one-stop clinic, the pre-appointment letter for clinic attendance should provide clear information regarding the procedure and investigations that might be performed.
- 1.1.3 A summary of the woman’s care should be available to her general practitioner (GP) within ten working days. This should be made the subject of a local strategy with the primary care trust/local health board.
- 1.1.4 A local mechanism should be in place to communicate urgent results to the woman and her doctor (telephone, textphone, letter, email).
- 1.1.5 Treatment and care should take into account women’s individual needs and preferences.⁴
- 1.1.6 There should be a dedicated telephone line with answerphone for specialist clinics and general queries directed to the departmental secretaries.
- 1.1.7 There should be a ‘did not attend’ (DNA) policy agreed within the operational unit.

Patient information

- 1.1.8 There should be clear verbal and written information on all aspects of treatment available.

- 1.1.9 There should be visible open access to written information leaflets.
- 1.1.10 Advocacy professionals or interpreting services should be used where required. Members of the family should not be used.
- 1.1.11 Local strategies on information sharing should be reviewed annually to reflect the needs of the local population.
- 1.1.12 There should be access to web-based information leaflets, guidelines and relevant websites, including patient support groups.

Consent and confidentiality

- 1.1.13 Valid consent should be obtained and clearly documented before any examination or treatment takes place.^{4,5}
- 1.1.14 Information should only be shared among professionals with the consent of the woman, unless there are public health issues.
- 1.1.15 Clear systems should be in place for communication between health professionals within a locally agreed information governance framework.
- 1.1.16 There should be a clear pathway for referral to local child protection teams, including the management of young people under the age of 13 years who are sexually active.^{6,7}
- 1.1.17 A policy should be in place to support and refer potential victims of domestic and sexual abuse.
- 1.1.18 Fraser competency guidelines should be in place in all clinical areas for women aged less than 16 years.⁸

1.2 Accessibility

- 1.2.1 Local arrangements should be in place for prompt access to a dietician and smoking cessation service. These pathways should be well publicised to clinicians, commissioners and patients.
- 1.2.2 Service providers should liaise with appropriate local user groups to support planning and development of information.
- 1.2.3 All units should have funding and facilities for patient-led support groups. Such funding should be independent of the unit budget.

1.3 Environment

- 1.3.1 The environment should meet all standards in relation to health and safety and a risk register should be maintained.
- 1.3.2 There must be a designated reception area, staffed with an appropriately trained receptionist.
- 1.3.3 There must be dedicated full-time clerical support.
- 1.3.4 There should be a dedicated senior staff member responsible for the clinical area.
- 1.3.5 There should be a designated examination room to provide privacy.

- 1.3.6 There should be an interview room to allow discreet communication of sensitive information.
- 1.3.7 There should be a facility for counselling and for imparting bad news.
- 1.3.8 Seats of various heights should be provided, as low chairs may be unsuitable for women with mobility problems.
- 1.3.9 Evening and weekend clinics should be provided to cater for those with difficulties in attending regular clinics and for those requiring weekend supervision.

1.4 Process

- 1.4.1 Verbal consent should be obtained before all pelvic examinations and a chaperone should be offered, irrespective of the gender of the gynaecologist.
- 1.4.2 A clearly defined pathway for relevant investigations and referral arrangements should be in place.
- 1.4.3 An in-house failsafe tracking system should be in place to ensure that none of the investigations requested is lost in the system.
- 1.4.4 Each unit should have in place systems for ensuring identification and notification of serious untoward incidents and for taking appropriate action.

1.5 Training, supervision and staffing

- 1.5.1 Each clinical service should have a designated lead.
- 1.5.2 Staff must be competent, up-to-date and able to establish and maintain good relationships with patients and colleagues.⁴
- 1.5.3 All new professional staff should have appropriate induction and should be offered a mentor. Trainee doctors should also have a named educational supervisor.⁹
- 1.5.4 To ensure competency, postgraduate trainees should be observed performing examinations and procedures as part of their formative assessment of skills.^{10,11}
- 1.5.5 All units should have written advice for training-grade doctors covering when to seek help and what procedures they may perform without direct supervision.¹²
- 1.5.6 Robust arrangements must be in place to ensure that locum, bank or agency staff receive an appropriate induction and are competent to perform their duties, and that they are provided with guidance in the form of a locum pack.
- 1.5.7 Staff should receive regular training in basic child protection awareness.
- 1.5.8 Staff should be trained to recognise potential victims of domestic abuse.

2. Early pregnancy loss

Rationale

Pregnancy loss is a very distressing event for women and their partners and women are particularly vulnerable at this time in their lives. They should have prompt access to a dedicated early pregnancy assessment unit (EPAU) that provides efficient management, patient counselling and access to appropriate information.

Standards

2.1 Patient focus

- 2.1.1 Women should be offered a range of management options with a full explanation of the processes involved.
- 2.1.2 There should be appropriately furnished room for breaking bad news.
- 2.1.3 All emotional and psychological counselling requirements should be provided within the EPAU.
- 2.1.4 There should be access to bereavement counselling.
- 2.1.5 Clear patient information should be available on pathology tests, postmortem examination and sensitive disposal options.

2.2 Accessibility

- 2.2.1 All units should offer a minimum service that includes a 5-day clinic opening during office hours with full staffing and scan support.^{13,14} Ideally, there should be a 7-day service.
- 2.2.2 There should be direct referral for women with a history of recurrent pregnancy loss or previous ectopic pregnancy.

2.3 Environment

- 2.3.1 All units should have a designated reception area constantly staffed during opening hours.
- 2.3.2 There should be direct referral access for other healthcare professionals such as accident and emergency departments, NHS Direct/NHS 24.

2.4 Process

- 2.4.1 All units should offer a full range of options for managing both miscarriage and ectopic pregnancy (conservative, medical and surgical). Care pathways should be in place for each management option.¹⁵⁻¹⁷
- 2.4.2 Guidelines and algorithms should be in place for the management of:
- pregnancy of uncertain viability
 - pregnancy of unknown location
 - suspected ectopic pregnancy.¹⁸
- 2.4.3 All units should have laboratory access to serum human chorionic gonadotrophin (hCG) measurement and blood group results available the same day. Ideally, blood group results should be available within 2 hours.
- 2.4.4 All women undergoing surgical intervention for miscarriage should be offered screening test for *Chlamydia trachomatis*.
- 2.4.5 Access to daily serum progesterone assay as part of a clinical algorithm will facilitate management of cases of pregnancy of unknown location.¹⁵

2.5 Audit

All units should have regular clinical governance meetings to review clinical protocols and critical incidents and to assess the need for continuing training.

2.6 Staffing and competence

- 2.6.1 All units should hold a register of staff competent in transabdominal and transvaginal scanning.¹⁴
- 2.6.2 All staff should undergo formal training for emotional and psychological support.

2.7 Auditable standards

- 2.7.1 All units should audit patient choice and uptake rates for medical/surgical/conservative management of miscarriage, together with complications and failure rates.
- 2.7.2 All units should audit on an annual basis adherence to the RCOG Green-top Guideline No. 25: *The Management of Early Pregnancy Loss*.¹⁵

3. Ectopic pregnancy

Rationale

Ectopic pregnancy is a life-threatening condition. Women need prompt access to a dedicated EPAU that provides efficient management, patient counselling and access to appropriate information.

Standards

3.1 Patient focus

- 3.1.1 All units should provide patient information on all aspects of ectopic pregnancy diagnosis, management and future care, together with information on future fertility.¹⁹
- 3.1.2 All staff should be trained to provide emotional support to women who experience an ectopic pregnancy.

3.2 Accessibility

- 3.2.1 All EPAUs should have a policy in place for referring women from primary care or accident and emergency setting with suspected ectopic pregnancy directly to an EPAU for immediate assessment or to the nearest gynaecology emergency ward.²⁰
- 3.2.2 All EPAUs should have a protocol in place for carrying out a pregnancy test and transvaginal ultrasound in women of reproductive age presenting with any type of abdominal pain, irregular vaginal bleeding or amenorrhoea.²¹

3.3 Process

- 3.3.1 All EPAUs should accept self-referral from women with pain or bleeding in early pregnancy, especially those with a previous history of ectopic pregnancy.¹⁹
- 3.3.2 All primary care organisations should use one type of urinary pregnancy test to confirm or exclude pregnancy to reduce the risk of error.
- 3.3.3 All EPAUs should have laboratory access to serum human chorionic gonadotrophin (hCG) measurement and blood group results available the same day. Ideally, blood group results should be available within 2 hours.
- 3.3.4 All EPAUs should have in place clear guidelines for the management of pregnancies of unknown location, based on the RCOG Green-top guideline No. 21: *The Management of Tubal Pregnancy*.¹⁹ A clear explanation of surgical, medical and expectant management options should be given, depending on the clinical scenario and local availability.^{19,22}
- 3.3.5 All EPAUs should offer laparoscopic management of ectopic pregnancy in women who are haemodynamically stable, at least during normal working hours.¹⁹

- 3.3.6 All EPAUs should offer medical treatment to suitable women, following a local protocol with methotrexate, but only in units where women can access 24-hour telephone advice and emergency admission if required.¹⁹
- 3.3.7 Women undergoing medical or expectant management for an ectopic pregnancy should have handheld notes documenting ultrasound findings, serum hCG levels, treatment given and follow-up serum hCG levels, in case of need for emergency attendance out-of-hours or at another unit.^{22,23}

3.4 Audit and outcome

- 3.4.1 All units should audit patient choice and uptake rates for medical/surgical/conservative management of ectopic pregnancy, together with complications and failure rates.
- 3.4.2 All units should audit on an annual basis adherence to the RCOG Green-top Guideline No. 21: *The Management of Tubal Pregnancy*.¹⁹

3.5 Staffing and competence

All gynaecologists should be proficient in the laparoscopic management of ectopic pregnancy. In the future, they should have completed an appropriate Advanced Training Skills Module.

3.6 Auditable standards

- 3.6.1 Audit of patient choice and uptake rates of medical/surgical/conservative management of pregnancy of unknown location, combined with outcome and complication rates, including surgical intervention.
- 3.6.2 All units should audit on an annual basis adherence to the RCOG Green-top Guideline No. 21: *The Management of Tubal Pregnancy*.¹⁹
- 3.6.3 All EPAUs should record their incidence of ruptured ectopic pregnancy and of failed diagnosis of an unruptured ectopic pregnancy.

4. Recurrent miscarriage

Rationale

All pregnancy losses are distressing and women need to be supported in making informed choices about their care and management. This distress and need intensifies with recurrent miscarriage (three consecutive pregnancy losses). These women need additional and specialist care.

Standards

4.1 Patient focus

- 4.1.1 Information leaflets should be available for women and their families on local referral pathways, investigation, management and future care.^{24,25}
- 4.1.2 All women with a history of recurrent miscarriage should be offered a follow-up visit to discuss issues such as fertility and early management of subsequent pregnancies.^{26,27}

4.2 Accessibility

All women who present with known criteria for recurrent miscarriage should be offered advice and referred to an EPAU/specialist clinic either locally or at a tertiary unit.

4.3 Environment

- 4.3.1 All women with recurrent miscarriage should have access to an EPAU/miscarriage clinic with appropriately trained healthcare professionals.
- 4.3.2 Arrangements should be in place for women with a future confirmed pregnancy test to attend an EPAU for an ultrasound scan and to receive shared antenatal care in a high-risk obstetric clinic.²⁸

4.4 Process

- 4.4.1 There should be a clearly defined protocol for investigating couples with recurrent miscarriage as regards prenatal karyotyping, thrombophilia screening and infection screening.^{27,28}
- 4.4.2 Couples should be informed that women whose ovaries have a polycystic appearance at ultrasound scan and who ovulate are not at increased risk of recurrent miscarriage and will not require antiestrogen treatment.²⁷
- 4.4.3 Three-dimensional ultrasound should be used for assessment of uterine malformations, as it may prevent the need for diagnostic hysteroscopy and laparoscopy.²⁹

- 4.4.4 Cervical weakness should be considered only in women presenting with recurrent mid-trimester miscarriages.³⁰
- 4.4.5 Preimplantation genetic screening has no place in the management of recurrent miscarriage.
- 4.4.6 Each unit should have a care pathway in place for managing a diagnosis of recurrent mid-trimester loss as regards cervical cerclage and transvaginal assessment of cervical length.^{30,31}
- 4.4.7 Thromboprophylaxis should be commenced with aspirin, with or without heparin, for women with antiphospholipid syndrome and thrombophilia from diagnosis of intrauterine pregnancy. Heparin should be continued for 6 weeks postpartum, with bone mineral density surveillance.³²
- 4.4.8 Cytogenetic analysis of the products of conception should be considered only for women who have undergone treatment in the index pregnancy or have participated in a research trial.^{27,32–34}

4.5 Audit and outcome

All clinical staff should attend regular clinical governance meetings and a record should be maintained. Standard agenda items should include audit, adverse incidents, protocols and service development.

4.6 Staffing and competence

- 4.6.1 All recurrent miscarriage clinics should have in place a named consultant with a special interest in recurrent miscarriage.
- 4.6.2 All recurrent miscarriage clinics should have multidisciplinary support from genetics, EPAU, pathology, radiology and haematology departments.
- 4.6.3 All staff dealing with recurrent miscarriage should be trained in emotional aspects of pregnancy loss, to provide immediate support and to enable access to specialist counselling.

4.7 Auditable standards

All services should audit on an annual basis adherence to the RCOG Green-top Guideline No. 17: *The Investigation and Treatment of Couples with Recurrent Miscarriage*.²⁸

5. Infertility

Rationale

The infertile couple needs to be treated with respect and supported in making informed choices about their care and management. They should have prompt access to an integrated multidisciplinary service that provides efficient and accurate assessment of the clinical situation. This should lead to individualised management based on evidence-based practice. Care should be reinforced by access to adequate information, appropriate counselling services and ethical and cultural considerations.

Standards

5.1 Patient focus

- 5.1.1 Counselling should take account of ethical and cultural sensitivities. It should be offered by a qualified counsellor or therapist throughout all stages of infertility investigation and treatment and also after the treatment process is complete.⁴
- 5.1.2 All fertility centres should have in place counsellors who are part of the staff complement.³⁵

5.2 Accessibility

- 5.2.1 Local protocols based on national guidelines should be agreed for the management of infertility in general practice, as well as referral to secondary care.^{35,36}
- 5.2.2 Local fertility clinics should have in place dedicated liaison staff to assist with the referral process.
- 5.2.3 Assessment, investigation and treatment (including ovulation induction, fertility-enhancing surgery and assisted conception services) should only be carried out in secondary care centres where appropriate facilities and trained staff are available.³⁶⁻³⁷
- 5.2.4 Managed clinical networks should be established throughout the country to facilitate equitable access to services.
- 5.2.5 Tertiary level care, including gamete donation services and *in vitro* fertilisation (IVF), should only be provided in centres holding licences in accordance with the European Union Tissues and Cells Directive (2004).³⁸

5.3 Environment

The initial interview should be in private facilities and should allow for discussion with men and women together and separately as required.

5.4 Process

- 5.4.1 Baseline investigations should be performed in line with current guidelines before referral to a fertility clinic, preferably in a primary care setting.³⁵
- 5.4.2 All patients should receive education relevant to diagnosis and management, with open explanation of expectant and interventional options, including success rates and risks of treatment.
- 5.4.3 A designated responsible person should direct assisted reproduction technology services.
- 5.4.4 All equipment and materials should be subject to procurement, verification, validation and traceability procedures in accordance with the current HFEA regulatory standards.³⁹
- 5.4.5 Treatment guidelines for the use of ovulation induction agents should be in place to minimise the risk of multiple pregnancy and ovarian hyperstimulation.^{40,41}
- 5.4.6 All processes and procedures within the centre should be documented, based on contemporary guidance on best practice, and should meet regulatory standards.
- 5.4.7 There should be regional access for centres to obtain adequate supplies of donated semen to meet clinical needs.

5.5 Audit and outcome

- 5.5.1 The lead clinician should coordinate regular monitoring of key performance indicators, which will include assessment of user satisfaction, monitoring and resolution of complaints, internal audit of management effectiveness, inter-centre comparisons and inter-laboratory quality assurance.
- 5.5.2 Centres should have in place systems to ensure identification and notification of serious untoward incidents and to take appropriate action.

5.6 Staffing and competence

- 5.6.1 A quality manager should be employed in tertiary centres.
- 5.6.2 Clinics should be led by staff who have undergone training in the general management of the infertile and will usually be certified by the appropriate national body.

5.7 Auditable standards

All services should audit on an annual basis adherence to the National Collaborating Centre for Women's and Children's Health Clinical Guideline, *Fertility: Assessment and Treatment for People with Fertility Problems*.³⁵

6. Pelvic inflammatory disease

Rationale

All women with suspected symptoms of pelvic inflammatory disease (PID) need access to appropriate services within the NHS for prompt assessment, efficient management, counselling and written and verbal information. There should be a clearly defined managed clinical network between general practitioners (primary care), genitourinary medicine service and the gynaecology service based in secondary care. The opportunity for self-referral to secondary care should be available.

Standards

6.1 Patient focus

- 6.1.1 Clear information on the availability of walk-in and other genitourinary medicine services, their location and working hours should be available.
- 6.1.2 Clear information on choice of anonymised testing, treatment and contact tracing through genitourinary medicine should be available.^{42,43}
- 6.1.3 All units should provide information on contraceptive services with their location and working hours.
- 6.1.4 In all cases, the woman should be provided with an explanation of the diagnosis, management, expected treatment outcome, complications and outcome of repeated infections.⁴⁴

6.2 Accessibility

- 6.2.1 The service should be run by a trained team/doctor, based on national evidence-based guidelines, and be accessible within 48 hours following first contact.⁴⁵
- 6.2.2 A comprehensive, integrated, community-based reproductive and sexual health walk-in service should be situated close to areas frequented by young people.⁴⁶
- 6.2.3 All units should hold regular dialogue with their primary care trusts/purchasers/local health boards and should be in contact with their local universities to assess the provision/uptake of service and how to inform women about available services.

6.3 Environment

- 6.3.1 The sexual and contraceptive service should be available in general practice, genitourinary medicine clinics and gynaecology outpatient departments.
- 6.3.2 Clearly defined routes of liaison with family planning services, child protection services and child and adolescent mental health services should be agreed.

6.4 Process

- 6.4.1 An established managed clinical network should be organised between general practice; genitourinary medicine clinics and gynaecology departments for review/admission in gynaecological wards for women with acute PID.
- 6.4.2 Those with acute PID should be able to get advice from their GP surgery by telephone.
- 6.4.3 All services should have in place peer-reviewed guidelines for clinical management and follow-up and these should be regularly reviewed. The topics should include tests for causative pathogens such as *Chlamydia* and gonorrhoea and screening for other infections.⁴⁵
- 6.4.7 Genitourinary medicine/inflammatory disease clinicians should have agreed referral pathways to an appropriate acute service for acute and non-acute PID.
- 6.4.9 All services should hold regular multidisciplinary meetings for case discussion, guideline review, patient access and choice.

6.5 Audit and outcome

Data should be collected for Health Protection Agency/Health Protection Service to enable national trends to be established and to ensure that appropriate and targeted incentives can be implemented.

6.6 Staffing and competence

- 6.6.1 Staff should have core knowledge in sexual health and necessary certification as laid down by relevant professional bodies.
- 6.6.2 The Modernising Medical Careers run-through training programmes for GP trainees should include sessions in genitourinary medicine.

6.7 Auditable standards

All services should audit, on an annual basis, adherence to the RCOG Green-top Guideline No. 32: *Management of Acute Pelvic Inflammatory Disease*.⁴³

7. Induced abortion

Rationale

Women seeking induced abortion need support and information in a non-directive manner at this emotional and stressful time in their lives. It is essential that they have all the necessary information to enable them to make the most appropriate decision for them. This is also an appropriate opportunity to identify vulnerable women, particularly those in abusive situations or with child protections issues, and enable them to disclose and receive support from or referral to trained advocates. In addition, all women should be offered comprehensive sexual health care, including full contraceptive provision, and a sexually transmitted infection (STI) risk assessment.

Standards

7.1 Patient focus

- 7.1.1 Emotional support and information should be provided on abortion methods, access to service, what to expect, adverse effects and post-abortion complications.^{47,48}
- 7.1.2 Local arrangements should be in place for women to access nondirective counselling when they are ambivalent about their options.
- 7.1.3 The service should have clear guidance for clinical staff to identify and respond appropriately to:
 - women at high risk of a further unplanned pregnancy
 - women undergoing abortion without personal support
 - women under the age of 18 years
 - women with coexisting physical and psychiatric disorders and those from a disadvantaged background.
- 7.1.4 Arrangements should be in place for women to self-refer and this information should be widely disseminated.

7.2 Accessibility

- 7.2.1 Services should be run by teams based on national guidance that are clear about legal restrictions and should be responsive to the needs of women and offer choices and preferences for method of management of abortion.^{49–52}
- 7.2.2 Five-day access during office hours should be available in easily accessible community/hospital based locations.

7.3 Environment

Permanent walk-in clinics specifically for women's health services should be available in the community, with evening and weekend opening hours, with separate waiting area and toilet facilities.

7.4 Process

- 7.4.1 All services should have access to ultrasound facilities to ascertain gestational age.
- 7.4.2 All women should be seen within five working days of initial contact with a professional and the abortion should be available within 2 weeks of initial contact, with a maximum of 3 weeks only if clinically appropriate.
- 7.4.3 Induced abortion should be managed on a daycase basis, although inpatient beds must be available for those women who are unsuitable for daycase care.
- 7.4.4 All women should receive a sexually transmitted infection risk assessment and should specifically be offered testing for *C. trachomatis* before abortion. Women with a positive test should be treated promptly, before abortion if feasible. If the results are unavailable, women should be offered antibiotic prophylaxis.⁴⁸
- 7.4.5 All methods of appropriate contraception should be discussed with women at the assessment session, specifically the long-acting reversible methods of contraception for use immediately following abortion. If this service is not available at the time of abortion, then a 'fast track' system should be in place with a local family planning provider.^{53,54}
- 7.4.6 Intraoperative ultrasound should be available for the management of difficult cases.

7.5 Audit and outcome

All clinical staff should attend regular clinical governance meetings and a record maintained. Standard agenda items should include audit, critical incidents, complaints and service development.

7.6 Staffing and competence

In each strategic health authority/health board, there should be a designated clinical lead for abortion services – a senior consultant in community or hospital gynaecology, public health or sexual health.

7.7 Auditable standards

All services should audit on an annual basis adherence to the RCOG National Evidence-based Clinical Guideline *Care of Women Requesting Induced Abortion* and the standards set by the Faculty of Sexual and Reproductive Healthcare.⁴⁸

The above does not include standards specific to pregnancy termination due to fetal abnormalities.

8. Female and male sterilisation

Rationale

All women and men seeking a permanent method of contraception (women: sterilisation and men: vasectomy) need counselling within the context of a service providing a full range of information about and access to long-term reversible methods of contraception and male sterilisation.

Standards

8.1 Patient focus

- 8.1.1 There should be clear and easily accessible local pathways for general practitioners, NHS Direct/NHS 24, accident and emergency departments and others to access acute trusts and other providers in the event of complications.^{55,56}
- 8.1.2 Services for women and men seeking sterilisation should include advice, information and adequate clinical and counselling from trained health professionals.⁵⁶

8.2 Accessibility

- 8.2.1 Effective networking should be in place to link sexual and productive health services/primary care/hospital services.
- 8.2.2 Clear clinical and user pathways should be in place for timely referral to specialist sterilisation services. GPs and community specialist services should have a referral pathway with an appropriate checklist for direct access to a day-bed sterilisation unit.^{55,58}

8.3 Environment

Laparoscopic sterilisation should be performed as a day case where possible, in settings with facilities for immediate major abdominal procedures and resuscitation support.

8.4 Process

- 8.4.1 Counselling and advice on sterilisation procedures (both vasectomy and tubal occlusion) should be provided in the context of services providing a full range of information about and access to long-term reversible methods of contraception.⁵⁹ The service must be able to demonstrate that additional care is taken in those under the age of 30 years or those without children to reduce the risk of later regret.⁵⁷⁻⁵⁹
- 8.4.2 A mechanism should be in place for identification of other sexual health issues, for example, sexually transmitted infection or psychosexual problems.

- 8.4.3 Specialist support for women and men with medical conditions should be available.⁵⁷
- 8.4.5 A mechanism should be in place to seek a court judgement for people without the mental capacity to consent as the procedure will remove their fertility permanently.⁶⁰
- 8.4.6 Vasectomy should be provided under local anaesthesia whenever possible and in the most appropriate and accessible settings, such as in community clinics. Good communication links should exist with accredited processing laboratories for seminal analysis post-vasectomy and a system should be in place for recording all results and notifying the man.⁶⁰

8.5 Audit and outcome

All clinical staff should attend regular clinical governance meetings and a record maintained. Standard agenda items should include audit, adverse incidents, protocols and service development.

8.6 Staffing and competence

- 8.6.1 There should be a lead clinician within a defined geographical area responsible for the service, governance and policy development, ensuring that governance standards are set and reported wherever procedures are undertaken and that all professionals are effectively and appropriately trained.
- 8.6.2 Clinicians undertaking sterilisation procedures should be appropriately trained and competencies assessed.^{57,60,61}

8.7 Auditable standards

All services should audit on an annual basis adherence to the RCOG National Evidence-based Clinical Guideline *Male and Female Sterilisation*⁵⁷ and standards set by the Faculty of Sexual and Reproductive Healthcare.

9. Diagnostic and operative hysteroscopy

Rationale

All women requiring hysteroscopic assessment or treatment will need prompt access to a hysteroscopic service that provides efficient management, counselling and access to appropriate information. They need to be supported in making informed choices about their care and management.

Standards

9.1 Patient focus

Women should have access to balanced and unbiased information leaflets before attending for diagnostic or operative hysteroscopy, including information on treatment options for menstrual problems and the services available.

9.2 Accessibility

9.2.1 Outpatient-based diagnostic services should be available in the community and hospital setting, including operative procedures for carefully selected cases.

9.2.2 Clinics should have in place appropriate and up-to-date equipment in line with national standards. It should be used in accordance with the manufacturers' guidelines.

9.2.3 Inpatient-based diagnostic services with facilities for operative procedures should be available as necessary, such as polyps too large for excision or a patient unable to cope with outpatient procedure.⁶²⁻⁶⁴

9.3 Process

9.3.1 The service should be run on up-to-date local protocols, based on national guidelines.

9.3.2 There should be formally agreed referral pathways, the treatments offered and their exclusion criteria and a 24-hour, 7-day access to trained staff to discuss complications.

9.3.3 The hysteroscopic examination and treatment notes should record a minimum dataset comprising a description of findings, especially submucous myomas; type of hysteroscope used, distension medium – saline, gas or other and any complications encountered.

9.4 Audit and outcome

- 9.4.1 Tracking facilities must be in place to identify the equipment used for each patient.
- 9.4.2 Annual review should be in place to monitor the:
- activity (outpatient and inpatient), including system failures and incident reporting
 - long-term outcomes of various treatment options for the treatment of menstrual symptoms.
- 9.4.3 Regular monitoring of quality of service provided by the hysteroscopy clinic team.

9.5 Staffing and competence

- 9.5.1 All professionals should be trained to national standards set by their national body.
- 9.5.4 Hysteroscopic specialists must have adequate workload, review their outcome data yearly and should have attended at least one recognised meeting every 3 years.

9.6 Auditable standards

All services should audit patient choice and uptake rates for various operative procedures combined with outcome and complication rates.

10. Laparoscopic surgery

Rationale

The risks associated with laparoscopy have been well documented and need to be balanced against the undoubted clinical benefits in terms of reduced postoperative pain, shorter length of stay and earlier return to normal activities, when compared with laparotomy. The focus is towards safe and effective practice and women need to be supported in making informed choices.

Standards

10.1 Patient focus

Verbal and written information should be available to women to make informed choices about their care and management. This should include potential benefits and risks associated with laparoscopic surgery, as well as alternatives to laparoscopy; and complication rates.⁶⁵

10.2 Accessibility

There should be access to a suitably equipped theatre with high-quality laparoscopic video equipment for both image acquisition and recording.

10.3 Process

- 10.3.1 Laparoscopy should be performed to a recognised standard and recorded in the notes.⁶⁶
- 10.3.2 Local protocols should be in place to deal with unexpected intraoperative complications.
- 10.3.3 A see-and-treat policy should be discussed with the patient undergoing laparoscopy and preoperative consent should be obtained.^{67,68}
- 10.3.4 A multidisciplinary-agreed protocol should be in place to treat women presenting postoperatively with possible complications related to laparoscopic surgery.
- 10.3.5 All women with laparoscopic complications should be assessed and an explanation provided on the outcome.
- 10.3.6 To improve delivery of care for women with severe endometriosis, regional and national referral pathways should be developed for advanced laparoscopic procedures as the specialist centres emerge.

10.4 Audit and outcome

- 10.4.1 Outcome data should be collected by laparoscopic operator and procedure.
- 10.4.2 The entry technique employed and any resultant complications should be continually and prospectively audited.

10.5 Staffing and competence

- 10.5.1 All professionals should be trained to national standards set by their national body.
- 10.5.3 Laparoscopy specialists must have adequate workload and should maintain their skills by attending at least one recognised meeting every 3 years.
- 10.5.4 All staff, including nursing and auxiliary theatre staff, should be familiar with the equipment and should attend regular training on its use.⁶⁹

10.6 Auditable standards

- 10.6.1 Each unit should adopt all national evidence-based recommendations and should benchmark its audited activity against the national standards.
- 10.6.2 All services should audit on annual basis adherence to the RCOG Green-top Guideline *Preventing Entry-related Gynaecological Laparoscopic Injuries*⁶⁶ and audit criteria devised by the British Society for Gynaecological Endoscopy.

11. Heavy menstrual bleeding

Rationale

Every organisation should clearly set out specific requirements relating to the management of excessive menstrual blood loss which interferes with a woman's physical, social, emotional and material quality of life.

Standards

11.1 Patient focus

- 11.1.1 Women with heavy menstrual bleeding should have the opportunity to make informed decisions about their care and treatment, in partnership with their healthcare professionals. The treatment should aim to improve quality of life rather than focusing on menstrual blood loss alone.⁷⁰
- 11.1.2 An information leaflet should be available that includes each treatment option for heavy menstrual bleeding, together with outcomes and complications.
- 11.1.3 Local guidelines should address the special needs of adolescent and perimenopausal women with menstrual disturbances.

11.2 Accessibility

- 11.2.1 Local protocols derived from national guidelines should be in place for speedy and evidence-based management of heavy menstrual bleeding in primary care.^{70,71}
- 11.2.2 Care pathways should be designed to ensure ready access and speedy treatment for women with heavy menstrual bleeding who have abnormal histopathological results.^{62,71}
- 11.2.3 Referral pathways between primary and secondary care should be agreed locally and reviewed annually.
- 11.2.4 Guidelines should be in place for direct referral to imaging services from primary care. Ultrasound scan should be undertaken if:
 - the uterus is palpable abdominally
 - body build precludes sufficient digital examination of the pelvis
 - a pelvic mass of uncertain origin is detected on vaginal examination
 - medical treatment fails or there is an abnormal bleeding pattern.

11.3 Environment

- 11.3.1 There should be a dedicated one-stop menstrual bleeding clinic with facilities within the clinic for diagnostic gynaecology, including hysteroscopy and ultrasound.

- 11.3.2 Gynaecology nurse specialists could be trained to facilitate the initial assessment and post-treatment follow-up of women with heavy menstrual bleeding, particularly in relation to quality-of-life measures and the provision of telephone advice.
- 11.3.3 Adequate facilities and trained individuals should be available for the insertion of levonorgestrel-releasing intrauterine system (LNG-IUS) in the outpatient clinic and in primary care settings.⁵⁴

11.4 Process

- 11.4.1 If the history suggests heavy menstrual bleeding without anatomical or histological abnormality, age less than 40 years and normal body mass index, pharmaceutical treatment can be started at initial consultation in primary care.
- 11.4.2 The possibility of clinical or subclinical endometritis should be considered and empirical anti-chlamydial therapy can be given at the initial consultation.⁷²
- 11.4.3 Persistent intermenstrual bleeding, age 40 years or above and failed or ineffective treatment are indications for an endometrial biopsy (with or without diagnostic hysteroscopy) to exclude endometrial cancer or atypical hyperplasia.⁷⁰
- 11.4.4 If suitable, endometrial ablation or resection should be considered as initial treatment for heavy menstrual bleeding in preference to hysterectomy.^{73–78} Uterine artery embolisation (UAE) is recommended for women with heavy menstrual bleeding associated with uterine fibroids and who want to retain their uterus and/or avoid surgery.^{79–80}
- 11.4.5 Hysterectomy should not be offered as a first-line treatment solely for heavy menstrual bleeding but if a woman is properly counselled and declines all the alternative options, she may choose hysterectomy for heavy menstrual bleeding.
- 11.4.6 Subject to an individual assessment of the woman with heavy menstrual bleeding, the route of choice for hysterectomy is vaginal, with abdominal hysterectomy as second choice. The woman should be advised that, in comparison with open surgery, there is a higher risk of urinary tract injury and of severe bleeding associated with the laparoscopic procedure.⁸¹
- 11.4.7 Healthy ovaries should not routinely be removed at the time of hysterectomy.
- 11.4.8 There should be local guidelines for prophylaxis against infection and venous thromboembolism for women undergoing major surgical treatment for heavy menstrual bleeding.^{82,83}

11.5 Audit and outcome

Complications resulting from ablation, UAE and other treatments should be reported locally and to the National Patient Safety Agency, Medicines and Healthcare Products Regulatory Agency, the UAE Registry and other agencies as appropriate.⁸⁴

11.6 Staffing and competence

- 11.6.1 Service providers should ensure that staff inserting the LNG-IUS have the required competency, particularly where the insertion is undertaken by a training-grade doctor.

- 11.6.2 Competency standards for surgical, imaging or radiological skills for heavy menstrual bleeding should be included in local protocols, as well as for maintenance of competencies.

11.7 Auditable standards

All services should audit on an annual basis adherence to the NICE Clinical Guideline *Heavy Menstrual Bleeding*.⁶²

12. Menopause

Rationale

Menopause has a huge impact on the quality of life of women and their families and on the healthcare systems. The adverse effect on the economy is often not appreciated, considering that women now make up nearly 50% of the workforce. A holistic approach to education for the public would benefit all areas.

Standards

12.1 Patient focus

- 12.1.1 Clear and objective information should be available to women on all aspects of menopause healthcare issues, including premature menopause, perimenopausal contraception, osteoporosis prevention, hormone replacement therapies.⁸⁵⁻⁸⁸
- 12.1.2 The potential long-term risks and benefits should be discussed with women before prescribing hormone replacement therapy (HRT). This discussion should be recorded in their notes, together with the indication for which HRT is prescribed.
- 12.1.4 There should be a multidisciplinary team approach to ensure a holistic approach to deliver direct education for the public with group sessions and discussion.

12.2 Accessibility

- 12.2.1 Locally agreed guidelines should be in place for the initial assessment and treatment of menopause in the primary care setting and referral pathways to secondary care to specialist clinics for those women who present with comorbidity.^{89,90}
- 12.2.2 Evidence-based practice in specialist nurse-led clinics, with a dedicated telephone contact, should be available. Where possible, an answering machine service should be available outside clinic times.⁹⁰

12.3 Environment

- 12.3.1 A dedicated menopause clinic service should be available, integrated with other women's health facilities.
- 12.3.2 Multidisciplinary meetings should be held to review complex cases with input from appropriately trained nurses, dieticians or pharmacists.

12.4 Process

- 12.4.1 Local protocols, derived from national evidence-based guidelines, should be in place and should be reviewed regularly.⁹¹

- 12.4.2 Appropriate links should exist between the menopause service and other relevant departments for relevant investigations, including breast screening, bone densitometry, ultrasound and haematology. These arrangements should be reviewed annually.
- 12.4.3 The prescription of HRT should be discussed proactively with all women with a premature menopause. If unsuitable, a clear alternative management strategy until the age of 50 years should be identified, which should be recorded in the case notes.
- 12.4.7 Regional links should be established with other support services for the care of young women with premature menopause, such as fertility, oncology and psychology.

12.5 Audit and outcome

- 12.5.1 Regular audit should take place of referral patterns, waiting times, access to investigations and treatment complications.
- 12.5.2 An annual meeting between the primary care practitioners and commissioners should take place to review the quality indicators.
- 12.5.5 Each unit should have in place a database of women with premature ovarian failure being treated with HRT.

12.6 Staffing and competence

- 12.6.1 The lead clinician should regularly monitor quality indicators for the service.
- 12.6.2 The lead consultant should hold an appropriate national qualification or other recognised certificate.

12.7 Auditable standards

- 12.7.1 Number of new referrals to each clinic, together with the reasons for referral.
- 12.7.2 Uptake rates of different treatments and complications reported (type of hormonal, medical and alternative treatments).
- 12.7.3 Appropriate use of investigations (such as endocrine investigations, bone density scans, endometrial biopsies).
- 12.7.4 Number of women with premature ovarian failure on HRT and their long-term outcome data (including osteoporosis and cardiovascular disease).

13. Urogynaecology

Rationale

Pelvic floor dysfunction has a huge impact on women's quality of life. Very often, they also find it difficult to seek help because of the personal nature of the problem. These women need information and support in making informed choices about their care and management.

Standards

13.1 Patient focus

- 13.1.1 Verbal and written information should be available to women attending urogynaecology clinics to enable them to make informed choices about their care and management options, such as conservative, surgical and medical. This should include operation-specific complications and outcomes.⁹²⁻⁹⁴
- 13.1.2 For preoperative counselling, surgeons should use both their own and national surgical data where available.

13.2 Accessibility

- 13.2.1 All services should be evidence based and of the same standard, whoever provides the service or the setting.
- 13.2.2 Ideally, nurse-led continence assessment clinics, supported by physiotherapists, should be set up in the primary care setting for a thorough assessment of symptoms and to offer a range of conservative treatments.⁹⁴⁻⁹⁶
- 13.2.3 Direct referral systems from primary care continence assessment clinics to the urogynaecology service should be established.⁹⁵

13.3 Environment

- 13.3.1 Urogynaecology services should be delivered by clinicians who regularly undertake a dedicated urogynaecology clinic or equivalent.⁹⁴
- 13.3.2 There should be access to videourodynamics, ambulatory urodynamics and ultrasound facilities in the regional referral centre. Multidisciplinary team should be available at the initial consultation to minimise the patient journey to various departments.⁹⁴

13.4 Process

- 13.4.1 Management of recurrent urinary incontinence should conform to national guidelines. Local multidisciplinary teams should meet annually to discuss clinic policy and guidelines.

- 13.4.2 Local referral pathways for urinary incontinence and pelvic organ prolapse should be agreed and local protocols developed for the management of pelvic floor dysfunction.
- 13.4.3 At the initial assessment, urinary incontinence should be categorised as stress urinary incontinence (SUI), mixed (MUI) or urge (UII) and a management plan should be formulated based on the category.
- 13.4.4 Women with pelvic floor dysfunction should be managed by multidisciplinary teams and systems should be in place to minimise their journey within secondary care.
- 13.4.5 Combined clinics with urogynaecologists and coloproctologists should be held to facilitate investigation and counselling of women with faecal incontinence following obstetric anal sphincter injury and for those with bowel dysfunction in association with pelvic organ prolapse.

13.5 Audit and outcome

- 13.5.1 Outcomes should include:
- subjective measures such as self-reported symptoms, quality of life and perceptions of care
 - objective measures such as bladder diary data, effectiveness of conservative interventions by all care providers and some aspects of urodynamics, such as referrals and diagnosis.

13.6 Staffing and competence

- 13.6.4 Lead urogynaecologist should perform an annual audit of treatment outcomes for their unit, individuals and department.
- 13.6.5 Clinicians should have an adequate annual workload in the procedure that they perform when undertaking primary surgery for SUI.

13.7 Auditable standards

All services should audit on an annual basis adherence to the NICE Clinical Guideline *Urinary Incontinence: The Management of Urinary Incontinence in Women*⁹³ and should also contribute to national database for new operative procedures devised by the British Society for Urogynaecology.

14. Benign vulval disease

Rationale

All women with suspected benign vulval problems should have prompt access to a clinic staffed by personnel with expertise in the assessment, diagnosis and management of vulval disorders. Staff should be competent to provide information regarding the nature of the condition diagnosed and appropriate counselling on treatment options and follow-up.

Standards

14.1 Patient focus

- 14.1.1 Information leaflets should be available for women about clinical conditions and management options.
- 14.1.3 There should be access to professional psychosexual counselling therapy sessions.
- 14.1.4 There should be access to dermatology, genitourinary medicine clinics, plastic and reconstructive surgery and chronic pain clinics.

14.2 Accessibility

There should be a dedicated consultant with a special interest in vulval disease available on a regular basis in a hospital or community setting, according to local needs.

14.3 Environment

- 14.3.1 Facilities for vulvoscopy (with a colposcope) should be available in benign vulval disease clinics. These are usually set in dermatology and genitourinary medicine clinics which do not have access to colposcopy.
- 14.3.2 There should be dedicated vulval clinics with multidisciplinary support from dermatological, genitourinary, psychosexual and pain clinic specialists.

14.4 Process

- 14.4.1 Each clinic should have written guidelines for assessment, including biopsy, and algorithms for clinical management of common benign vulval conditions.
- 14.4.2 There should be same day access to colposcopy/vulvoscopy from the vulval clinic.
- 14.4.3 All vulval clinics must have patient information leaflets to explain the use of emollients, topical steroids, and other topical or systemic treatments.

14.5 Audit and outcome

- 14.5.1 Multidisciplinary team meetings should take place at least once a year to review and update guidelines and to assess compliance.
- 14.5.4 Annual audits should take place of outcomes/response to treatment.

14.6 Staffing and competence

- 14.6.1 All vulval disease clinics must have a named consultant or senior specialist gynaecologist who runs the service with established links with genitourinary physicians and dermatologists.
- 14.6.2 There should be a dedicated nurse to care for women with disease of the lower genital tract and one healthcare assistant in each clinic room.
- 14.6.4 All professionals (clinicians/nurse specialists) should be competent in colposcopic assessment of lower genital tract lesions.
- 14.6.5 Clinic staff should have access to e-learning resources, such as the International Society for the Study of Vulvovaginal Diseases website for continuing professional development.

14.7 Auditable standards

- 14.7.1 Outcome data for the diagnosis and management of premalignant conditions of the lower genital tract, vulval intraepithelial neoplasia and extra-mammary Paget's disease, and patients' view of intervention.
- 14.7.2 Record of treatment, complications and effectiveness of intervention for various dermatoses.

15. Colposcopy

Rationale

The NHS Cervical Screening Programme has been a great success; now that more than 80% of eligible women are being screened in the UK, it is possible to reduce deaths from cervical cancer by 95%. However, it is important that women with suspicion of cancer should be seen quickly and provided with high quality care.

Standards

15.1 Patient focus

- 15.1.1 Information leaflets about colposcopy and related procedures should be sent to the woman in advance, together with the clinic appointment letter and verbal information offered to women attending for colposcopy.^{97,98}
- 15.1.2 Counselling must be available in a private area before the woman changes for colposcopy.
- 15.1.3 There should be an open explanation of expectant and surgical options. Expectant management can be offered to those women with minimal abnormalities in a cervical biopsy.

15.2 Accessibility

- 15.2.1 There should be a dedicated colposcopy suite fulfilling the National Health Service Cervical Screening Programme (NHSCSP) standards.^{99,100}
- 15.2.2 An evening service should be available to cater for those with difficulty in attending regular clinics.

15.3 Environment

- 15.3.1 There must be separate waiting and recovery areas.
- 15.3.2 Adequate resuscitation equipment must be immediately available and staff must be familiar with its use.

15.4 Process

- 15.4.1 Direct referral systems from the cytology laboratory to the colposcopy clinic should be established.
- 15.4.2 The colposcopy clinic team should meet regularly to discuss clinic policy and guidelines. Regular meetings should also be held with cytopathologists to discuss cases of interest and difficulty.

- 15.4.3 Women with suspicion of cancer should be seen within 2 weeks.
- 15.4.4 Women with high-grade cytological changes should be seen within 4 weeks.
- 15.4.5 Women with low-grade cytological changes should be seen within 8 weeks.

15.5 Audit and outcome

- 15.5.1 Mandatory data collection should be carried out by the standard colposcopy quality indicator returns, such as KC65 in England.
- 15.5.2 Data on auditable standards should be collected annually and benchmarked against national standards.^{99,100}

15.6 Staffing and competence

- 15.6.1 The service and service providers should be accredited by the British Society for Colposcopy and Cervical Pathology (BSCCP).
- 15.6.2 All colposcopists should be certified by the BSCCP/RCOG and should comply with recertification every 3 years. A unit register of staff with certificates of competencies should be updated regularly.
- 15.6.3 The lead colposcopist should monitor annually quality standards for colposcopy.

15.7 Auditable standards

All services should audit on an annual basis adherence to the RCOG/BSCCP report, *Standards for Service Provision in Colposcopy Services*.⁹⁷

16. Gynaecological oncology

Rationale

All women with suspected gynaecological cancer will need prompt access to dedicated multidisciplinary teams, patient counselling services and access to appropriate information at all times. Women should be supported in making informed choices about their care and management.

Standards

16.1 Patient focus

- 16.1.1 Women should be encouraged to bring a partner, close friend or relative with them to clinic appointments, particularly when they could be told of a cancer diagnosis.
- 16.1.2 Women should be given as much information as they want on the short- and long-term effects of the proposed treatment and potential adverse effects. Full, clear and accurate information, both verbal and written, should be provided.
- 16.1.3 Women who have undergone radical treatment should be informed about possible long-term adverse effects and should have a clear access route to specialist help if symptoms develop.
- 16.1.4 Women should be encouraged to make their personal priorities clear to clinicians, who should respect their views.
- 16.1.5 There is no good evidence to support one type-of follow-up over another. When eligible, women should be randomised within appropriate trials. Follow-up outside trials should be tailored to the needs and preferences of individual women.
- 16.1.6 Women should be given full information about how they can access services for any problems or symptoms that may develop after treatment for gynaecological cancer.
- 16.1.7 All patients should have a named gynaecological cancer nurse specialist and this should be clearly identified in the woman's record.
- 16.1.8 Women who have treatment that is likely to affect sexual activity (in particular, radiotherapy to the cervix, vagina or vulva) should be offered counselling with their partners to reduce adverse effects on their relationship.

16.2 Accessibility

- 16.2.1 Delays between initial suspicion of cancer, referral and treatment should be kept to a minimum and should meet the nationally agreed targets.
- 16.2.2 All providers should have a one-stop diagnostic service with access to ultrasound scanning for both abnormal vaginal bleeding and pelvic mass presentations.

- 16.2.3 There should be access to both hospital-based and primary care palliative care teams.

16.3 Environment

- 16.3.1 There should be adequate facilities for medical staff and cancer nurse specialist consultations.
- 16.3.2 Private rooms should be available in both clinics and wards for communicating information and breaking bad news.
- 16.3.3 All gynaecological teams operating on women with ovarian cancer should have access to both high-dependency and intensive therapy units.
- 16.3.4 Gynaecological oncology inpatients should have designated ward beds and facilities and should be reviewed daily by a gynaecological oncologist. Postoperative care should be provided by nurses with training in gynaecological care.

16.4 Process

Multiprofessional teams

- 16.4.1 Women with possible or suspected gynaecological cancers should be referred to dedicated diagnostic and assessment services based in recognised cancer units/centres.
- 16.4.2 Women with gynaecological cancers should be managed by specialist multiprofessional gynaecological oncology teams.
- 16.4.3 Gynaecological oncologists and gynaecologists with a special interest in gynaecological oncology are core members of the specialist multiprofessional gynaecological oncology teams in cancer units and centres.
- 16.4.4 There should be agreed, evidence-based, documented local guidelines on the management of gynaecological cancers, which should be operational throughout the local cancer network.
- 16.4.5 Multidisciplinary management guidelines should be reviewed annually using a process agreed within the cancer network site-specific group.
- 16.4.6 There should be a documented policy for the working and decision-making process of the multidisciplinary team meetings and communicated to patients and GPs.
- 16.4.7 There should be established links between gynaecological nursing services and those in the community and palliative care services.
- 16.4.8 The gynaecological cancer multidisciplinary team requires a radiologist, clinical and medical oncologists, gynaecologists, histopathologist, specialist nurses and coordinators as part of the core group. The external group should include psychologists, a geneticist, palliative care specialists, and so on. Ideally, there should be more than one representative of each specialty to aid discussion. These teams must be supported with adequate administrative, secretarial, clerical and data management and information technology support.

Clinical management

- 16.4.9 Women with symptoms suggestive of gynaecological cancer should be referred using the criteria and pathways recommended by the NICE guidelines and according to local cancer network guidelines.^{101–105}
- 16.4.10 Surgery should be performed only by suitably trained members of the gynaecological cancer team.
- 16.4.11 Wherever possible, women should be offered management within recognised clinical trials.

16.5 Audit and outcome

- 16.5.1 Each multidisciplinary gynaecological team should have a system in place to record the procedures that have been undertaken by each team member by operative procedure and morbidity.
- 16.5.2 Each team should be able to demonstrate that the service provided is in line with the agreed local clinical policy.

16.6 Staffing and competence

- 16.6.1 All gynaecological oncology clinicians should devote at least 50% of their activity to gynaecological oncology.
- 16.6.2 Clinicians should comply with clinical benchmarking standards identified by the relevant professional body.

16.7 Auditable standards

All services should audit, on an annual basis, adherence to the nationally agreed standards.

17. Risk management

Rationale

There is evidence that risk management systems can identify factors that could expose patients, staff, visitors and hospital property to harm. To minimise risk, it is important that a proactive approach is in place within a risk management framework that integrates all aspects of clinical governance, including clinical audit, training, complaints handling, research and service development.

Standards

17.1 Structures for managing risk

- 17.1.1 Each unit should have a risk management lead.
- 17.1.2 Each unit should have a risk management strategy in place and this should be circulated to all staff. The strategy document should be cross-referenced with the hospital or trust's governance strategy.
- 17.1.3 Patient safety should be coordinated by a multidisciplinary risk management committee. The role of the committee should include: ^{84,106-108}
 - identification, monitoring and control of risks
 - embedding continual risk assessment in all clinical areas
 - promoting awareness and understanding of patient safety issues within the unit and providing feedback.
- 17.1.4 There should be a nominated lead person for risk in each department and responsible persons in the various clinical areas.
- 17.1.5 Each clinical area (clinic, ward, operating theatre, endoscopy suite, general practice, and so on) should have a risk management manual containing policies, protocols and clinical practice guidelines.
- 17.1.6 Users of the service should be engaged in the risk management process, for example in developing policies and protocols, systems analysis and feedback.
- 17.1.7 Each unit should have easily accessible referenced, evidence-based multidisciplinary guidelines for the management of common gynaecological conditions. These should be reviewed and updated at 3-yearly intervals.⁸⁴

17.2 Identifying and responding to risk

- 17.2.1 All units should have a risk register to record all patient safety incidents and corrective actions taken.^{109,110}
- 17.2.2 A local 'trigger list' should be developed to encourage reporting.

- 17.2.3 All units should have a root cause analysis in place to investigate unexpected perioperative severe incident or death. Each report should include learning points and an action plan.¹¹¹
- 17.2.4 A system must be in place to highlight risks identified from national alerts (such as National Patient Safety Agency, confidential enquiries).
- 17.2.5 All units should have policies and processes in place that protect patient safety when new technologies are introduced.
- 17.2.6 There should be a local mechanism in place to learn from complaints.

17.3 Audit

- 17.3.1 Each unit should have a multidisciplinary annual programme of clinical audit that monitors local practice against national standards.
- 17.3.2 The clinical audit programme should be informed by the unit risk register and led by a risk management lead.

18. Gynaecological examination

Rationale

Gynaecological examination is an important part of the assessment of symptoms in the practice of gynaecology. However, such examination is a common source of complaint from patients.^{112–115}

Standards

18.1 Patient focus

Information

- 18.1.1 An explanation must be provided to the woman as to why the examination is necessary. She must be given an opportunity to ask questions.
- 18.1.2 An explanation must be provided as to what the examination will involve so the woman has a clear idea of what to expect, including any potential pain or discomfort.

Consent

- 18.1.3 Valid patient consent should be obtained before the examination and recorded in the case notes.^{4,112–118}
- 18.1.4 The healthcare practitioner undertaking the examination must discontinue if asked by the woman.

18.2 Process

- 18.2.1 A policy should be in place to ensure a chaperone is available to assist with gynaecological examination, irrespective of the gender of the gynaecologist.
The name and job title of the chaperone should be recorded in the notes.¹¹⁶
- 18.2.2 Facilities must be provided to give the woman privacy to undress and dress. Drapes must be available to maintain dignity.
- 18.2.3 Examination facilities must be within a closed room to avoid interruption while the examination is in progress. A garment should be available to ensure dignity while awaiting clinician.
- 18.2.4 Latex-free gloves should be provided for pelvic examinations.
- 18.2.5 Single-use instruments and specula of different sizes should be available in the clinic.
- 18.2.6 A policy should be in place to follow national guidelines to ensure best practice.^{116,117}
- 18.2.7 A policy should be in place on consent, specifically for student doctors.

19. Organisation of outpatient clinics

Rationale

It is essential that sufficient time is allowed for consultations and investigations in all settings to ensure appropriate management of the patient's clinical condition. This is especially relevant in newer settings, such as one-stop clinics, because they will be undertaking additional tasks.

To ensure that future doctors are appropriately trained, the appointment system for clinics should allow adequate time for discussion between a trainee and a trainer.

Standards

19.1 Patient focus

- 19.1.1 Consultation time for each patient should reflect complexity of clinical condition (double appointment slot for complex cases) and clinical skill mix.
- 19.1.2 The service should be customised to meet the needs of the individual woman.

19.2 Process

- 19.2.1 There should be agreed integrated management pathways between the secondary and primary care for arranging relevant baseline investigations prior to first hospital appointment.
- 19.2.2 Foundation year and year 1–2 specialty trainees should be supernumerary for service provision.
- 19.2.3 Junior trainees (specialty trainee years 3–5) should have a longer appointment slot (over 30 minutes) to see the woman and to discuss patient management with the consultant.
- 19.2.4 Experienced trainees (specialty trainee years 6–7) should see patients independently with indirect consultant supervision if required.
- 19.2.5 For consultant-led general gynaecology clinics, a maximum of seven new and seven returning patients should be booked, to allow adequate time for consultation, discussion of the management plan, obtaining consent, teaching and dictation.

Clinic	=	4 hours of programmed activity
7 new patients	=	20 minutes each (140 minutes)
7 review patients	=	10 minutes each (70 minutes)
Time for dictation	=	15 minutes
Time for case discussion with trainees	=	15 minutes

19.2.6 Specialist and subspecialist clinics should reflect the complexity of the clinical condition and the clinical experience.¹¹⁹

The numbers of patients recommended in Table 1 are based on advice received from various professional societies and RCOG publications.

Table 1. Recommended numbers of patients for one-stop and subspecialist clinics

Clinic type	Patients/1 programmed activity (<i>n</i>)
<i>One-stop</i>	
Menstrual disorders	7–8 new patients/consultant and 4–5 new patients for an experienced middle-grade doctor
Rapid access for gynaecological	No more than 10 new and review patients/senior doctor malignancies (for postmenopausal bleeding and pelvic masses)
Termination of pregnancy	No more than 8 patients/senior doctor
Urodynamics	No more than 10 patients/doctor
Chronic pelvic pain	No more than 6 new and 6 follow-up patients
Premenstrual syndrome	No more than 6 new and 6 review patients/senior doctor
Menopause	No more than 6 new and 6 review patients/senior doctor
<i>Subspecialist</i>	
Gynaecological oncology	No more than 6 new or 12 review patients
Reproductive medicine	3–6 new referrals or 6 couples for follow-up
Urogynaecology	3 new and 6 review patients/consultant and 2 new and 4 review/experienced middle-grade doctor

19.2.7 Community-based specialist nurse/midwife-led clinics (early pregnancy clinics, continence assessment clinics, contraception, colposcopy, level 1 infertility, menopause, and so on) should have direct supervision from and access to consultants, with appropriate clinical governance arrangements.

19.3 Staffing and competence

19.3.1 There should be adequate support staff (one per consulting room) and administrative assistance to run the clinic efficiently.

19.3.4 There should be a system in place to monitor staffing levels, together with their training, skills and experience.

19.4 Auditable standards

19.4.1 The proportion of DNAs against agreed local standard.

19.4.3 Yearly review of 20 clinics to monitor adherence to local standards.

19.4.4 Annual patient satisfaction survey to monitor waiting times to be seen.

20. Record keeping in gynaecology

Rationale

There is a need for doctors to keep clear, accurate and legible records, reporting the relevant clinical findings, the decisions made, the information given to patients and any drugs prescribed or other investigation or treatment. Poor record keeping is a contributory factor in many medical negligence claims.^{120,121}

Standards

20.1 Process

- 20.1.1. Patient records must be in line with national best practice; for example:
- written legibly and indelibly in black or blue ink
 - have the patient's name and hospital number or date of birth on each page
 - every entry, deletion or alteration should be dated, timed and signed, including status
 - abbreviations should conform to agreed local protocols.
 - there should be at least one entry every 24 hours on inpatient's progress.
- 20.1.2 The reports of investigations and laboratory results must be signed and dated before being filed in the notes. Any follow-up action required should be clearly annotated in the case notes.
- 20.1.3 Processes should be in place to ensure that patients' health and other sensitive information is safeguarded against loss, damage or unauthorised access and kept confidential in accordance with the latest legislation and guidance.
- 20.1.4 Until a full electronic system is in place nationally to record all patient case notes, it will be necessary to keep hard copies of electronic communications on the patient's paper case note file, to ensure that this record is a complete and continuous one.^{122,123}

20.2 Auditable standards

An annual audit of medical records should be undertaken to ensure that the content and storage is in line with the local policy.

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