



Royal College of
Obstetricians &
Gynaecologists

PROVIDING QUALITY CARE FOR WOMEN

STANDARDS FOR
GYNAECOLOGY CARE





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Service standards for the provision of gynaecology care in the NHS

Introduction

IN 2015, the RCOG established the Safer Women's Health Care working party to identify the workforce and service standards needed to deliver safe, high-quality maternity and gynaecological care. This report is the output of the gynaecology standards work stream. It sets out a framework for commissioners and service providers of high-level service standards that aim to improve outcomes and reduce variation in gynaecological care. There is also an accompanying framework for maternity services.

The framework is a progression of the national standards for gynaecological care published by the RCOG in 2008. The 2008 document covers a mixture of clinical and organisational standards and continues to be a highly relevant reference resource for service providers, commissioners, healthcare professionals and for women, and for quality improvement in UK gynaecological care. However, health care provision is changing rapidly, so this new framework for gynaecology service standards builds on the 2008 document to offer providers and commissioners a contemporary structure for the delivery of quality improvement and safe care in gynaecology.

SAFETY CULTURE WITHIN AN ORGANISATION

High quality services for women needing gynaecological care are best delivered where organisations focus on patient safety, clinical effectiveness and the patient experience. The Department of Health have issued Standards for better Health outlining the different domains of care which include safety, clinical and cost effectiveness, governance, patient focus, accessible and responsive care and the care environment and facilities.

Indicators of a well-functioning unit might include:

- **Clear pathways for referral into the service and between services.**
- **Care pathways that are described in evidence based clinical guidelines and benchmarked against national guidance such as NICE and RCOG.**
- **Patient centred care as evidenced by involvement of women in all aspects of**

their care and the decision making process and enhanced recovery programmes.

- **Evidence of multidisciplinary care and team working such as multispecialty clinics and discussion forums, consultants working together in teams and also supporting each other in decision making for difficult or controversial cases, offering a second opinion where appropriate.**
- **Awareness of complication rates from therapeutic interventions for the unit as a whole which are shared with the service users, the medical teams and the managers.**

However, to be effective, organisations also need to have a well-developed clinical governance structure in place in order to continually review and develop the services that they provide. This will incorporate clinical guidelines, clinical incident reporting, training and patient feedback.

Each unit should have a nominated lead for clinical governance in gynaecology.

They will be responsible for:

- **Promoting an awareness and understanding of patient safety by engaging with clinicians, training and education and through a robust communications strategy.**
- **Developing a risk management strategy in line with the organisation's overall risk strategy. Terms of reference should be provided.**
- **Chairing a multidisciplinary risk management committee who are expected to meet on a regular basis, quarterly as a minimum. Representation should include a member from each clinical area, users, allied specialties such as anaesthetists, radiologists, theatre nurses, etc.**
- **Ensuring all clinical areas have access to relevant protocols and procedures. These need to be reviewed and updated on a three yearly basis or more often in light of clinical incidents or if new evidence emerges.**



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- **Responsive to the publication of national guidance or evidence (e.g. NICE). These should be reviewed and incorporated into local practice where appropriate or a statement of noncompliance made to the board where implementation is not possible.**
- **Instigating and reviewing investigations, and undertaking root cause analyses in response to clinical incidents.**
- **Monitoring rates of complications and readmissions and where necessary developing action plans for rising rates or emerging trends and themes.**
- **Monitoring action plans generated in response to clinical incidents.**
- **Escalating gynaecological risks to the unit board when there is felt to be a significant risk to patient safety that remains despite local actions. These are usually incidents rated 12 or over using a conventional risk scoring matrix.**

Each unit should have a risk register to record all patient safety incidents.

This will usually comprise a local 'trigger list'. All incidents reported should be investigated within the timeframes specified by the organisation and an action plan to reduce recurrence developed if necessary. The investigation results and lessons learned should be shared with the department as a whole via departmental meetings and newsletters and where appropriate, shared with the organisation as a whole.

Essential elements of safety culture in gynaecology include:

- **Clinical guidelines and standards, such as National Safety Standards for Invasive Procedures (NatSSIPs).**
- **Effective communication strategy such as SBAR.**
- **Robust mechanisms for handover of care.**
- **Use of operating theatre safety checklists.**

All units should have a system in place for responding to national alerts.

The lead for clinical governance will normally be responsible for this.

All units should have a system in place for introducing new interventional procedures.

This will protect patient safety where new technology is introduced and should include an audit or feedback on each new procedure after no more than one year.

All units should consider and review the services they provide and develop an annual plan for audit and quality improvement. Suggestions for auditable criteria and patient feedback are described in the individual sections of the standards.

Electronic systems should be in place to enable the capture and sharing of information to support risk identification and allow data to be collected and made available for audit and research purposes. Medical staff must be trained to use these systems and allowed access for audit and research purposes.

Audits and quality improvement projects should be conducted to ensure that a department is treating women according to NICE, RCOG and other guidance for specific conditions, e.g. management of heavy menstrual bleeding, urinary incontinence procedures, etc.

Service standards for the provision of gynaecology care in the NHS

Scheduled care

1.1 POINT OF REFERRAL

This section describes guidance for the management of referrals to gynaecology services and communication with women prior to initial assessment.

1.1 RATIONALE

Wherever care is provided, the aim should be to provide a safe, effective, caring service tailored to the population being served and adapted to the facilities available. Where care cannot be provided locally, arrangements should exist with neighbouring or tertiary units or other care providers so that all women have access to the services they need. Regional networks should be organised to deliver complex or specialised gynaecological services.

Open-access, community-based clinics should be offered for sexual and reproductive health, contraception and fertility control services.

Some organisations (particularly primary care clinical commissioning groups) may also offer community-based clinics in general gynaecology, and some outpatient procedures such as hysteroscopy.

Community-based clinics may take place in GP practices, healthcare clinics or purpose built units. These standards do not cover individual visits by healthcare providers to women's homes or other venues such as schools and colleges.

Comprehensive standards exist for sexual and reproductive services and are not covered again in this document but adhere to the same general principles of providing an equal and women-centred service.

Referrals should be triaged by an appropriately trained healthcare professional to ensure women are seen in the correct clinic to aid the flow of her journey. Pathways, agreed between primary and secondary care, should be in place so that any tests or investigations needed prior to the appointment should be arranged beforehand. Telephone consultations should be made available, as well as face-to-face, either within a designated gynaecology clinic or as a separate booked session.

Abortion services must offer assessment within five working days of referral or self-referral.¹

1.1.2 PATIENT FOCUS

1.1.2.1 COMMUNICATION

STANDARD 1

When a referral to secondary care services is made, the woman should receive written confirmation of the appointment within 14 days of the referral being received.

As well as the date, time and place of the appointment, the information should include the name of the consultant or practitioner under whose care the woman is placed. She should also be informed as to the allocated length of the clinic appointment. Where it is not possible to issue an appointment within this time frame, as a minimum, women should receive written confirmation that a request for consultation has been made.

STANDARD 2

Women should be offered electronic or text reminders of their appointments, if they give consent.

Women should also be given contact numbers should they need to cancel or change the appointment. Where this is electronic or via an answerphone service, women should receive acknowledgement of their message within two working days.

STANDARD 3

The need for interpreting services should be identified at the point of referral and this information given at the time of referral.

Arrangements should be made for appropriate interpreting services to be available for all appointments and avoid reliance on family members. Ideally, the interpreter would have sufficient training to appreciate the problems women may face. To ensure confidentiality the woman and interpreter should not know each



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other socially. This should allow the woman to feel in control to freely discuss her concerns and be able to make decisions about her care without pressure.

A face-to-face interpreter should be present for a new consultation or if the consultation is likely to involve the delivery of bad news. Ideally this should be a female interpreter.

If a woman declines an interpreter, this should be documented in the notes and the reasons explored with her. If face-to-face interpretation is declined, telephone interpretation should be offered.

STANDARD 4

Women should receive a minimum of 10 working days' notice for routine appointments.

This is in order to allow the woman to make arrangements to attend and a minimum of 10 working days' notice of any cancellation, unless there is a sudden staff illness when the notice may be shorter. Urgent appointments and 'fast track' will be at much shorter notice and should be communicated by telephone due to the short timescales. If a woman cannot be contacted by telephone for an urgent appointment, she must be given five working days' notice in writing. Organisations must take into consideration the time it takes for a letter to get to the woman.

STANDARD 5

Follow-up appointments in the clinic should be made before leaving the clinic for all appointments within the next six weeks.

The nature of the clinic should be made clear in any communication so that the woman is aware of what to expect in relation to the length of the appointment, examination, hysteroscopy, colposcopy or other procedures.

It should be made clear at each appointment what the follow-up arrangements are. Follow-up appointments in the clinic should be made before leaving the clinic for all appointments within the next six weeks. For appointments later than six weeks, written appointments should be sent as per Standard 4.

Women should be made aware if they are likely to be approached about involvement in research and reassured that this is entirely voluntary.

For women where the healthcare professional is uncertain about whether the referral is appropriate, there should be a forum for providing

advice and feedback. This may be an electronic referral requesting advice or an email service providing feedback on queries which could be administered by the specialty lead or a nominated colleague at consultant level.

1.1.2.2 PATIENT INFORMATION

STANDARD 6

Women should receive written information regarding their clinic visit.

Information should include the type of healthcare professional they will see, the expected duration of the appointment and anything they need to bring with them. The letter should explain that they may be seen by a consultant or a member of the team. The GP should have notified any other requirements (e.g. specific disability, request to see female doctor, etc.). In the case of those with learning difficulties there should be a designated number where the GP and/or the carer or woman can contact the clinic to advise what support and reasonable adjustments would be required for the appointment. A pre-visit to help the woman and her carer familiarise with the clinic setting before the scheduled appointment should be considered if appropriate.

Women should be informed if a partner (especially for fertility clinics) or a family member may accompany them to the appointment.

For one-stop clinics, additional written information should include procedure specific leaflets for anticipated procedures such as a scan, IUS/IUD insertion or hysteroscopy. It should also include information about pain relief to be taken by the woman prior to her visit and whether an escort home is needed, and whether the woman can return to work after the appointment.

If the visit results in attending other services, e.g. preoperative assessment clinic, on the same day, this should be included in the information along with the likely duration of the entire clinical episode.

Information should be available in languages other than English depending on the main languages of the women who use the services. Women should be provided with a contact number to request information in other formats, e.g. large print, Braille. Women should be informed if the clinic is a virtual or telephone consultation and given clear information on what to expect from the consultation. They should be able to access face-to-face consultation if preferred.¹

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1.1.2.3 ACCESSIBILITY

Women should be given clear instructions of how to find the clinic including information on public transport and parking. Instructions should be compatible with local signposting.

Women should be provided with a number to contact if they require transport to attend the appointment.

1.1.2.4 CONSENT AND CONFIDENTIALITY

Women should be informed if students may be present in the clinic and be given information on how to agree or decline their presence.

Care must be taken to ensure appointments are sent to the correct address and labelled 'private and confidential'. Careful note must be taken if the GP has made specific requests as to how to contact the woman.

1.1.3 SAFETY

The referring GP should ensure that information about relevant comorbidities and other concurrent treatment is available to the gynaecology team. The GP should ensure that a woman is 'fit for referral' and by initiating the collaborative decision-making process.² This should identify and optimise medical conditions amenable to treatment, appropriate lifestyle advice and support regarding smoking, obesity, malnutrition or inactivity.^{3,4} There should be a pathway to tertiary medical care abortion services for women with significant medical conditions.¹ Contraception must be discussed where relevant and mentioned in the referral letter.

1.1.3.1 STAFFING LEVELS

Appropriate time should be allocated within the job plans of medical staff to allow for triage of referrals and to allow advice and guidance to be available to referring clinicians.

1.1.4 CLINICAL GOVERNANCE

Regular review and audit of the service provided should be made including a patient satisfaction survey at least once every two years.

This review and patient satisfaction survey will provide feedback on:

- **Acceptability of waiting times for the appointment.**
- **The provision of written information regarding the clinic appointment.**
- **Satisfaction with the follow-up arrangements.**

- **Satisfaction with the timing and availability of follow-up appointments.**

- **The clinic environment.**

- **Confidence in the healthcare team.**

Auditable standards include:

- **The proportion of women appropriately offered an interpreter.**

- **The number of women receiving an appointment within 14 days of referral.**

- **The number of appointments cancelled by the hospital.**

- **The number of women receiving at least 10 working days' notice of their appointment for a routine referral.**

- **The number of women receiving a follow-up appointment before leaving the clinic (when the appointment is within six weeks).**

- **The number of women being seen in the incorrect clinic.**

1.2 INITIAL ASSESSMENT

1.2.1 RATIONALE

This section describes the guidance for the clinic based initial assessment of women who have undergone scheduled referral to gynaecology services. It is acknowledged that initial assessment may be undertaken by telephone or online.¹ However, women should be able to access face-to-face consultation, if preferred. Guidelines should be in place to support these approaches.

Survivors of female genital mutilation (FGM) should have ready access to high-quality multi-agency care. FGM services should provide patients with the opportunity for high-quality health care and the opportunity to consider the need for safeguarding any women and girls in the family unit, and to initiate a suitable multi-agency response which includes the police and social services.

1.2.2 PATIENT FOCUS

Where there is patient feedback about the outpatient services, this should be displayed and taken into account to improve services.



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1.2.2.1 COMMUNICATION

STANDARD 7

Each woman should have a named consultant gynaecologist or lead professional who is a current employee of the organisation, responsible for her overall care.⁵

STANDARD 8

Co-morbidities should be clearly recorded at the first visit.

This includes weight/BMI, diabetes and the output from consultations with women at increased risk of mortality or morbidity. These must be documented in the woman's medical notes. In addition, mechanisms for clear communication of these consultations and co-morbidities to women, anaesthetists, surgeons, general practitioners and other healthcare workers must be in place.³ General advice regarding health improvement prior to surgery should be given.¹⁹⁻²⁰

STANDARD 9

There should be access to a complete set of hospital notes either in paper or electronic format for every woman at every visit.

Documentation should be in line with both GMC and local standards. As a minimum it will include the date (and time if relevant) of the consultation, the name, signature and designation of the care provider and the arrangements for follow up. All samples or other investigations taken should be noted. The people present at the consultation should be documented, including name of chaperone for examination.⁶

If any tests are undertaken on the day (e.g. blood tests or microbiology samples), the woman should be informed how and when she will receive the results. She should be given a contact number if the proposed communication is not received within the stated timeframe.

The gynaecology team should be aware of how the local preoperative assessment services work and explain them to the woman. Details of the admission process will be given at the preoperative appointment and any hospital computer/paperwork completed in preparation for admission.

Where specialist patient support services exist (e.g. counsellors, fertility specialist nurses and social services) women should be told how to contact them.¹

Where interpreting services are required for treatment they should be organised as soon as the date for treatment is known. Interpreters should be organised for a suitable duration as their services may be required postoperatively to explain operative findings.

STANDARD 10

Discharge planning should be started as soon as the woman agrees to have surgery.

This will ensure that all essential resources and any obstacles to discharge can be identified and dealt with, including liaison with social services. This will minimise late cancellation of operations and reduce length of stay in hospital. Discussion should include contraception and HRT as appropriate.

1.2.2.2 PATIENT INFORMATION

STANDARD 11

Real-time information should be provided on current waiting times in the clinic which should be no more than 30 minutes.

For walk-in clinics this should be no more than two hours.⁷ Women should be encouraged to alert staff if these times are exceeded.

STANDARD 12

If treatment is planned, women should receive comprehensive verbal and written information regarding the procedure in clinic.¹ This should include information about preoperative changes in medication and/or lifestyle and discharge from hospital and recovery.

Women should be given information which should include options of other treatments, including the proposed operation, and the information they have received documented in the notes. This may be by leaflet or reference to the organisation's website where leaflets have been uploaded. The RCOG has a large number of patient information leaflets which can be downloaded (<https://www.rcog.org.uk/en/patients/patient-leaflets/>). Information regarding the anaesthetic can also be accessed from the Royal College of Anaesthetists (<http://www.rcoa.ac.uk/clinical-standards-quality/patient-information-leaflets>). Services are encouraged to adapt nationally developed patient information for local

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use. There should be access to leaflets in the main languages of women who use that unit and they should be available in different formats.

Women should be informed of the increasing number of decision aids available at NHS Choices to help them with their choices. They should also be informed of relevant patient societies that might help to support them with their condition. Where appropriate, women should be cautioned against websites or sources of information that contain significant bias.

In some cases, women may have to alter their lifestyle (e.g. smoking cessation) or medication. This may include the changing of medication that affects coagulation or the stopping of hormone replacement therapy (HRT) preoperatively. Regimens will need to be discussed with the woman and GP and this may affect the timing of her surgery.

STANDARD 13

The woman should be given a minimum of four weeks' notice for routine treatment or surgery unless she agrees to accept a date at short notice.

A date for treatment or surgery may be decided during the clinic consultation.¹ If the date is to be decided after the consultation, waiting times should be explained. Women should be given details of how to make contact to check arrangements, whether this is a phone number, a designated person or an email address.¹ Women should be told that they have a right to delay or cancel appointments and/or the procedure should they wish.

For example, for a woman using abortion services, to minimise delay, service arrangements should be such that:

- **Referral to an abortion provider should be made within two working days.**
- **Abortion services must offer assessment within five working days of referral or self-referral.**
- **Services should offer women the abortion procedure within five working days of the decision to proceed.**
- **The total time from seeing the abortion provider to the procedure should not exceed 10 working days.**
- **Women requiring abortion for urgent medical reasons should be seen as soon as possible.**

All departments should introduce enhanced recovery pathways for care of woman having elective surgery in order to enhance perioperative care for women and their experience/recovery.⁸

STANDARD 14

It should be made clear at the end of each appointment what the follow-up arrangements are.

If a subsequent appointment is required, it should be made before leaving the clinic for all appointments within the next six weeks. For appointments later than six weeks, written appointments should be sent as per Standard 4.

It should be clear where the next appointment will be, especially if it is not in the same setting. The woman should be given information regarding the waiting time for her next appointment and should be supplied with contact details should she not receive notice of this appointment within 20 working days.

If further tests or treatment are advised, she should receive comprehensive information regarding this either in written format or by reference to an organisation website. Further information may be obtained from other recognised sources, e.g. RCOG.

1.2.2.3 CONSENT AND CONFIDENTIALITY

Healthcare professionals should ask women for permission for students (medical and/or nursing) or support workers to be present during the consultation and during examinations. This can be verbal consent, but the agreement must be documented in the woman's records by the supervising healthcare professional.

Information provided in gynaecology is likely to be of a sensitive nature. The woman should be informed that it is usual practice to record all relevant information (in paper or electronic notes) but she is invited to specify any details she wishes to not be shared in correspondence with the GP or with anyone else that may accompany her to the consultation. These must be clearly identified and marked in the notes.

If the appointment generates a letter, women should be asked if they would like to receive a summary of the consultation. This could be either a copy of the letter sent to the GP or a separately constructed letter to the woman if the original is too technical or could cause harm or distress. The woman should have an option to opt out of receiving these letters if she desires.

Minors aged less than 16 years should be assessed for Fraser competency but ideally are encouraged to be seen with a responsible adult and to explain any agreed treatment or surgery to their parents.⁹



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STANDARD 15

If a woman requires an examination, she should be offered a chaperone.⁶

The name of the chaperone should be recorded in the clinical records. If the woman declines a chaperone this should be recorded. If a family member is used with the woman's consent, they should be over the age of 18 years. Their relationship to the woman and ideally the name should also be recorded. The use of a family member is in addition to an impartial chaperone. All chaperones must be adults. An independent interpreter cannot be used as a chaperone. The consulting healthcare professional has the right to decline to examine the woman if she declines a chaperone/impartial chaperone. This must be explained to the woman and documented in the notes.

STANDARD 16

Consent should usually be taken by the healthcare professional who recommends that the woman should undergo the intervention or by the person carrying out the procedure.¹⁰

Consent may also be delegated to a healthcare professional who is suitably trained and qualified, is sufficiently familiar with the procedure and possesses the appropriate communication skills. The recent Montgomery ruling must be taken into account when consenting a woman.¹¹

STANDARD 17

A woman's understanding of the discussion of treatment and consent should be documented separately to the completion of the consent form, within her notes.

If a surgical procedure is decided upon, the consent process should be commenced in clinic. The consent form should be completed and discussed, to include benefits, risks and alternative management. The woman should be given accompanying information to read alongside it. What has been discussed with the woman and her understanding of her options and choices should be documented in the hospital records but clarified verbally at each stage of care.

In order to be given sufficient time to read the consent form and consider the information, she should be given the option to take the consent form home and return it on the day of admission

to sign together with the surgeon who will be operating.

If pre-printed consent forms are used, there should be space to indicate that individual items of the consent have been discussed with the woman.

1.2.2.4 ACCESSIBILITY

There should be clear signage to other areas within the hospital that women may need to visit such as pharmacy and a provision that this service is open during clinic times.

1.2.2.5 ENVIRONMENT

STANDARD 18

Within clinics there should be a clearly identified reception area where women are able to book in for their appointment.

If there is an electronic self-check in system, there should be members of staff available who are sufficiently familiar with the system to help and direct women as needed. There should be a waiting area with adequate seating for patients. The waiting area may be shared with other services but being mindful of the sensitive nature of the specialty and co-location of clinics. Try to avoid early pregnancy loss clinics and/or fertility clinic being located adjacent to antenatal clinic.¹ For example, the assessment (including support services such as ultrasound) should be provided within a dedicated time and space and by a team committed to women requesting abortion, specifically separate from miscarriage and antenatal services.

A member of staff should be immediately available for women in case of any difficulties or queries. This will usually be a member of the administrative team but with easy access to other staff members.

STANDARD 19

Consultations should take place in a closed room to maintain confidentiality.

Women should be asked who they would like to be present for the consultation. Consideration should be given to having at least part of the consultation alone to allow for exploration of coercion and domestic abuse/gender-based violence.

There should be adequate toilets provided for both women and their family members in the immediate vicinity of the clinic including disabled access. There should also be baby changing and breastfeeding facilities.



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STANDARD 20

If a woman requires an examination, she should have privacy to undress/change. Once undressed, a woman should be seen and examined as soon as possible and certainly within 15 minutes.

If there are delays, the woman should not be left alone for more than 15 minutes.

1.2.3 SAFETY

1.2.3.1 HANDOVER

STANDARD 21

Where care is transferred between two lead health professionals the woman should be informed who her new lead professional will be and the reasons for the transfer of care.

The arrangements for transfer of care should be documented in the woman's clinical records.

1.2.3.2 STAFFING LEVELS

There should be adequate nursing and healthcare assistants for the clinic to run without delays for chaperoning and assistance, e.g. IUS insertion procedure (see Standard 15). Specific staffing levels are recommended by the RCOG for clinics involving procedures such as hysteroscopy and colposcopy.¹³

In addition to nursing staff, each clinic should have local arrangements for phlebotomy, either within the department or hospital. This role may be undertaken by the appropriately trained clinic nurses or healthcare assistants.

STANDARD 22

There should be a minimum of two healthcare practitioners present in clinics at any time including during breaks.¹²

1.2.3.3 SUPERVISION

STANDARD 23

Trainees should have direct access to a consultant at all times.

This access ranges from a consultant being physically present in clinic or an adjacent clinic, to telephone access to an identified consultant when a consultant is not present. The degree of supervision is dependent on the individual trainee's competencies. Trainees should only work without a consultant present if they have been assessed

to be competent to manage the majority of cases with no direct supervision or assistance (level 3) for the specific specialty clinic. This includes taking consent for the relevant surgical procedures that are commonly listed from that clinic (see Standard 16). Trainees must always be aware of who their supervising consultant is.¹⁴ The supervising consultant should be appropriate to the case-mix of the clinic and available for consultation. The above also applies to clinics away from the main organisation site.

1.2.4 ORGANISATION OF SERVICES

STANDARD 24

In routine gynaecology clinics new patient appointments should be allocated a minimum of 25 minutes and follow-up patients a minimum of 15 minutes. In clinics where teaching and training is provided, all appointment lengths should be longer to facilitate this. In specialist gynaecology clinics longer clinic appointments may be necessary.

If an appointment is expected to include a procedure, additional time should be allocated accordingly.

Sufficient time should be allocated during the clinical session to complete all patient administrative tasks related to the women seen in that session. This includes dictating letters, onward referral, completing electronic requests for further investigations and listing for procedures. This time may be added onto the individual appointment times, allocated in blocks of time during the clinic or after the last appointment, depending on the administrative task. This time would equate to at least five minutes per woman and up to 10 minutes for new patients or those listed for surgery.

When a consultant is not present in the clinic, the unit will have to cancel all activity if it cannot guarantee in advance, a trainee of appropriate competencies to be in that specific clinic. Alternatively, an individual (e.g. an SAS grade doctor) with the appropriate clinical competencies and training competencies to GMC standards could replace the consultant and therefore provide appropriate supervision to trainees. These decisions should be taken at the time it is known the consultant will not be present to ensure that women are given appropriate notification of cancellation.

Where care is provided by a nurse or other practitioner, they should be competent to carry out these activities. There should be a clear



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pathway for escalation in the event of any concerns and there should be support available from a doctor, even if by telephone only.

1.2.4.1 EDUCATION AND TRAINING

If a clinic is providing training, additional time should be allowed for appointments (see Standard 24). Where workplace based assessments are undertaken with the woman present, the process should be explained to her and her consent to take part ascertained, e.g. for a mini CEX the woman should be told that the trainee is being assessed and that the more senior doctor will be observing only and not directly contributing during the actual assessment but may elucidate further before the end of the appointment. The woman should be reassured that confidentiality will be maintained at all times. For assessments of aspects of the clinical consultation, the woman may be asked to share her perspective of the trainee's performance.

It is good practice for the consultant to review the cases seen by trainees at the end of the clinic and perform workplace based assessments or sign off completed curriculum targets.

Trainees may undertake a community-based clinic in the absence of a consultant if they are assessed as competent to do so and have telephone access to a named consultant for advice. SAS grade doctors can work independently but best practice would have to be at least telephone access to a consultant.

1.2.5 CLINICAL GOVERNANCE

All staff should be familiar with the principles of clinical research and comfortable with giving information about on-going research activity within the department.

All staff involved in recruiting to research studies should have up-to-date Good Clinical Practice (GCP) training.

All staff obtaining consent for research studies should have undertaken appropriate training in ethics and obtaining consent for research.

Clinical audit should be carried out according to a rolling programme set out by the speciality.

Auditable standards include:

- **Number of women seen within 30 minutes of their appointment time.**
- **Standards of documentation.**
- **Availability of previous notes.**
- **The ratio of new patient to follow-up patients.**
- **The number of women offered**

a surgical or other therapeutic intervention as a proportion of new referrals.

- **Number of women where the chaperone is clearly identified.**
- **Number of women provided with written information regarding their planned treatment or procedure.**
- **Number of women provided with written information regarding discharge from hospital and recovery after their planned treatment or procedure.**
- **Number of missed appointments.**
- **Women who have had physiological observations, including blood pressure and BMI at their first visit.**

A review of service provision should address satisfaction with

- **Waiting time to be seen.**
- **The waiting environment.**
- **The attitude of the staff in clinic.**
- **The knowledge and competency of the staff providing care.**
- **Their involvement in the decision-making process.**
- **The quality of the written information provided.**

1.3 TREATMENT

1.3.1 RATIONALE

Women should be seen and assessed prior to any planned procedure in order to ensure that all necessary steps have been taken to optimise their treatment and recovery and minimise their hospital stay.

1.3.2 PATIENT FOCUS

STANDARD 25

All women who are to have surgery should have a preoperative assessment.¹⁵

All women should attend a preoperative clinic. These services are usually nurse led. There should be



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facilities for this assessment to be conducted on the day of the clinic appointment if the woman wishes, to reduce inconvenience. The assessment should give time to optimise the woman's health for surgery and identify and correct modifiable risk factors.

STANDARD 26

Women with significant co-morbidities should meet an anaesthetist for additional assessment.¹⁶

The pre-operative assessment should identify women with specific problems such as diabetes, dementia (with risk of post-operative delirium) and poor nutritional status (with increased risk of morbidity) and hence allow appropriate planning including discharge arrangements.

Healthy women having minor day-case surgery can undergo assessments over the telephone.

As a result of the assessment, the appropriate level of post-operative care should be determined and booked in a day surgery facility, inpatient ward, high dependency unit or critical care unit, enabling both optimum care and efficient planning.

Enhanced recovery pathways should be discussed. See Standard 46 for more details on this.

1.3.2.1 COMMUNICATION

STANDARD 27

Each woman should have a named consultant gynaecologist or other lead healthcare professional, who is a current employee of the organisation, responsible for their overall care during any in-patient episode.

All women (and relatives where relevant) should be fully informed about the planned procedure and be encouraged to be active participants in decisions about their care (collaborative decision-making).²

1.3.2.2 PATIENT INFORMATION

STANDARD 28

The woman should be given practical verbal and written information regarding her admission.

This should include – what to bring, where to go, expected length of stay and postoperative expectations. Arrangements should be made prior

to surgery for those women who will require additional nursing or social services support after hospital discharge.

Clear information should be provided to the woman about what to expect in the anaesthetic room, operating theatre and in recovery.¹⁷ Women with learning and other disabilities may need special assistance and consideration. There should be consideration for women with learning disabilities to allow them to visit the hospital beforehand with their carer to see the ward/theatre. Early consultation with the Disability Nurse Specialist is advised. Interpreters must be used when needed (see Standard 3).

1.3.2.3 CONSENT AND CONFIDENTIALITY

STANDARD 29

Valid consent must be taken prior to any operative procedure.¹⁸

The woman should have had sufficient time to consider the information prior to signing the form as the consent process will have started in clinic (see Standard 16). The person carrying out the procedure should discuss the consent form again with the woman, answering any questions, prior to signing the form themselves.

The consent form should be checked for the woman's signature and if she has not already done so, she should sign it on admission. If the woman signed the form prior to admission and changes are made to the form then she must resign it and date it. Once signed, the woman should be offered a copy of the consent form.

Children under the age of 16 may sign their own consent form if deemed competent.⁹

If the woman agrees that a medical student may perform a vaginal examination on her under anaesthesia, then this should be written on the consent form before the woman signs it.⁶

Where the care episode involves management of miscarriage or abortion, the woman's wishes regarding the sensitive disposal of tissue should be established and documented.

1.3.2.4 ACCESSIBILITY

Elective gynaecological surgery may take place in non-NHS settings, however, they all must comply with basic standards of service and clinical governance that would be expected in an NHS facility. Surgery may take place in a day case unit or general inpatient theatre suite which might be for obstetrics and gynaecology only or shared with general surgical specialities. The day case unit may be on the main organisation site, satellite site or a stand-alone facility.



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STANDARD 30

The planned place for surgery should be discussed with the woman and the most appropriate location agreed with her. Procedures should be conducted as day cases whenever possible.

This is in order to reduce patient inconvenience and hospital acquired complications. It would be expected that, for a general gynaecological service, 80% of the elective procedures are conducted as day cases.¹⁹

The woman must be issued with clear instructions of how to find the pre-operative ward and signposting must be clear within the hospital.

1.3.2.5 ENVIRONMENT

STANDARD 31

There must be appropriate facilities, particularly toilet and bathroom facilities for women undergoing gynaecological surgery. There should also be sufficient, suitably trained staff throughout the patient pathway.

STANDARD 32

Women should be admitted to a gynaecological admission ward on the day of surgery.

Unless there are serious medical issues, women should be admitted to a gynaecological admission ward on the day of surgery, thereby reducing unnecessary days in hospital.

On the day of admission, the woman should experience a welcoming environment, space for accompanying relative(s) to wait with her, and privacy when being seen pre-operatively by the anaesthetist and gynaecologist and being prepared for theatre.

There should be an identified member of the nursing staff preparing her for theatre and explaining the process.

If the woman prefers, and is physically able, she should be allowed to walk to the theatre area accompanied by a member of staff.

The anaesthetic room and operating theatre must conform to Department of Health building standards.²⁰ The theatre must be stocked with the appropriate and sterile equipment to perform the required procedure. High-quality camera, photographic and video recording, preferably digital, equipment should be available.

Procedures may be performed in one-stop diagnostic and treatment clinics such as colposcopy, outpatient hysteroscopy and minor operations.

The clinic set-up will vary by provider and facility but should include adequate space for changing in private, toilets, adequate couches and equipment. There should be access to a recovery area if needed for longer operative procedures such as endometrial ablation.

There are guidelines detailing these clinics in the RCOG Green-top Guideline on Best Practice in Outpatient Hysteroscopy.¹³

1.3.3 SAFETY

STANDARD 33

There must be a locally agreed protocol for the thromboprophylaxis and antibiotic prophylaxis to women undergoing surgery.²²

There must be access to a blood bank if blood transfusion is required or anticipated.²¹

STANDARD 34

There should be a finalised theatre list available at least 48 hours prior to surgery

The unit should agree local protocols to determine when a theatre list should first be published. However, barring unforeseen issues around bed availability, a finalised theatre list should be available at least 48 hours prior to surgery. This will allow theatre staff to plan equipment availability. Changes in list order should be kept to a minimum and the whole operating team must agree to any change to a published operating list.²³ Operating lists should include details of the woman's operation, date of birth, hospital identification number, any alerts and the ward in which she is located. Local protocols should decide whether additional information should be added as standard. See the National Safety Standards for Invasive Procedure (NatSSIP) <https://www.england.nhs.uk/patientsafety/never-events/natssips/>

STANDARD 35

Locally agreed protocols must be in place for checking for pregnancy before surgery in all women of reproductive age.

The woman's last menstrual period and contraceptive history must be documented and, for women of reproductive age, if her period was more than 28 days from the date of surgery, a



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pregnancy test must be performed with informed consent²⁴ and the results documented. It must also be documented that these results have been shared with the surgeon. Units may want to consider formalising this as part of their team brief.

Make sure women who could possibly be pregnant are aware of the risks of the anaesthetic and the procedure to the fetus. If there has been any unprotected intercourse around ovulation or there is a suspicion of the risk of pregnancy then discuss postponing the procedure with the woman. These discussions should be documented. This will depend on the type and urgency of surgery and the anaesthetist must be informed of the uncertainty regarding an early pregnancy, if the woman elects to proceed with the operation.

STANDARD 36

Clear policies should be in place for surgery carried out in satellite units.

If surgery is being performed in a satellite unit, there must be a defined pathway for the anaesthetist and surgeon to call for additional help of a colleague and a transfer pathway to the nearest emergency gynaecological inpatient hospital. In the event of a complication and where relevant, facilities to convert to abdominal surgery must be available. A rapid access ambulance and transfer team must be available if a higher level of care is required postoperatively.

Wherever the surgery is being conducted, there must be a clear pathway to call for assistance from a general, gastrointestinal, vascular or urological surgeon if complications occur.

If inpatient surgery is in a satellite unit to the main gynaecological department, there must be arrangements in place for night cover by appropriately trained staff and a consultant anaesthetist and gynaecologist able to attend within 30 minutes.

STANDARD 37

A safer surgery checklist (e.g. WHO checklist) must be conducted for all women.²³

This commences with all members of the theatre team introducing themselves at the start of the theatre list (briefing). If a new member of staff joins the list later, they must also be introduced. It is important that all staff know who each other are, understand their roles and all members of staff should be able to speak out during a theatre session. Sign in, time out and sign out must be

conducted for each woman and the theatre team should spend time at the end of the list debriefing, including trainees in the process.²⁵

1.3.3.1 HANDOVER

STANDARD 38

The woman's clinical notes and investigations must be available for the surgical team on the day of the procedure.

STANDARD 39

All women must be seen on the day of the operation by the gynaecologist and anaesthetist.

The consultant responsible for a theatre list should work with the booking coordinators to ensure that the composition of the list is appropriate in terms of timing, expertise and equipment availability.

The woman may have been allocated from a shared waiting list. The consultant must have the opportunity to review the notes prior to agreeing to do the procedure and, if not confident of the assessment, to either reject the allocation or arrange to see the woman in an outpatient clinic first. Units need to decide whether the consultant who operates becomes the responsible consultant for the woman's on-going care or the consultant who saw her in the outpatient department retains responsibility. The named consultant for on-going care must be clear to the woman and other members of the team.

Time must be given for the notes of the women booked on the list to be reviewed prior to her operation by the surgeon. It is for the individual or unit to decide whether this is on the day of surgery or prior to this if there is insufficient time to do this in sufficient detail on the day of surgery.

The woman's clinical notes must be available for the surgical team on the day of procedure. If electronic, there must be access to a computer terminal in the clinical area where the woman is being seen.

Confirmation must be gained that the woman wishes to undergo the operation, she signs the consent form (if not already done) and the surgeon signs the confirmation of consent.

Written guidelines should cover the policy for the collection of women from the ward or admissions unit, as well as the handover by ward staff to a designated member of the operating department staff.



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1.3.3.2 STAFFING LEVELS

STANDARD 40

For procedures performed in outpatient clinic areas, there must be adequate nursing support with at least two additional staff within the procedure room.

Day case and operative procedures require adequately trained staff to assist effectively in the smooth running of lists and procedural clinics. These will be a mix of qualified nurses, healthcare practitioners and associate practitioners. Where staff are unfamiliar with their environment or the team that they are working with, extra time may be needed to allow them to familiarise themselves with the setting and working practices of their colleagues in order to provide safe patient care.

Staff must be trained in the handling of the equipment, including cleaning and decontamination. The procedure may be performed by a gynaecology nurse specialist or a doctor.

STANDARD 41

To provide both scheduled and unscheduled surgical services, a gynaecologist should be doing at least one elective half day theatre list every two weeks.

Surgical procedures must be conducted by an appropriately trained gynaecologist. It is the responsibility of the department's clinical lead to ensure this is the case.

If this list is minor/intermediate procedures, then the gynaecologist should ensure they maintain their competence at emergency laparoscopic procedures and the department must have arrangements in place for a colleague to be available to undertake or assist with any difficult laparotomies/caesarean hysterectomy. Gynaecologists who only practice 'office style' gynaecology and who do not have operating lists (day-case or inpatient) should not be on call unless additional cover for surgical procedures is provided.

Sufficient assistants must be available, which as a minimum would be one for major abdominal surgery and two for vaginal procedures, although these may be either medical or allied healthcare professionals with relevant training and competencies. Laparoscopic surgery requires an assistant to hold the camera and a second for the uterine manipulator. These do not necessarily need to be doctors but they must have had sufficient training to be able to assist appropriately and be under the direction of the surgeon.

STANDARD 42

Each department must nominate one gynaecologist to be the lead for theatre.

This individual will attend theatre management meetings and negotiate equipment requirements. This person must lead the liaison between the operating department, gynaecological, surgical and anaesthetic teams.

The nursing and other theatre staff should be experienced and trained in gynaecology (post registered qualification, if possible) to deal with the spectrum of gynaecological procedures and conditions, including abortions, and miscarriage, at all gestations (surgical and medical).

If gynaecological surgery is being performed for NHS patients in non-NHS facilities, trainees cannot train on these sites unless contracts and indemnity have been formalised and the site approved by the GMC. The approval should be gained by the HEE/NES locality to allow access to training and for this to be recognised.²⁶ With future changes in contracting, the Clinical Director, working with the HEE locality, should strive to ensure trainees are included in these new contracts.

1.3.3.3 SUPERVISION

STANDARD 43

Doctors in training should have direct access to a named consultant at all times.

This access ranges from a consultant being physically present in the theatre to telephone access to an identified consultant when a consultant is not present. The degree of supervision is dependent on the individual trainee's competencies. Trainees must be assessed as being competent to manage the cases with no direct supervision or assistance (level 3) for the specific operations, to be left without a consultant present in theatre. Careful consideration should be given to the comorbidities of the patients as this may affect the trainee's ability to perform the procedure safely. Where cases are being performed by a trainee without a consultant being present, they must be specifically selected by a consultant for a named trainee who is known to them. Where whole lists, rather than individual cases, are being left for trainees, the consultant must have also considered the trainee's portfolio with respect to non-technical skills for surgeons.



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STANDARD 44

Trainees must always be aware of who is their supervising consultant.

The supervising consultant should be appropriate to the case-mix of the theatre list, and if available by telephone they must be in the hospital and freely available to attend.

1.3.4 ORGANISATION OF SERVICES

When a consultant is not present in the theatre, the unit will have to cancel the theatre list if it cannot guarantee in advance, that a named trainee with appropriate competencies, matched to the women on the list, has appropriate supervision. These decisions should be taken at the time it is known a consultant will not be present to ensure that women are given appropriate notification of cancellation.

1.3.4.1 SKILL MIX

The theatre manager should ensure that nursing and healthcare assistant (HCA) staff allocated to the gynaecology operating list have the appropriate experience.

The consultant gynaecologist must ensure that he/she has appropriate assistance before commencing an operation.

If appropriate resources are not available, the level of clinical activity should be limited to ensure safe provision of intra-operative care.²³

1.3.4.2 EDUCATION AND TRAINING

STANDARD 45

All gynaecological staff, including locum and agency staff, must have undergone an appropriate organisation induction including IT processes.

Any locum should be met by a designated member of the team, identified and taken through the organisation's locum induction.

Where specialist trainees are allocated to theatre lists, sufficient time must be planned to allow for their training in order to achieve the gynaecology curriculum competencies.

Trainees will all have different training needs and these should be assessed at the beginning of a list. Workplace-based assessments should be performed when appropriate, and feedback provided as soon as possible.

Operating theatres can be a high-pressure area and therefore care should be taken in order not to leave a trainee, or other members of

staff, feeling undermined.²⁷ Trainees must also be aware of patient safety requirements and waiting list pressures which may prevent them from accessing particular operations on a certain list.

Medical students may assist at surgery, provided they are directly supervised by the consultant.

1.3.5 CLINICAL GOVERNANCE

Gynaecologists who perform elective surgery should be able to demonstrate their competency at the procedures they perform. This will be by continuous personal audit of the number of different procedures and log of outcomes (when possible, as many women are now not seen for hospital review), any complications, readmissions, return to theatre and complaints. This information is required for consultant appraisal.

Surgical complications must be reported according to organisation governance guidelines. Each department should have a gynaecology governance lead who collates the information, identifying lessons learnt and sharing these at a regular gynaecology surgical morbidity meeting.

Departments should undertake annual staffing audits of clinic, theatre and ward staffing. This should include the provision of a named gynaecology nurse on each shift and a named lead for gynaecology theatres. Departments should hold regular morbidity and mortality meetings (at least once a year).

Clinical audit should be carried out according to a rolling programme set out by the speciality.

Auditable standards include:

- **Efficient use of available theatre time. Quality improvement projects should look towards achieving occupancy of at least 80%.**
- **Number of women having a pre-operative assessment on the same day as clinic.**
- **Number of women having a pre-operative assessment.**
- **Percentage of procedures carried out as day cases.**
- **Number of women who had a pregnancy test performed prior to procedure/ adherence to local guideline.**
- **Number of women admitted on the day of surgery.**
- **Number of procedures performed as a day case.**



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- **The standard of written consent.**
- **Administration of antibiotic prophylaxis.**
- **Provision of adequate prophylaxis for venous thromboembolism.**
- **Completion of all elements of safer surgery checklist.**

A review of service provision should address satisfaction with:

- **The woman's satisfaction with the location and availability of surgery.**
 - **Number of staff having a local induction.**
- In addition, a clinical incident report should be completed:
- **If the hospital records are not available on the day of surgery.**
 - **Any return to theatre following complications of an operative procedure.**
 - **All readmissions within 30 days of treatment.**
 - **Staffing levels below a minimum level of one to eight women.**

1.4 POST-OPERATIVE AND IN-PATIENT CARE

STANDARD 46

All departments should introduce enhanced recovery pathways for care of their elective surgical patients in order to enhance the perioperative care for women and their experience/recovery.⁴

1.4.1 PATIENT FOCUS

The appropriate level of post-operative care should be determined and arranged for the woman, be this in a day surgery facility, inpatient ward, high dependency unit or critical care unit.

1.4.1.1 COMMUNICATION

Choices about care should be fully explained to the women, and their understanding, as well as their decisions, should be documented.

1.4.1.2 ACCESSIBILITY

Visiting arrangements should be explained to the woman and her relatives.

1.4.1.3 ENVIRONMENT

Women undergoing gynaecology operations or admissions may have complex needs. In order to meet these needs, women should be nursed in a specific gynaecology ward or area. Women should not be cared for in mixed sex units.²⁸

Care should be taken when allocating women to beds in bays or open wards to do this with sensitivity. For example, do not place a woman for an abortion next to a woman with a miscarriage or infertility.

There should be provision of side rooms for women who are undergoing mid or late pregnancy loss, or either medical termination or late miscarriage.

There should be an adequate number of toilets and showers for women with a minimum of one for each bay of six.

1.4.2 SAFETY

The facilities for safe post-operative and general ward management must be available, including an ability to escalate care to High Dependency care (HDU) if necessary and have access to critical care outreach teams. If surgery has been performed away from the main gynaecological unit, then transfer arrangements must be clear.

Women should be monitored as per local guidelines, including basic observations and fluid balance as her condition dictates.

1.4.2.1 HANDOVER

STANDARD 47

The gynaecology team looking after the wards must hand over information between shifts.

This can be either electronically or by paper to include the current condition of the woman, investigations to order or review and discharge planning.

1.4.2.2 STAFFING LEVELS

STANDARD 48

On each nursing shift there should be at least one nurse who is specifically trained in gynaecology.

All nurses caring for women should be aware of the psychological aspect to gynaecology care.

Women should be monitored as per local guidelines, including basic observations and fluid balance as the condition dictates.

STANDARD 49

There should be a minimum of one trained member of staff for every eight in patients.²⁹



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Research suggests that if staffing levels have fewer than one health professional to eight patients, there is an increase in risk and adverse incidences and hence this would be a minimum staffing requirement. However, depending on the complexity of need, the staffing levels may only have a ratio of one to four/six and local guidelines for assessing acuity should be developed. Lower levels of staffing should be highlighted to nursing management via the clinical incident reporting system.

STANDARD 50

All women remaining in hospital should be seen at least once a day by the gynaecology ward medical team and regularly by a consultant gynaecologist.

This should include a doctor with the appropriate competencies to understand the surgery that the woman has undergone. It is good practice for the woman's consultant to see her after the surgery and for there to be a consultant ward round on a daily basis to review all women.

There must be a first on-call doctor available 24 hours a day and if not gynaecologically trained, there must be a clear pathway of how that doctor seeks advice from a gynaecologist.

1.4.2.3 SUPERVISION

The doctors looking after the gynaecological ward must have adequate competencies to manage gynaecological emergencies and postoperative women and know who to ask for help from, with ready access to a consultant opinion.

1.4.3 ORGANISATION OF SERVICES

STANDARD 51

Whilst an inpatient, observations should be made on a national early warning score (NEWS) chart.³⁰

Frequency of observations should be specified on admission but will be a minimum of twice a day for any inpatient. Fluid balance charts should be maintained accurately where required, and the medical staff informed if the woman's condition deteriorates.

Hospital inpatients must have scheduled seven-day access to diagnostic services such as x-ray, ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI) and pathology.³¹

There must be regular communication between the medical and nursing staff on the ward, both

to co-ordinate care on the ward and discharge planning.

1.4.3.1 EDUCATION AND TRAINING

If ward cover is allocated to more junior members of the team, there must be a doctor allocated to do the rounds with them who has the appropriate competencies, for patient safety and education.

A consultant should be part of the daily ward round to provide a senior clinical opinion and teaching. Hospital inpatients should be reviewed by an on-site consultant at least once every 24 hours, seven days a week, unless it has been determined that this would not affect the woman's care pathway.³²

1.4.4 CLINICAL GOVERNANCE

Regular review and audit of the service provided should be made, including a patient satisfaction survey at least once in a two-year period. This will provide feedback on:

- **Women's experience of and satisfaction with their post-operative recovery.**
- **The facilities available to women in the inpatient area.**
- **The level of staff providing care.**

Clinical audit should be carried out according to a rolling programme set out by the speciality. Auditable standards include:

- **Medical handover of care.**
- **Number of women reviewed on a daily basis by the gynaecology team and/or the consultant.**
- **Recording of early warning scores at appropriate time intervals.**
- **Staffing levels and skill mix.**



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1.5 FOLLOW UP AND DISCHARGE

1.5.1 RATIONALE

STANDARD 52

All women must be informed about the investigations and treatment they have undergone, whether this was conservative, medical or surgical.

Following discharge from hospital, whether or not the woman was admitted, there should be a clear plan shared with all relevant healthcare professionals and the woman herself. This should make clear the next stage of care, where and when it will be provided and who is responsible for ongoing care.

1.5.2 PATIENT FOCUS

Women should be involved in discussions about on-going care and their views taken into account. The woman's preferences should be documented along with reasons why her preferences cannot be met if applicable. Discharge planning should start as soon as possible after admission onto the unit and involve other family members if appropriate.

STANDARD 53

It should be clear who is responsible for arranging the next stage of care.

Women must be fully informed before discharge from the unit. This involves details of:

- **What procedure, if any, has been carried out.**
- **What treatment is planned.**
- **Any discharge medication and how long it should be continued, including contraceptives or HRT.**
- **Where and when any follow up will occur.**

This information should be given at a suitable time, bearing in mind the nature of the treatment so that the information is likely to be understood and retained. Women should be asked if they would like a family member or other support to be present during explanations.

1.5.2.1 COMMUNICATION

STANDARD 54

Women should receive an explanation of their procedure before discharge from the unit.

Following the treatment or surgery, one of the healthcare professionals involved in the procedure should see the woman and explain the findings and describe the procedures undertaken. She should be given written information about her condition, when possible. Interpreters should be arranged as described in Standard 3.

If the woman has had an admission which has not resulted in surgery, she must be given appropriate information of her diagnosis, or presumed diagnosis and results of investigations preformed.

The woman should be given information about expected length of stay and what will happen on each day. Care of drips, drains and catheters should be explained.

STANDARD 55

Women should be given clear information about postoperative medication.

If she needs to use medication after the admission/surgery, then the route of administration, timing and length of treatment must be clearly explained. If the woman is not assimilating information clearly, this information should be given in the presence of a relative. It must be made clear whether the medication is to be continued by her GP and for how long.

STANDARD 56

The GP must receive an electronic discharge summary within 24 hours of discharge or a paper copy be issued within 24 hours.

It is preferable that this is sent electronically and the woman must be given a copy of the summary as she leaves the ward.

This should contain enough information about the procedure to allow another practitioner elsewhere to manage any complications.

1.5.2.2 PATIENT INFORMATION

STANDARD 57

Women should receive information about their recovery and a copy of their discharge summary before leaving the unit.



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Where possible, women should be given an anticipated date for discharge when admitted.

Generic and specific procedure-related post-treatment care instructions should be provided both verbally and in writing.¹ This includes symptoms they may experience, emphasising those which would necessitate an urgent medical consultation. For example, for those patients who have undergone an abortion this will include symptoms of a continuing pregnancy. If the patient should avoid pregnancy for a specific amount of time, this must be documented. Similarly, if there has been a change in contraception, e.g. a long-acting contraceptive has been removed, then this must be documented and the woman clearly informed.¹

A 24-hour telephone helpline number should be available for women to use after abortion if they have any concerns.

The woman should be informed as to whether she will have a hospital or community follow-up appointment and who to contact if any problems arise. She should be given a copy of her discharge summary.

1.5.2.3 CONSENT AND CONFIDENTIALITY

Given the sensitive nature of the specialty, it should be agreed with the woman who she wishes to be informed of her admission and what information may be shared. This includes information sent to the GP. Particular care must be taken over young adults, ensuring that confidential information is not disclosed, except if there are suspected safeguarding issues.

If further surgical treatment is planned, written consent should be obtained prior to discharge and the woman offered a copy of the consent form. Interpreters should be used as necessary as described in Standard 3.

A private room must be available in day surgery or a procedures clinic to explain operative findings and further management. There should also be access to a private room on the ward when sensitive information needs to be discussed.

1.5.2.4 ACCESSIBILITY

Relatives should be made aware of when discharge is likely to happen and where to collect the woman from, as this may be different to where they were admitted.

STANDARD 58

Where a follow-up appointment is required, the woman should be offered a choice of location.

Ideally this would be provided within a 30-minute journey of her usual place of residence. However, where specialist services are required, it should be made clear why this is not in the local area and the advantages of travelling to that facility. Women should be offered help with transport to their follow-up appointment, and translation services, where appropriate.

1.5.2.5 ENVIRONMENT

The ward arrangements have been discussed in Standards 18, 19 and 20.

Whilst waiting for discharge from the unit, women should be offered an area where they may wait comfortably until they leave; a so-called discharge lounge. This may be while waiting for discharge medication, further test results or transport home.

While waiting, women should be provided with hot and cold beverages and refreshments and there should be access to toilet facilities in the immediate area. There should be a designated member of staff available should they require assistance and this member of staff should be aware of who is awaiting discharge at any point in time.

Relatives must be informed how to find the ward or discharge lounge and at what time they are expected to collect.

There should be appropriate equipment available within each organisation for women with morbid obesity such as beds, trolleys, operating tables.

1.5.3 SAFETY

1.5.3.1 HANDOVER

Discharge summaries, preferably electronically generated, should be commenced early during the woman's admission so that they can be completed in a timely manner and ready for the day of discharge. Operative findings should be documented on them after the operation by the team present in theatre. There should be a shorter discharge format after day case or minor operation procedures.

Medications required for discharge should be prescribed in advance and dispensed promptly to reduce delays.

The handover to the woman's primary care team should be by a concise, informative discharge summary, preferably typed and sent electronically.

There should be both verbal and written communication between the discharging or transferring staff and the receiving team when women are not discharged home or where there is a need for on-going support at home, e.g. intermediate care team. This would also apply to women discharged to social care services.

1.5.4 ORGANISATION OF SERVICES

Women, and their relatives, must have been informed that they might be sent to a discharge lounge to await collection and this should be clearly signposted.

There should be arrangements in place for speedy organisation of medications to take home and this should include some medications available on the ward for out-of-hours discharge. The woman should have her discharge medication fully explained and a check made of her understanding. The discussion should be documented in the hospital records and on the discharge summary. Ideally, the medications will have been organised the day before discharge. There should be sufficient support from pharmacy to prevent a woman, or her family, returning to collect medications.

1.5.5 CLINICAL GOVERNANCE

Clinical audit should be carried out according to a rolling programme set out by the speciality.

Auditable standards include:

- **Length of time from the decision to discharge and leaving the ward.**
- **Number of discharge summaries available to the GP within 24 hours of discharge.**
- **Standard of completion of observation charts including fluid balance.**
- **Timely availability of discharge medications.**
- **Review of quality of discharge summaries.**
- **Number of discharge summaries ready to go with the woman.**
- **Length of stay for different procedures.**

The quality of service provided should be reviewed with feedback received on:

- **Acceptability of the waiting time for discharge.**
- **The waiting environment.**
- **The quality of information provided.**
- **The clarity of information on discharge medication.**
- **The choice and availability of follow-up care.**

Service standards for the provision of gynaecology care in the NHS

2 Unscheduled care

THERE IS considerable overlap in service standards for women on scheduled and unscheduled pathways. Therefore only standards that are different for acute patients will be detailed in this section. For all other standards please see the scheduled patient pathway.

The term 'unscheduled' will be used to cover unplanned admissions or assessments.

Emergency patients are amongst the sickest in the hospital. They have a high incidence of co-morbidity and frailty, and an increased risk of death or serious complications.³³ The need for improvement in the care of emergency patients has become widely recognised. The Royal College of Surgeons of England has stated recently that emergency surgical patients should receive priority over elective work.³⁴

2.1 POINT OF REFERRAL

2.1.1 RATIONALE

The principles guiding the review and admission of unscheduled gynaecology patients include: early senior input, assessment and planning, identification of high-risk patients and avoidance of delays. This section outlines guidelines for the referral of patients from multiple points of access to specialist gynaecological services.¹ This includes independent providers of early pregnancy ultrasound and screening services and abortion services, who should have arrangements in place for referring women into NHS services for emergency assessment/admission.

2.1.2 PATIENT FOCUS

STANDARD 59

There must be clear pathways in place for unscheduled referral to gynaecology services from all different clinical areas including primary care, the emergency department and other hospital departments and wards.

STANDARD 60

Women should be informed by the healthcare professionals referring them, who they have been referred to and why.

Women should be given a time frame during which they can expect to be seen and a number to contact, should review not occur as expected. Following review and assessment, it should be clear who is the consultant or healthcare professional in charge of their care, particularly if this has changed.

Where gynaecology services accept self-referrals from women, particularly in early pregnancy, clear information on the process should be available to women. This information should include referral criteria, points of contact for self-referral and information on where to seek help if the referral criteria are not met.

If the woman has been referred by her GP, she should have an accompanying summary of her medical history. Where available there should be electronic access to patient records in order that the gynaecology team can access detailed shared information about the woman.

There should be local protocols in place and agreement between services to cover women initially referred from primary care or seen in the emergency department and then referred to gynaecology. The seniority of the original gynaecological opinion then sought depends on the patient status and local protocol. These protocols should allow for appropriate advice and guidance to reduce inappropriate admissions.

There should be local protocols in place for the referral of women to the gynaecology team for assessment from within secondary care and for current inpatients. This should involve the transfer of information (verbally and/or electronically) to the relevant second on-call gynaecologist or above and is required prior to considering further investigations and/or transfer to gynaecology.

There must be locally agreed protocols for the management of patients where only advice and guidance is given by the gynaecology team, or where a subsequent outpatient appointment for a gynaecology clinic is made.



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STANDARD 61

The woman should be informed of the name of the consultant gynaecologist to whom she has been referred for advice/assessment.

This should be explicit, whether the initial referral results in either advice and guidance or formal assessment and admission or an outpatient appointment.

2.1.2.1 COMMUNICATION

STANDARD 62

The need for interpreting services should be identified at the point of referral, and assessment should not be delayed by waiting for a face-to-face interpreter.

This will allow arrangements to be made for appropriate interpreting services to be available and avoids reliance on family members. It is suggested that a face-to-face interpreter, if required, is present for an unscheduled admission. As a minimum a telephone-based service should be offered for the initial assessment and a face-to-face interpreter within 12 hours of admission.

However, in the case of emergency care, the use of family members may be acceptable if it allows more rapid assessment and treatment and the family member is in agreement.

If a woman declines an interpreter, this should be documented in the notes. A telephone interpreter should be used to emphasise why an interpreter is needed and the implications for her subsequent care. In particular how the lack of an interpreter may impair the ability of the team to undertake definitive, life-saving emergency treatment, such as hysterectomy, if they have doubts about her understanding or ability to give consent due to language barriers.

Each woman should have a named consultant gynaecologist responsible for their overall care during their admission. For women who are already admitted into hospital under the care of another specialty, it should be clear to both the woman and the admitting specialty, when a transfer of care takes place and when this is just specialist input into her care. This should be documented in the hospital notes.

2.1.2.2 PATIENT INFORMATION

Information should be displayed in waiting areas showing the patient pathway through the unit. Ideally information should be available as to waiting times and women updated about any likely delays to their care.

STANDARD 63

Women attending an acute assessment or triage unit should be provided with verbal and written information about the purpose of the unit and what to expect during the initial episode.

2.1.2.3 CONSENT AND CONFIDENTIALITY

As in all areas of gynaecology, a woman's confidentiality should be respected with particular emphasis on not divulging information to family members without the woman's consent (see Standards 16 and 17 for more information).

2.1.2.4 ACCESSIBILITY

The priority of urgent and emergency services in the organisation should be made explicit, including a commitment to prioritise unscheduled work over elective cases.³⁵

STANDARD 64

All women should be able to access their local Early Pregnancy Unit (EPU) within 24 hours of concern being raised.

This may be telephone access or physical attendance. The optimal provision of an EPU service is one across seven days of the week.³⁶ The provision of a weekend service may require the sharing of service provision between different EPU units on a rotational basis.

All women requiring emergency contraception should be seen within 72 hours.

STANDARD 65

There must be agreed pathways so that it is clear to GPs, emergency medicine staff and hospital switchboards how to refer women with early pregnancy problems.

2.1.2.5 ENVIRONMENT

Gynaecology emergencies should be evaluated in an appropriate clinical setting by a member of the gynaecology on call team prior to admission to the gynaecology ward.

STANDARD 66

There must be adequate privacy provided within the assessment area.



2 Unscheduled care

This includes for both history taking and examination, including vaginal examination.

Within this assessment unit, the following should be available:

- **Point of care urine pregnancy tests and urinalysis.**
- **Speculums and functional lighting.**
- **Swabs for urogenital microbiology samples.**
- **Vaginal packs.**

There should be adequate provision of toilet facilities.

Where women are assessed with pain and bleeding in early pregnancy, this should be done in a setting which has immediate access to medical staff. This may be within the emergency department or the gynaecology ward or the gynaecology assessment unit that is appropriately staffed and resourced with reliable immediate access to a member from the gynaecology medical team.

2.1.3 REFERRAL AND TRIAGE

The on-call gynaecology consultant must be updated on all unscheduled referrals at a minimum of every 14 hours.³¹ It must be clear to primary care, emergency department staff and hospital switchboards which member of the gynaecology team is available to accept referrals.

Women must be referred to the gynaecology team according to local protocols. If women are bleeding heavily, or have evidence of respiratory or circulatory collapse, they must be admitted directly to the emergency department for resuscitation, assessment and triage. There should be a system in place to urgently contact the on-call gynaecology team for these women, e.g. emergency call system and a clear escalation plan, should they not be immediately available.

2.1.4 SAFETY

There should be appropriate transfer of information at the point of referral. Please see Standards 59 and 60.

2.1.4.1 HANDOVER

STANDARD 67

There must be both a verbal and written handover of care whenever a woman is transferred between clinical areas.

Handover should use a recognised tool such as the SBAR format. Ideally handover should be multi-professional and involve all the team.

STANDARD 68

All women on an unscheduled pathway should be discussed at the handover.

An electronic or paper record should be kept of all women having an episode of unscheduled care and discussed at each handover between shifts. This must include women under the care of the gynaecology team on outlying wards, women in high dependency and critical care beds, women under the care of other specialties requiring gynaecology input and women being managed as outpatients.

The on-call gynaecology consultant must be made aware of referrals from other specialties and involved in the management plan.

2.1.4.2 STAFFING LEVELS

There must be sufficient staff allocated to see unscheduled care patients throughout a 24-hour period. Staffing will vary depending on the size and activity of the unit. As a minimum there should be a first on-call doctor or an advanced non-medical practitioner with a similar level of skill immediately available. A higher specialty doctor in gynaecology (ST3 or above) or equivalent and/or a consultant should be available, if required, within 30 minutes.

In smaller units the first on-call review may be by a doctor working in another surgical specialty through shared care and the hospital at night system. However, systems must be in place for the woman to be immediately discussed with a more senior gynaecologist (ST3 or above) or reviewed by them within an appropriate time frame which may be guided by the NEWs score and other clinical information. See Standard 69.

Similarly, there must be sufficient nursing and healthcare assistants to triage women as they are admitted, care for them and to chaperone and assist the medical staff.

In all parts of the UK, the provision of treatment to save the life or to prevent grave permanent injury to the physical or mental health of a pregnant woman which always overrides any other legal or ethical consideration, and the statutory protections for HCPs who have a conscientious objection to participating in abortion does not "affect a duty to participate in treatment which is necessary to save the life or to prevent grave permanent injury to the physical or mental health of a pregnant woman".³⁷



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2.1.4.3 SUPERVISION

Doctors and advanced non-medical practitioners providing first on-call care should have direct access to a consultant at all times. In the majority of units, they will also have direct access to a doctor with the competencies of ST3 or above.

Similarly, where nursing or support staff undertake advanced roles such as ultrasound examinations, they should have direct access to a senior gynaecologist (ST5 or above) should problems arise.

2.1.5 CLINICAL GOVERNANCE

Clinical audit should be carried out according to a rolling programme set out by the speciality. Auditable standards include:

- **Number of referrals received according to local protocols.**
- **Documented handover of care between specialties.**
- **Handover of care at each shift change.**

A review of service provision should address patient satisfaction with:
- **The information provided on need for and referral to a named service.**
- **The availability of additional information prior to the initial contact if required by provision of a contact number or other method of obtaining advice.**
- **Time waiting for first contact.**
- **The clinical environment including privacy for waiting.**
- **The information provided on initial contact.**

2.2 INITIAL ASSESSMENT

2.2.1 RATIONALE

The emergency gynaecology service should be consultant led, with decision-making made in a timely manner, and at a sufficiently senior level.

Survivors of female genital mutilation (FGM) should have ready access to high-quality multi-agency care. FGM services should provide patients with the opportunity for high-quality health care and the opportunity to consider the need for safeguarding any women and girls in the family unit, and to initiate a suitable multi-agency response which includes the police and social services.

STANDARD 69

All emergency admissions must be seen by a consultant gynaecologist within 14 hours.³¹

2.2.2 PATIENT FOCUS

There needs to be a focus on patient-centred care and despite the urgency of care, an attempt should be made for any plans to be made through shared decision making.

2.2.2.1 COMMUNICATION

STANDARD 70

Women attending the gynaecology unit should be introduced to a named member of staff who will be responsible for their initial assessment.

For acute assessment and early pregnancy units, there should be a clear reception area where women or their carers can announce their arrival. The unit should be clearly signposted from all points of entry into the organisation. Women should be introduced to a named member of staff who will be responsible for their initial assessment.

Women referred for specialist gynaecological opinion from other specialities should be seen and assessed by a second on-call gynaecologist as a minimum. Where the woman can be managed on an existing care pathway (e.g. early pregnancy) this should be followed. Following initial assessment, it should be agreed if care is to be transferred to the care of the gynaecology team or if the woman should continue under the care of her current healthcare professional. The woman should be informed of this decision and the plan documented in the medical records.

2.2.2.2 PATIENT INFORMATION

STANDARD 71

A working diagnosis should be presented to the woman within 24 hours of admission.

This should include whether or not she is likely to need a surgical procedure or other intervention. Where a diagnosis has not been reached then a plan of further investigation and/or referral should be made and shared with the woman within the same timeframe. This should be supplemented with written information wherever possible as for the elective patient pathway.



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2.2.2.3 CONSENT AND CONFIDENTIALITY

Care must be taken around confidentiality as in an unscheduled presentation the woman may be accompanied by people who are not close family or friends. The woman should be asked who she wishes to remain with her for the consultation and examination, and this should be documented in the notes.

Examination should be with verbal consent, chaperoned and within a private area even outside of a dedicated gynaecology area. This may involve moving the woman into a side room or treatment room for the examination or, if not possible, at least ensuring that only clinical staff and other patients are in the immediate vicinity, and staff may need to ask visitors to leave the area temporarily.

2.2.2.4 ACCESSIBILITY

STANDARD 72

An acute gynaecological service should be available 24 hours a day and seven days a week.

The majority of emergency gynaecology relates to the diagnosis and management of early pregnancy complications. Where possible and appropriate, such referrals should be managed via an early pregnancy unit (EPU). The composition of an EPU, the services provided, protocols for diagnosis and management, etc. are described by the Association of Early Pregnancy Units (AEPU) and should be adopted where appropriate.

2.2.2.5 ENVIRONMENT

There must be appropriate and adequate facilities for patient care available throughout the patient pathway. This includes a private room for history-taking and intimate examination, the provision of chaperones and adequate toilet facilities, especially for women who are bleeding.

If unscheduled gynaecological patients are seen in an accident and emergency department without access to gynaecological services or admissions, then there must be policies in place to enable safe transfer to the gynaecological unit, rapid access ambulance service and direct communication to the admitting unit.

2.2.3 SAFETY

STANDARD 73

Women should be triaged by a healthcare professional within 15 minutes of arrival in the unit in order to prioritise their care.

STANDARD 74

The initial assessment must include a full set of physiological observations plotted on an early warning chart (e.g. NEWS).

The frequency of subsequent observations will be determined by the initial score but, as a minimum for an unwell woman, this should be every four hours until a full assessment has taken place and a plan of care has been made. Any abnormal observations should be escalated to the appropriate healthcare professional according to local guidelines.

Women should be told not to eat or drink (including chewing gum) until a full initial review has taken place. This is to ensure that where surgery is required, patient safety is increased by optimising the fasting time prior to anaesthesia.

All women should have a venous thromboembolism (VTE) risk assessment completed within 24 hours of admission and repeated every 48 hours. The assessment should include an assessment of the bleeding risks and take into account the potential need for urgent surgery.

2.2.3.1 HANDOVER

All women should be included in the handover of care at each change of medical staff. This should include:

- **Women in the acute gynaecology unit.**
- **Women awaiting admission to the unit.**
- **Women under the care of the gynaecology team in other wards and clinical areas.**
- **Women in other clinical areas who need or have already had a gynaecological opinion or review.**
- **Women being managed as out-patients.**

If the diagnosis is of a non-gynaecological condition, e.g. appendicitis, there must be pathways in place for liaison with other specialties.

Handover should be documented electronically or on paper.

2.2.3.2 STAFFING LEVELS

Each department should appoint a consultant(s) to take responsibility and leadership of the emergency gynaecology services, overseeing the early pregnancy unit, emergency gynaecology clinics/ambulatory emergency gynaecology as well as the



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provision of theatre time with adequate equipment and staffing.

There should be a minimum of two healthcare professionals present at all times on the unit, including during meal breaks, of which one should be qualified staff.¹² There should be sufficient staff to ensure there are no delays in the woman's journey, such as waiting for a chaperone or waiting for blood tests to be taken.

STANDARD 75

A first on-call doctor or equivalent should be immediately available at all times to look after the woman when required. A gynaecologist with the competencies to be second on-call (ST3 or above) should be available within 30 minutes at all times in case of the need for emergency surgery.

During normal working hours in units with over 2500 births/year, a dedicated higher specialty doctor (ST3 competencies or above) and/or consultant gynaecologist should be immediately available.³⁸ Outside normal working hours, where the acute team cover both obstetrics and gynaecology, there should be a clear escalation policy in the event that urgent interventions are required simultaneously.

2.2.3.3 SUPERVISION

Trainees should have direct access to a consultant for advice, to review unwell women and for surgical interventions. The consultant should be informed of any decision to take a woman to theatre for emergency surgery.

STANDARD 76

Women scoring four or more on their NEWS must be seen promptly by a member of the gynaecology team, with the competencies of ST3 or above and discussed with the consultant.

If her condition deteriorates, the initial score is seven or more, or she fails to respond to treatment, then local referral systems should be in place for early referral to the critical care outreach team and the consultant gynaecologist must attend the patient within one hour.

For patients who are stable and with low NEWS scores, see standard 69.

Medical students may see women in the acute setting and assist in theatre but consent for examination should be sought as described in Standards 16 and 17.

2.2.4 ORGANISATION OF SERVICES

If the woman is admitted by a first on-call doctor or equivalent, the woman must be discussed with and ideally reviewed by a doctor with the competencies of an ST3 or above, prior to discharge. The higher specialty doctor or equivalent responsible for women on the unit should be aware of all women admitted and updated as to their condition at least at every handover of medical care. This is to avoid unnecessary admissions, avoid any delays in discharge and to ensure unwell women are reviewed by suitably experienced medical staff.

Once transferred from the acute area of the hospital to a general ward patients should be reviewed during a consultant-delivered ward round at least once every 24 hours, seven days a week, unless it has been determined that this would not affect the patient's care pathway.

Laboratory and imaging diagnostic capabilities should be readily available as determined by the clinical condition. Availability of transabdominal and transvaginal ultrasound examination by appropriately trained and experienced healthcare personnel should be available within 24 hours of admission.

STANDARD 77

Unscheduled admissions to gynaecology services should be reviewed by a suitably trained member of staff before discharge home.

In some circumstances, this may be a member of the nursing staff with enhanced experience and training or skills such as an early pregnancy nurse or an advanced practitioner in gynaecology. They should work according to set protocols and have direct access to a gynaecologist (higher specialty doctor or consultant), should they require additional advice or input, i.e. an experienced nurse practitioner should not take advice from a doctor with the competencies of a core specialty trainee regarding discharge home.

2.2.4.1 SKILL MIX

During normal working hours, a core and a higher specialty doctor should be available for gynaecology supported by a consultant. Trainees working at the level of a core specialty doctor may be a trainee in another specialty training programme, e.g. general practice or in a foundation training programme. In smaller units this role may be shared between both obstetrics and gynaecology.



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Out of hours, there should be a doctor, equivalent of a core specialty doctor, immediately available to review any unwell woman. In the smallest units this may involve sharing the role with other specialities, e.g. in 'the hospital at night'. Where this occurs there must be a clear escalation policy to call the higher specialty doctor or consultant to ensure that the patient is seen and assessed in a timely manner.

2.2.4.2 EDUCATION AND TRAINING

Where training in gynaecology is provided, there should be adequate opportunity for all levels of trainees to assess unscheduled admissions, discuss care with a senior gynaecologist, to complete workplace-based assessments and to undertake operative procedures under direct supervision at least during normal working hours.

2.2.5 CLINICAL GOVERNANCE

Clinical audit should be carried out according to a rolling programme set out by the speciality. Auditable standards include:

- **Number of women triaged within 15 minutes of arrival.**
- **Number of women with recording of full NEWs score.**
- **Number of women seen within appropriate time frames by a consultant.**

A review of service provision should address patient satisfaction with:

- **Waiting time to be seen and assessed.**
- **Waiting time for discharge from the Unit.**
- **Waiting environment.**
- **Confidence in the healthcare team providing initial care.**
- **The amount and quality of information provided.**
- **Contact details for additional advice and information after leaving the clinic.**

In addition a clinical incident report should be generated for:

- **Unavailability of a senior gynaecologist to review a woman with a raised NEWs score within an appropriate timeframe.**

2.3 TREATMENT

2.3.1 RATIONALE

Provision of unscheduled in patient gynaecological care will be similar in many respects to that of elective treatments. However, not all women admitted will require surgery but they do need a plan of care and timely discharge. This may include admission for further investigation or treatment, referral to other specialties or discharge from the unit.

Where surgery is planned it must be safe, timely, and necessary that the woman is fully informed of the procedure, risks and consequences. There should be shared decision-making where clinical condition and time constraints allow. However, there are additional organisational issues that units must have in place since urgent and emergency anaesthesia and surgery comprises an estimated 40-50% of the surgical workload in the UK but accounts for up to 80% of all adverse outcomes, and consumes disproportionate resources.¹

2.3.2 PATIENT FOCUS

STANDARD 78

All unscheduled admissions should have a plan of care documented as to the next stage of treatment.

The aim of any initial management for unscheduled admissions should be stabilisation followed by any further investigations required to reach a working diagnosis. Subsequent management of gynaecological conditions may involve no treatment, a period of observation, medical treatment or surgical treatment. Surgical procedures may involve minor procedures under local anaesthesia (e.g. manual vacuum aspiration for miscarriage) as well as formal procedures under general anaesthetic.

Wherever possible, non-operative options of management should be offered in order to reduce risks of surgery, hospital acquired infections, wait for theatre lists, longer recovery time. Where a patient has been fasting and a decision is made not to operate, the patient should be offered something to eat and drink.

STANDARD 79

Women admitted and undergoing unscheduled surgery, should undergo an equivalent process to those admitted electively before anaesthesia is induced.



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The patient's clinical condition may necessitate a change in process in order to reduce delay. Appropriate checks should be in place so that this does not compromise patient safety.

STANDARD 80

Anaesthetic preoperative assessment should take place as early as possible for those women where surgery is a likely outcome.

This will usually be by the duty anaesthetic team.³

Women should be optimally resuscitated before emergency surgery with early involvement of critical care services.

When further active management is likely to be futile, senior clinicians should discuss limits to care, including end-of-life pathways both with the woman and/or relatives, and preferably with all relevant specialties. Clear documentation is essential, and limits to care including 'DNR' should be regularly reviewed.

2.3.2.1 COMMUNICATION

STANDARD 81

Decision to operate may have to be made on an urgent basis but whenever there is time, the woman must be given sufficient information to agree to proceed to surgery.

The need for an independent interpreter should have been considered earlier as described in Standard 62.

2.3.2.2 PATIENT INFORMATION

The degree of urgency for treatment should not lessen the amount of information given to the woman about her care. See Standard 63 for more on patient information in unscheduled care.

2.3.2.3 CONSENT AND CONFIDENTIALITY

Care should be taken to respect confidentiality as described in section 2.2.2.3.

As in other areas, women should be seen in private by a member of the healthcare team and asked about domestic violence at each contact with secondary care.³⁹ The same standards for consent apply as for women undergoing scheduled treatment and the woman has the right to give or withhold consent to examination, investigation or treatment. If the woman is unable to give consent due to being incapacitated (e.g. unconscious), and requires emergency surgery to save her life, then a senior clinician should conduct the operation in her best interest. The reasons why treatment was

necessary must be fully explained when the woman has recovered.

It is good practice to keep her family informed but they cannot legally give consent for her.

Girls under the age of 16 can give consent if they fulfil the Fraser competency requirements but should be encouraged to explain the surgery to their parents.

2.3.2.4 ACCESSIBILITY

Treatments for all gynaecological emergencies should be provided at the site of admission.

Where care cannot be provided in the local unit, arrangements must be in place for the safe transfer of the woman to a unit providing that treatment.

Where not provided, the woman should be re-directed at the point of initial referral or following initial assessment.

All units should be implementing ambulatory outpatient-based emergency gynaecology services as an alternative to an operative theatre procedure. This should include medical management of miscarriage and ectopic pregnancy and outpatient manual vacuum aspiration for miscarriage.

STANDARD 82

Most unscheduled gynaecological surgical procedures can be performed during daytime hours.

This reduces the risk of out-of-hours operating for women.⁴⁰ Departments must organise daytime unscheduled gynaecology theatre operating – the number of lists available per week will depend on the volume of emergency cases.

There must be access to emergency theatre out-of-hours for women with life-threatening conditions.

2.3.2.5 ENVIRONMENT

Women admitted under the care of a gynaecologist should be in a female-only ward. There should be a private area available for intimate examinations as a minimum and ideally also for consultation. There should be ready access to toilets and bathroom facilities dedicated to female patients. The woman should be orientated to the unit and told where to find the appropriate facilities.

STANDARD 83

A hospital receiving emergency gynaecology patients requiring anaesthesia must have 24-hour availability of a staffed and dedicated emergency operating theatre and access to critical care and high-dependency beds if required.



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Where unscheduled procedures are required, a decision should be made as to the urgency of the treatment and where possible arranged to take place within a scheduled session, e.g. added to an elective list, booked onto a daytime emergency list.

There must be appropriate equipment available to perform vaginal examinations and to obtain urogenital microbiology samples. There should be access to equipment for minor procedures such as MVAs and drainage of Bartholin's cysts and these services should be offered as day cases. Systems must be in place for the sensitive disposal of any pregnancy tissue obtained whether at examination, during surgery or presented by the woman herself. The woman must sign written consent for any histological examination of pregnancy tissue. She must be clearly informed verbally and in writing what the options are for disposal of the tissues and who to contact to make arrangements.

In the theatre area, there should be equipment in order to perform the majority of pelvic procedures laparoscopically, provided the surgeon is familiar with the equipment and has the technical ability.

There should be appropriate equipment available within each organisation to care for women with morbid obesity. This includes appropriate beds, trolleys, operating tables and equipment for women with morbid obesity.

Clearly signed and appropriate blood storage facilities need to be in close proximity to the emergency operating theatre. There should be policies in place for the safe and rational use of blood and blood products¹⁸⁻²² and appropriate equipment immediately available for rapid transfusion.

2.3.3 SAFETY

2.3.3.1 HANDOVER

Emergency gynaecology cases requiring theatre should be discussed with the on-call gynaecology consultant.

STANDARD 84

The care of unscheduled patients must be handed over between shifts.

Handover should use a recognised communication tool such as SBAR (situation, background, assessment, recommendation) and there should be either written information or electronic information produced.

STANDARD 85

There must be a formal protocol for ensuring that the gynaecological team are informed of and review all gynaecology patients that are outlying away from gynaecological wards.

The current location of the woman should be noted if they are not within the gynaecology unit and a daily review undertaken on all women under the care of gynaecology. Attempts should be made to re-locate gynaecology patients to a gynaecology ward as soon as possible in order that they can receive specialist nursing care as well as medical input.

The gynaecologist who is going to perform the emergency surgery must see the woman before she is anaesthetised and familiarise themselves with the case and the consent if it has already been signed.

STANDARD 86

The WHO surgical safety checklist must be completed in theatre for unscheduled procedures.

The pre- and post-operative care arrangements must be appropriate to enable recognition of and adequate response to the acutely ill woman.⁵

2.3.3.2 STAFFING LEVELS

STANDARD 87

Every woman should be reviewed on a daily basis by a gynaecologist (ST3 or above).

Once transferred from the acute area of the hospital to a general ward patients should be reviewed during a consultant-delivered ward round at least once every 24 hours, seven days a week, unless it has been determined that this would not affect the patient's care pathway. Whilst it is good practice for the woman to be reviewed daily by a consultant, this is analogous to routine post-operative care described in Standard 50.

The clinical condition of some women will require a more frequent review or escalation of referral to senior medical staff. A defined referral pathway should be available to nursing and junior medical staff.

During a normal working day, the review should be by the on-call consultant or consultant responsible for the overall care of the woman, along with the other members of the medical team responsible for her care. This will facilitate appropriate decision-making and timely interventions and discharge. The case record



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should reflect the medical review and plan of care for the next 24 hours.

The urgent and emergency gynaecology theatre must be staffed by nurses who are familiar with gynaecology procedures and with the necessary equipment, particularly laparoscopic.

2.3.3.3 SUPERVISION

Daytime urgent and emergency gynaecology theatre lists should have an allocated consultant, and a specialty doctor or trainee.

STANDARD 88

Trainees should have direct access to a named duty consultant at all times.

This access ranges from a consultant being physically present in the theatre or on the Unit to telephone access. If the duty consultant is not present in theatre, they must be readily available and on site. The degree of supervision is dependent on the individual trainee's competencies. Trainees must have been assessed as competent to manage the cases with no direct supervision or assistance (level 3) for the specific operations, to be left without a consultant present in theatre. Careful consideration should be given to the co-morbidities of the woman as this will affect the trainee's ability to perform the procedure safely.

Trainees have to acquire certain skills early in their career, e.g. surgical completion of miscarriage. Senior trainees can appropriately directly supervise these procedures, with the knowledge of the duty consultant.

2.3.4 ORGANISATION OF SERVICES

2.3.4.1 SKILL MIX

The skill mix and the staffing should be the same as for the scheduled patient pathway.

2.3.4.2 EDUCATION AND TRAINING

Where trainees are allocated to emergency gynaecological theatre lists, sufficient time must be allowed for training and for them to complete their curriculum requirements providing it does not compromise patient safety.

Unscheduled care is also an opportunity for trainees to learn the non-technical skills required including communication, time management and team working.

2.3.5 CLINICAL GOVERNANCE

Gynaecologists who perform unscheduled surgery should be able to demonstrate their competency at the procedures they perform. This will be by continuous personal audit of the number of different procedures and log of outcomes (when possible as many women are now not seen for hospital review), any complications, readmissions, return to theatre and complaints.

Clinical audit should be carried out according to a rolling programme set out by the speciality.

Auditable standards include:

- **Medical handover at each change of shift.**
 - **Number of women reviewed by an experienced gynaecologist on a daily basis.**
 - **Number of procedures carried out outside normal working hours.**
 - **Number of women having a pre-operative assessment prior to unscheduled surgery.**
 - **Number of women with a documented discussion of risks and benefits of treatment.**
 - **The quality of consent for unscheduled treatment.**
 - **Use of the safer surgery theatre checklist for unscheduled surgery.**
- In addition, a clinical incident report should be generated by:
- **Unavailability of a suitably trained gynaecologist to undertake an operative procedure.**
 - **Lack of available critical care bed when required.**



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2.4 FOLLOW-UP AND DISCHARGE FROM THE SPECIALTY

2.4.1 FOLLOWING AN UNSCHEDULED ADMISSION

STANDARD 89

A clear discharge plan should be made and shared with all the relevant healthcare professionals and the woman herself.

Whether or not the woman was admitted, there should be a clear discharge plan that makes clear the next stage of care, where and when it will be provided and who is responsible for ongoing care.

STANDARD 90

The woman must be given a discharge summary to take home and a copy sent to her GP within 24 hours.

The follow-up and discharge of women admitted through the unscheduled pathway is identical to that described within the scheduled pathway in Section 4.

2.4.2 CLINICAL GOVERNANCE

Clinical audit should be carried out according to a rolling programme set out by the speciality. Auditable standards include:

- **The number of women where the GP receives a discharge summary within 24 hours of discharge.**
- **The number of women discharged on the day planned and any reasons for a delay explored.**
- **The availability of discharge medications.**



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STANDARD 91

Local gynaecology departments must have referral pathways to specialist services or for management of complex gynaecological problems.

There are a number of areas within gynaecology where specialist services should be available to support the general gynaecologist (Table 1). Women presenting with complaints requiring these specialist gynaecological services should have the same access to high-quality services regardless of where they live within the UK and uniform access should be ensured. This may involve travel to another unit or an outreach clinic in the local unit. The need for and place of referral should be discussed and agreed with the woman and documented in the notes.

STANDARD 92

Individualised referral pathways must be agreed for each unit.

Availability of these specialist services will vary in each region and unit and referral pathways will vary according to local practice and the availability of local expertise.

3.1 EXAMPLE MODELS OF CARE

3.1.1 GENERAL GYNAECOLOGICAL TRIAGE

For many areas of specialist gynaecology it may be appropriate that women are seen, assessed and initial management started within general gynaecological services. Women who require more specialist care can then be referred on as appropriate. This approach is appropriate when it is expected that the general gynaecology team will be able to diagnose and treat a high proportion of women, particularly where national guidelines exist, only having to refer a few on for a more specialist opinion.

3.1.2 DIRECT REFERRAL TO SPECIALIST GYNAECOLOGY SERVICES

With conditions where there is a low probability of successful management in general gynaecology services, it may be appropriate for the primary referring clinician to refer the woman directly to specialist gynaecological services.

Where specialist gynaecological services are not available in every unit, a hub and spoke model of care should be used to ensure access to services. It is not expected that hub units will take on a hub role for all areas of specialist gynaecology as the distribution of local expertise may not allow this. Hence for each area of specialist gynaecology, the hub and spoke units may be different. For example, a hospital may be the hub for urogynaecology and gynaecology oncology and a spoke for vulval disease and paediatric and adolescent gynaecology.

The requirements for the assessment and treatment of women with specialist gynaecological complaints may differ significantly from those set out in this guidance and processes should be tailored to the requirements of each specialist area.

SCHEDULED

- Advanced Laparoscopic Surgery for the Excision of Benign Disease
- Urogynaecology
- Subfertility and Reproductive Medicine
- Menopause
- Sexual and Reproductive Health
- Gynaecology Oncology
- Vulval Disease
- Paediatric and Adolescent Gynaecology
- Abortion care

UNSCHEDULED

- Gestational Trophoblastic Disease
- Forensic Gynaecology/Sexual Assault Referral Centres (Adult and Paediatric)

Table 1. Areas of specialist gynaecological practice



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3.2 FURTHER INFORMATION

Further support and information is available from the resources below and the relevant specialist societies.

3.2.1 ADVANCED LAPAROSCOPIC SURGERY FOR THE EXCISION OF BENIGN DISEASE

1. NHS standard contract for complex gynaecology – severe endometriosis: <https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2014/04/e10-comp-gynae-endom-0414.pdf>
2. Requirements to be a BSGE Accredited Centre: <http://bsge.org.uk/requirements-to-be-a-bsge-accredited-centre/>

3.2.2 UROGYNAECOLOGY

1. National Institute for Health and Care Excellence (NICE) Clinical Guidance 171 – Urinary incontinence in women: <https://www.nice.org.uk/Guidance/CG171>
2. Bristol Urological Institute (BUI): <https://www.nbt.nhs.uk/bristol-urological-institute>
3. NICE Clinical Guidance 148 – Urinary incontinence in neurological disease: <http://guidance.nice.org.uk/CG148>
4. British Society for Urogynaecology (BSUG) – Standards for service provision in urogynaecology units: <http://bsug.org.uk/accreditation-of-units.php>
5. The British Associate of Urological Surgeons (BAUS) & The Royal College of Surgeons (RCS) – Commissioning guide: Lower urinary tract symptoms: <http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/luts>
6. Scottish Intercollegiate Guidelines Network (SIGN) – Management of suspected bacterial urinary tract infection in adults: <http://www.sign.ac.uk/pdf/sign88.pdf>
7. NICE Quality Standard 36 – Urinary tract infection in infants, children and young people under 16: <https://www.nice.org.uk/Guidance/QS36>
8. NICE Quality Standard 90 – Urinary tract infection in adults: <https://www.nice.org.uk/guidance/qs90>
9. NICE Quality Standard 77 – Urinary incontinence in women: <https://www.nice.org.uk/guidance/qs77>
10. NHS standard contract for complex gynaecology – urogenital and anorectal conditions: <http://www.england.nhs.uk/>

[wp-content/uploads/2013/06/e10-comp-gynae-urogenital.pdf](http://www.england.nhs.uk/wp-content/uploads/2013/06/e10-comp-gynae-urogenital.pdf)

11. NHS standard contract for complex gynaecology – recurrent prolapse and urinary incontinence, particulars: <http://www.england.nhs.uk/wp-content/uploads/2013/06/e10-comp-gynae-recur-pro-urina-incon.pdf>
12. NHS standard contract for complex gynaecology – urinary fistulae: <http://www.england.nhs.uk/wp-content/uploads/2013/06/e10-comp-gynae-urin-fistulae.pdf>
13. NICE support for commissioning for urinary tract infection in infants, children and young people under 16: <https://www.nice.org.uk/guidance/qs36/resources/support-for-commissioning-for-urinary-tract-infection-in-children-and-young-people-253629757>

3.2.3 SUBFERTILITY AND REPRODUCTIVE MEDICINE

1. Human Fertilisation & Embryology Authority (HFEA) – Multiple births from fertility treatment in the UK: a Consensus statement: http://www.hfea.gov.uk/docs/2011-05_Multiple_Births_Consensus_Statement_-_FINAL.pdf
2. NICE Clinical Guideline 156 – Fertility problems: Assessment and treatment: <http://www.nice.org.uk/guidance/CG156>
3. NICE Quality Standard 73 – Fertility problems: <https://www.nice.org.uk/guidance/qs73>
4. NHS England – Interim Clinical Commissioning Policy: Assisted Conception: <http://www.england.nhs.uk/wp-content/uploads/2013/11/N-SC037.pdf>
5. Department of Health – Regulated fertility services: a commissioning aid http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_101068.pdf
6. RCOG & British Fertility Society (BFS) Standards in the Care of the Infertile <https://britishfertilitysociety.org.uk/press-release/standards-in-the-care-of-the-infertile/>
7. RCOG Green-top Guideline No. 5 – Ovarian Hyperstimulation Syndrome, Management: <https://www.rcog.org.uk/en/guidelines-research-services/guidelines/gtg5/>



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3.2.4 MENOPAUSE

1. British Menopause Society (BMS) – Hormone Replacement Therapy Consensus Statement: <http://thebms.org.uk/clinical-statements/consensus-statements/hormone-replacement-therapy/>
2. NICE Guideline 23 – Menopause: diagnosis and management: <https://www.nice.org.uk/guidance/ng23>
3. BMS – Non-estrogen based treatments for menopausal symptoms: <http://thebms.org.uk/clinical-statements/consensus-statements/non-estrogen-based-treatments-for-menopausal-symptoms/>
4. BMS – Premature Menopause: <http://thebms.org.uk/clinical-statements/consensus-statements/premature-menopause/>

3.2.5 GYNAECOLOGY ONCOLOGY

1. NICE Clinical Guidance 122 – Ovarian cancer: recognition and initial management: <http://www.nice.org.uk/guidance/cg122>
2. NICE Quality Standard 18 – Ovarian Cancer: <http://www.nice.org.uk/guidance/qs18>
3. NHS Commissioning Board – Service specification No.11 Human papillomavirus (HPV) immunisation programme: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213161/11-HPV-specification-121024.pdf
4. NHS standard contract for complex gynaecology – specialist gynaecological cancers: <https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2014/04/e10-cancer-gynae-0414.pdf>
5. RCOG Green-top Guideline No. 62 – Management of Suspected Ovarian Masses in Premenopausal Women: <http://www.rcog.org.uk/womens-health/clinical-guidance/ovarian-masses-premenopausal-women-management-suspected-green-top-62>
6. British Gynaecological Cancer Society (BGCS) & RCOG – Guidelines for the diagnosis and management of vulval carcinoma: <https://www.rcog.org.uk/globalassets/documents/guidelines/vulvalcancerguideline.pdf>

3.2.6 VULVAL DISEASE

1. British Society for the Study of Vulval Disease (BSSVD) Guideline Group – Guidelines for the management of vulvodynia: <http://onlinelibrary.wiley.com/doi/10.1111/j.1365-2133.2010.09684.x/epdf>
2. BSSVD – Pathways of vulvar intraepithelial neoplasia and squamous cell carcinoma: <http://www.ncbi.nlm.nih.gov/pubmed/23190170>
3. BSSVD – Vulval Lichen Sclerosus Guidance for Healthcare Professionals: <http://emuevents.co.uk/BSSVD/documents/Lichen%20Sclerosus%20management.pdf>
4. British Association for Sexual Health & HIV (BASHH) and RCOG – UK National Guideline on the Management of Vulval Conditions: <http://www.bashh.org/documents/UK%20national%20guideline%20for%20the%20management%20of%20vulval%20conditions%202014.pdf>
5. British Gynaecological Cancer Society (BGCS) & RCOG – Guidelines for the diagnosis and management of vulval carcinoma: <https://www.rcog.org.uk/globalassets/documents/guidelines/vulvalcancerguideline.pdf>

3.2.7 PAEDIATRIC AND ADOLESCENT GYNAECOLOGY

1. The British Society for Paediatric & Adolescent Gynaecology (BritSPAG) – Clinical Standards for Service Planning in PAG: <http://www.britspag.org/sites/default/files/downloads/authenticated/others/Standards%20in%20PAG%20final%20draft.pdf>
2. NHS standard contract for complex gynaecology – congenital gynaecological anomalies: <https://www.england.nhs.uk/wp-content/uploads/2013/06/e10-comp-gynae-congen-gynae-anomalies.pdf>



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3.2.8 GESTATIONAL TROPHOBLASTIC DISEASE

1. RCOG Green-top Guideline No. 38 – Gestational Trophoblastic Disease: <https://www.england.nhs.uk/wp-content/uploads/2013/06/e10-comp-gynaecongen-gynaec-anomalies.pdf>
2. NHS service specification for Gestational Trophoblastic Disease: <https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/01/e10-serv-spec-gestatnl-trphlstic-disease.pdf>

3.2.9 FORENSIC GYNAECOLOGY

1. NHS Commissioning Board – Service specification No.30: Sexual assault services: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213172/30-Sexual-Assault-Services-specification-121029.pdf

3.2.10 SEXUAL AND REPRODUCTIVE HEALTH/ COMPLEX CONTRACEPTION

1. Faculty of Sexual and Reproductive Health (FSRH) – Quality standards for contraceptive services: <https://www.fsrh.org/documents/fsrhqualitystandardcontraceptiveservices/fsrhqualitystandardcontraceptiveservices.pdf>
2. FSRH – Service standards for sexual and reproductive healthcare: <https://www.fsrh.org/documents/consultation-service-standards-for-sexual-and-reproductive/service-standards-for-srh-consultation.pdf>
3. NICE Quality Standards for Contraceptive Services: <https://www.nice.org.uk/guidance/gid-qsd132/documents/draft-quality-standard>

3.2.11 ABORTION CARE

1. RCOG Evidence-based Clinical Guideline No. 7 – The Care of Women Requesting Induced Abortion: https://www.rcog.org.uk/globalassets/documents/guidelines/abortion-guideline_web_1.pdf
2. Department of Health – Guidance in Relation to Requirements of the Abortion Act 1967 for all those responsible for commissioning, providing and managing service provision: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/313459/20140509_-_Abortion_Guidance_Document.pdf



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