NHS
Bristol, North Somerset and South Gloucestershire
Integrated Care Board

Reference: FOI.ICB-2324/157

Subject: Community Services

*I can confirm that the ICB **does hold some of the information requested**; please see responses below:*

QUESTION	RESPONSE
Please refer to documents enclosed.  Appendix 1 - HVS Reporting 2021-22.x  Appendix 2 - HVS Reporting 2022-23.x  Appendix 3 - Vasectomy Service S|	

The information provided in this response is accurate as of 5 September 2023 and has been approved for release by Sarah Truelove, Deputy Chief Executive and Chief Finance Officer for NHS Bristol, North Somerset and South Gloucestershire ICB.

	Do you have this Community Service? (please tick all that apply)	Type of contract: Block, cost/volume, other (please detail)	Volume of activity (to nearest 1000) for 2021-22	Volume of activity (to nearest 1000) for 2022-23	Contract Value 2021-22	Contract Value 2022-23	Contract Value 2023-24	How was the service commissioned (full system or PBP), procurement or other means (ie lead provider, provider collaborative, etc)	What is duration of contract?	Could you please share your pathway and service specification
Community MSK	X	Block	720,000	119,000	*£116,543,538	*£123,027,198	**£142,825,992	Competitive Tender	10 Years – 01/04/2020 – 31/03/2030	Act as an integrated system of care with other services provided elsewhere. Manage and coordinate consistent, timely musculoskeletal care for people registered with a Bristol, North Somerset (NS) or South Gloucestershire (SG) GP. Referrals are accepted from primary care, community services, and secondary care. Bristol and SG MSK physio accepts referrals for people aged 16yrs and above. NS accepts referrals for people aged 5yrs and above Bristol and SG MSK Interface accepts referrals for peopled aged 16+. NS accept referrals for people aged 10+. Bristol MSK foot & ankle accepts referrals for 16+ and SG & NS accept 10+. MSK Interface also provide advice & guidance to health care professionals. Further details are available in the 2022 BNSSG Adult Community Contract.
Community Ophthalmology	BNSSG ICB does not currently commission a Community Ophthalmology service.									

Community Dermatology	X	Block	21/22 Activity = 5000 (4954)	22/23 Activity = 5000 (5009)	*£116,543,538	*£123,027,198	**£142,825,992	Competitive Tender	10 Years – 01/04/2020 – 31/03/2030	
Community Gynaecology	BNSSG ICB does not currently commission a Community Gynaecology service.									
Community Vasectomy	X	Zero Volume (Paid on activity)	*Covered in Appendix 1	*Covered in Appendix 2	£255k	£453k	£410k *(allocated budget)*	Competitive Tender	7 Years - 01/10/2019 – 30/09/2026	*Appendix 3
Termination of Pregnancy	BNSSG ICB is an associate commissioner with Bristol City Council as the contract holder. Please contact Bristol City Council - https://www.bristol.gov.uk/council-and-mayor/data-protection-and-foi/freedom-of-information-foi									
ICB Name:	Bristol, North Somerset & South Gloucestershire									

**Please note the finance figures are for the Sirona Adult's Community block contract which these services sit under*

***2023-24 finance figures subject to final agreement*

	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Totals
New referrals	223	180	114	99	153	**769**
Counselling appts offered	24	102	89	120	97	**432**
Counselling appt cancelled by pt	0	0	0	0	1	**1**
Counselling Cancelled by service	0	0	0	0	1	**1**
counselling DNAs	1	23	15	19	18	**76**
Counselling completed	23	79	60	100	74	**336**
Procedure appts offered	[redacted]	38	52	53	75	**218**
Pre-op assessments	[redacted]	0	0	0	0	**0**
Procedure cancelled by Pt	[redacted]	0	0	1	1	**2**
Procedure cancelled by service	[redacted]	0	0	1	2	**3**
Procedure apt DNA	[redacted]	5	5	7	7	**24**
Procedure Completed	[redacted]	31	48	50	72	**201**

Patients who are referred for whole process

	TARGET	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Totals
Number of new referrals received				182	117	99	155	133	135	100	131	123	127	**1302**
Total number of counselling appt. booked				102	89	120	97	100	127	105	90	78	171	**1079**
Number of initial counselling appt. booked within 6 weeks of receipt of referral												0	0	**0**
% of initial counselling appt. booked within 6 weeks of receipt of referral	100%									0	0	0	0	
Number of initial counselling appt. booked *after* 6 weeks of receipt of referral												78	171	**249**
% of initial counselling appt. booked *after* 6 weeks of receipt of referral										100	100	100	100	
Number of pts waiting for counselling appt. to be booked												367	387	**754**
Total number of counselling appt. completed				79	63	101	79	53	119	86	83	68	160	**891**
Number of counselling appt. cancelled by service				0	0	0	1	33	63	0	0	0	0	**97**
Percentage of counselling appt. cancelled by service - rebooked within 6 weeks of receipt of referral	100%							100	100	n/a	n/a	n/a	n/a	
Number of counselling appt. cancelled by pt				6	8	6	2	5	5	3	3	5	13	**56**
Number of counselling appt. pt DNA (on the day)				23	15	19	18	5	8	20	7	10	10	**135**
Number of pts discharged from counselling service: pt chose not to proceed / DNA appt & did not engage with service within 3 months								2	3	0	0	0	9	**14**
Total number of procedure appt. booked								79	84	71	94	80	80	**488**
Number of procedure appt. completed within 18 weeks of receipt of referral												0	0	**0**
% of procedure appt. completed within 18 weeks of receipt of referral	95%											0	0	
Number of procedure appt. completed *after* 18 weeks of receipt of referral												75	73	**148**
% of procedure appt. completed *after* 18 weeks of receipt of referral												100	100	
Number of pts waiting for procedure appt. to be booked												0	0	**0**
Total number of procedure appt. completed				31	48	50	72	72	66	59	88	75	73	**634**
Number of procedure appt. cancelled by service: clinical reason										0	0	0	0	**0**
Number of procedure appt. cancelled by service: non-clinical reason				0	0	0	1	12	21	0	0	0	0	**34**
Percentage of procedure appts. cancelled by service: non-clinical reason - **rebooked within 28 days**	100%							100	100	n/a	n/a	n/a	n/a	
Number of procedure appt. cancelled by pt				27	33	34	43	42	39	31	42	39	55	**385**
Number of procedure appt. pt DNA (on the day)				5	5	7	7	4	11	5	6	5	8	**63**
Number of pts discharged from procedure service (pt chose not to proceed / DNA appt & did not engage with service within 6 months)								5	2	2	3	6	28	**46**
Number of post vasectomy test completed				92	30	72	120	19	45	33	55	50	48	**564**
Number of post vasectomy 2nd test completed				16	9	22	10	11	20	8	5	8	5	**114**
Number of Warm sample completed				4	7	5	9	4	1	1	6	1	0	**38**

Patients who are referred for PVSA only

	TARGET	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Totals
Number of new referrals received		0	0	0	0	0	0	0	0	0	0	1	0	**1**
Total number of counselling appt. booked												1	0	**1**
Number of initial counselling appt. booked within 6 weeks of receipt of referral												1	0	**1**
% of initial counselling appt. booked within 6 weeks of receipt of referral	100%											100	0	
Number of initial counselling appt. booked *after* 6 weeks of receipt of referral												0	0	**0**
% of initial counselling appt. booked *after* 6 weeks of receipt of referral												0	0	**0**
Number of pts waiting for counselling appt. to be booked												0	0	**0**
Total number of counselling appt. completed		0	0	0	0	0	0	0	0	0	0	0	1	**1**
Number of counselling appt. cancelled by service													0	**0**
Percentage of counselling appt. cancelled by service - rebooked within 6 weeks of receipt of referral	100%												0	**0**
Number of counselling appt. cancelled by pt													0	**0**
Number of counselling appt. pt DNA (on the day)													0	**0**
Number of pts discharged from service: pt DNA appt & did not engage with service within 6 months													0	**0**
Number of post vasectomy test completed													1	**1**
Number of post vasectomy 2nd test completed													0	**0**
Number of Warm sample completed													0	**0**

Patients who are referred for whole process

	TARGET	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Totals
Number of new referrals received		110	141	140	173	131	179	169	146	110	150	155	187	**1791**
Total number of counselling appt. booked		100	148	116	122	146	160	97	176	88	94	86	134	**1467**
Number of initial counselling appt. booked within 6 weeks of receipt of referral		0	0	0	0	0	0	0	0	0	0	0	0	**0**
% of initial counselling appt. booked within 6 weeks of receipt of referral	100%	0%	0	0	0	0	0	0	0	0	0	0	0	
Number of initial counselling appt. booked *after* 6 weeks of receipt of referral		94	148	116	122	146	160	97	176	88	94	86	134	**1461**
% of initial counselling appt. booked *after* 6 weeks of receipt of referral		100	100	100	100	100	100	100	100	100	100	100	100	
Number of pts waiting for counselling appt. to be booked		330	301	280	390	352	440	505	450	511	578	549	666	**5352**
Total number of counselling appt. completed		92	137	101	110	134	155	92	153	82	92	86	133	**1367**
Number of counselling appt. cancelled by service		7	0	10	0	10	0	7	0	12	0	0	0	**46**
Percentage of counselling appt. cancelled by service - rebooked within 6 weeks of receipt of referral	100%	0%	n/a	0	0	0	0	0	0		0	0	0	
Number of counselling appt. cancelled by pt		9	12	6	9	22	15	6	17	5	1	6	7	**115**
Number of counselling appt. pt DNA (on the day)		1	10	4	12	12	5	5	6	6	2	0	1	**64**
Number of pts discharged from counselling service: pt chose not to proceed / DNA appt & did not engage with service within 3 months		see below												
Total number of procedure appt. booked		89	96	83	85	79	93	106	102	69	114	94	148	**1158**
Number of procedure appt. completed within 18 weeks of receipt of referral		0	0	0	0	0	0	0	0	0	0	0	0	**0**
% of procedure appt. completed within 18 weeks of receipt of referral	95%													
Number of procedure appt. completed *after* 18 weeks of receipt of referral		89	96	83	81	75	86	97	102	69	114	94	129	**1115**
% of procedure appt. completed *after* 18 weeks of receipt of referral			100	100					100	100				
Number of pts waiting for procedure appt. to be booked		7	0	0	0	0		17	102	106	65	30	18	**345**
Total number of procedure appt. completed		82	92	79	81	75	86	97	95	66	98	94	129	**1074**
Number of procedure appt. cancelled by service: clinical reason		0	0	0	0	0	0	0	0	0	0	0	0	**0**
Number of procedure appt. cancelled by service: non-clinical reason		0%	0	0	0	0	0	0	0	0	0	0	0	**0**
Percentage of procedure appts. cancelled by service: non-clinical reason - **rebooked within 28 days**	100%	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	
Number of procedure appt. cancelled by pt		54	56	65	53	45	34	52	50	34	17	27	60	**547**
Number of procedure appt. pt DNA (on the day)		7	4	3	4	4	7	9	7	7	4	3	1	**60**
Number of pts discharged from procedure service (pt chose not to proceed / DNA appt & did not engage with service within 6 months)		see below												
Number of post vasectomy test completed		59	46	49	45	80	63	72	53	74	86	97	95	**819**
Number of post vasectomy 2nd test completed		3	10	6	5	9	6	6	4	22	49	49	28	**197**
Number of Warm sample completed		0	1	0	1	2	2	1	0	5	4	0	1	**17**
NEW! Total number of Discharged Patients		152	81	115	79	143	131	122	114	43	154	132	137	**1403**
Care incompleted - DNA		15	4	5	3	8	16	13	5	8	3	5	6	**91**
Does not want procedure		4	20	26	12	15	18	11	10	3	18	10	10	**157**
Procedure successful		62	55	76	51	95	66	89	54	15	98	94	72	**827**
Procedure success not confirmed (patient has not returned PVSA despite 2 chasing letters)		0	0	0	0	20	18	0	32	10	6	1	20	**107**
Moved out of area		1	0	0	1	1	1	0	0	1	0	1	1	**7**
Patient cannot be contacted		69	2	0	7	0	1	2	3	2	20	9	9	**124**
Patient has already been referred into the service		0	0	0	2	1	8	3	3	3	2	2	6	**30**
Patient requires secondary care referral		1	0	0	1	1	0	0	0	0	1	0	1	**5**
Referral incomplete		0	0	0	2	1	3	4	7	1	6	10	12	**46**

Patients who are referred for PVSA only

	TARGET	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Totals
Number of new referrals received		1	0	0	1	0	0	1	0	0	1	0	0	**4**
Total number of counselling appt. booked		**1**	0	0	1	0	0	1	0	0	1	0	0	**4**
Number of initial counselling appt. booked within 6 weeks of receipt of referral		1	0	0	0	0	0	1	0	0	1	0	0	**3**
% of initial counselling appt. booked within 6 weeks of receipt of referral	100%													
Number of initial counselling appt. booked *after* 6 weeks of receipt of referral		0	0	0	0	0	0	0	0	0	0	0	0	**0**
% of initial counselling appt. booked *after* 6 weeks of receipt of referral														

Number of pts waiting for counselling appt. to be booked		0	0	0	0	0	0	0	0	0	0	0	0	**0**
Total number of counselling appt. completed		0	1	0	1	0	0	0	1	0	0	0	0	**3**
Number of counselling appt. cancelled by service		0	0	0	0	0	0	0	0	0	0	0	0	**0**
Percentage of counselling appt. cancelled by service - rebooked within 6 weeks of receipt of referral	100%	0%	0	0	0	0	0	0	0	0	0	0	0	
Number of counselling appt. cancelled by pt		0	0	0	0	0	0	0	0	0	0	0	0	**0**
Number of counselling appt. pt DNA (on the day)		0	0	0	0	0	0	0	0	0	0	0	0	**0**
Number of pts discharged from service: pt DNA appt & did not engage with service within 6 months		0	0	0	0	0	0	0	0	0	0	0	0	**0**
Number of post vasectomy test completed		0	1	0	0	1	0	0	0	1	0	0	0	**3**
Number of post vasectomy 2nd test completed		0	0	0	0	0	0	0	0	0	1	0	0	**1**
Number of Warm sample completed		0	0	0	0	0	0	0	0	0	1	0	0	**1**

NHS
Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Group

SCHEDULE 2 – THE SERVICES

A. Service Specifications

This is a non-mandatory model template for local population. Commissioners may retain the structure below, or may determine their own in accordance with the NHS Standard Contract Technical Guidance.

Service Specification No.	002 April 2019
Service	Non-Scalpel Vasectomy Service – BNSSG CCG
Commissioner Lead	XXXX, Contracts Manager Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group
Provider Lead	
Period	5 years plus a 2 year optional extension
Date of Review	April 2020

1. Population Needs

1.1 National/local context and evidence base

Bristol, North Somerset and South Gloucestershire CCG are a NHS organisation responsible for shaping healthcare services for 900,000 people who are resident in the area and registered with a BNSSG GP. BNSSG CCG is a vibrant, dynamic area with a diverse and growing population the CCG is dedicated to improving the health of local people, reducing health inequalities and ensuring NHS services are fit for the long term. BNSSG CCG are seeking to commission under NHS Standard Contract a vasectomy service as part of the full range of contraceptive options for their patients to be provided in accordance with the Royal College of Obstetricians and Gynaecologists (RCOG) guidelines as a means of reducing unwanted pregnancies.

1. Vasectomy is a procedure that stops sperm from travelling to the testis through the cutting of the vas. It is recommended by the RCOG) as the preferred method of male sterilisation. The minor procedure takes 15 minutes and is very safe in competent hands. The failure rate of vasectomy is very low (1 in 2000 after clearance has been given). Vasectomies carry a lower failure rate (in terms of post-procedure pregnancies) with less risk related to the procedure, than female sterilisation.
2. Discussion of sterilisation is a routine part of contraceptive advice offered by health professionals. Vasectomy is indicated when a man wishes to make a permanent and irreversible decision that they should never subsequently conceive a child of their own. It is a voluntary act with the request coming from the man wishing to be rendered infertile and the procedure may be offered irrespective of age or marital status.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	**Preventing people from dying prematurely**	
Domain 2	**Enhancing quality of life for people with long-term conditions**	
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	
Domain 4	**Ensuring people have a positive experience of care**	**X**
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	**X**

2.2 Local defined outcomes

There are several significant benefits for patients to this initiative:

- Improved access and convenience for patients
- Improved patient experience, clinical outcomes and robustness of service
- Targeted interventions

Then for CCGs:

- Improvement in the robustness of the vasectomy service delivering more choice for patients
- Support in meeting national and local targets (e.g. waiting times.)
- Value for money through reduced cost and increased quality outcomes

Opportunity to develop the patient pathway within community-care setting.

3. Scope

3.1 Aims and objectives of service

The main purpose of this Service Specification is to provide clarity of understanding for the partners around the costs of the services being provided, the levels of service and volumes expected from that investment and the quality standards and performance measures by which it is to be monitored. It is the key to understanding where the boundaries of responsibility lie for operational delivery of the service. This specification is intended to reflect existing service levels and aims to continue them. Additional services will be subject to discussion between the commissioner and provider.

Vasectomy service should not be confused with (and sits outside of) essential and additional General Medical Services.

Long-acting reversible contraceptive (LARC) should be considered first by couples before considering sterilisation as a permanent method of contraception. For those couples who choose sterilisation a vasectomy should be carried out in preference to female sterilisation as it carries a lower failure rate in terms of post-procedure pregnancy and there is less risk related to the procedure.

"Couples in the UK who have completed their families still tend to choose sterilisation, despite the availability of long-acting methods that are easy to use and reversible in the event of wishing to resume childbearing with a new partner." https://**www.rcog.org.uk**

Marital breakdown, change of partner or remarriage is not unusual. Such events would not be considered sufficient grounds to give an individual priority for funding reversal of sterilisation. Therefore the NHS, other than in exceptional individual circumstances, will NOT fund reversal of the procedure.

3.2 Service Description/care pathway

3.2.1 Minimally Invasive Vasectomy

This is an advanced surgical procedure, which does not need the use of a scalpel to make a cut in the scrotum. Under local anaesthetic, a small surgical clamp is used to hold the vas deferens. The vas is lifted through a tiny keyhole made on the skin. The vas occlusion method should be compliant with FRH 2014 guidelines.

The advantages of Minimally Invasive Vasectomy compared with the traditional Vasectomy are:

- No stitches
- Less damage to the tissues
- Shorter operating time
- Faster recovery
- Reduced complications like pain, bleeding, haematoma (blood clot in the scrotum)
- Reduced risk of infection

3.2.2 How does it work?

Sperms are produced in the testes and carried along the tube, called the vas deferens. It mixes with the seminal fluid near the prostate and is ejaculated through the penis during intercourse. When the vasectomy operation is carried out, the vas is divided and heat-sealed to stop the sperm reaching the seminal fluid and the penis. The ejaculation contains only the seminal fluid but not the sperm.

The vasectomy will not affect the male hormone as the testosterone from the testes continues to be released into the blood stream directly.

There are three stages to the Vasectomy Services the CCG is commissioning:

3.2.3 Stage 1: Pre Vasectomy Counselling

a) Men should be informed that reversal operations or intracytoplasmic sperm injections are rarely provided within the National Health Service.

b) The provider will be required to offer counselling appointments at various times to meet the needs of patients who may wish to access the service. The provider must ensure that counselling appointments are available up to 14 days in advance on the choose and book system. Ideally the counselling sessions should be delivered to both the patient and their partner.

c) The counselling session should inform the patient of the purpose of vasectomy and determine the patients understanding of the procedure and decision that is being taken within the context of a service providing a full range of information about and access to other long-term reversible methods of contraception. This should include information on the advantages, disadvantages and relative failure rates of each method.

d) All verbal counselling must be supported by accurate, impartial printed or recorded information (in translation, where appropriate and possible), which the person requesting sterilisation may take away and read before the operation.

e) As a precaution against the risk of later regret, additional care must be taken when counselling people under the age of 30 years or people without children.

f) Care should also be exercised in discussions with people taking decisions during pregnancy, or in reaction to a loss of relationship, or who may be at risk of coercion by their partner or family or health or social welfare professionals.

g) Counsellors and advisers should also be aware and take account of cultural, religious, psychosocial, psychosexual and other psychological issues, some of which may have implications beyond fertility.

h) If there is any question of a person not having the mental capacity to consent to a

procedure that will permanently remove their fertility, guidelines from the Official Solicitor make it clear that the case should be referred to court for judgement.

i) Men should be informed that vasectomy has an associated failure rate and that pregnancies can occur several years after vasectomy. The rate should be quoted as approximately one in 2,000 after clearance has been given.

Evidence of the understanding of the counselling should be obtained from **both parties**. The patient documentation should cover:

a) the undertaking of this procedure is viewed as a permanent form of contraceptive. That if circumstances change there is no automatic right to seek a reversal which are rarely funded within the NHS and reversals are rarely successful

b) details of the procedure to be undertaken and the arrangements that the patient should make on the day of the operation

c) details of the post-operative testing required and precautions that should be undertaken following the procedure until such time as the testing confirms sterilisation is complete

d) details of any contra indications or complications that may occur as a result of this operation and how to access the provider (not their registered GP) for advice or actions on any complications that may occur including those complications requiring urgent medical attention.

The documentation should also include the agreed date of the operation (within 4 weeks of the counselling appointment). Where a patient wishes to further consider their options, details of how to access the service for an operation date when a decision to proceed is made, should be provided. (The open arrangement should not be offered more than 6 months after the initial counselling appointment)

A complete history and examination to rule out any conditions that may complicate the procedure or result in complications (see RCOG guidelines) should be performed on all men requesting vasectomy by the person performing the procedure..

Recording should be made regarding the history, counselling process, problems with the vasectomy and follow-up arrangements, to include the sharing of patient's records with their GP.

3.2.4 Stage 2: Surgical Operation

For many men this will be the first time they have had any operation. The doctor gives the patient a small injection of local anesthetic into the skin of the scrotum (the sac holding the testicles), not the testicles themselves. This numbs the area, but leaves the patient alert. The local anesthetic used is much the same as used by dentists, and therefore the sensation felt is similar, an initial stinging followed by complete numbness of the area. A small incision (approx. 1 centimetre) is made in the scrotum, and the tubes are located and fused using cautery (a process which seals both the tubes using heat). A small section of each tube is removed to enhance the effectiveness of the operation. No internal or external stitches are used, but a small dressing will be applied to the site of the incision.

a) The operating doctor will need to ensure that the counselling, information exchange, history and examination have been completed and be satisfied that the patient does not suffer from concurrent conditions which may require an additional or alternative procedure or precaution. This will include a check that informed consent has been obtained.

b) The provider should deliver a service where 85% patients Operation appointments are seen on time and 100% should be seen within 15 minutes of their operation time.

c) The provider is required to ensure that all premises and equipment meet the required standards for delivery of an invasive vasectomy service. Including current infection prevention and control requirements.

d) Except when technical considerations dictate otherwise, a minimally invasive approach

should be used to identify the vas, as this results in a lower rate of early complications.

e) Vasectomy should be performed under local anaesthetic wherever possible. Where there are contraindications to vasectomy under local anaesthesia a general anaesthetic may be necessary in which case the patient should be referred to secondary care for the procedure.

f) Pathology: Excised portions of the vas should only be sent for histological examination if there is any doubt about their identity.

g) The provider is required to ensure that all personnel involved in the vasectomy service are appropriately qualified and accredited to undertake this service

h) The provider is required to ensure that both individuals and corporate entities have appropriate indemnity insurance.

i) Patients should receive written advice about post-operative care and post-operative semen analysis including the use of effective contraception until azoospermia has been confirmed.

j) The post-operative care should include how to access the provider (not their registered GP) for advice or actions on any complications that may occur. Information regarding complications should form part of discharge information.

3.2.5 Stage 3: Post Vasectomy testing

The provider will be required to provide patients with appropriate information about post vasectomy semen analysis and how to access the service after the procedure to check for azoospermia and proceed accordingly. In the event of sperm being present a fresh sample 7 months after the procedure should be provided, a special clearance can be considered when <100,000 non motile sperms are present in a fresh sample (see RCOG guidelines http://www.rcog.org.uk/resources/Public/pdf/sterilisation

a) The patient information should include the rules for provision of samples and how to ensure they arrive at the correct laboratory

b) Information should include the notification procedure that the provider will follow with regard to semen analysis results to the patient and the referrer.

c) The provider should make suitable arrangements for additional samples where the patient's original samples fail to produce negative results.

3.2.6 Access

The service opening hours must reflect the needs of the patients. On receipt of referral all patients must be offered a choice of appointments. It is expected that referred patients will be able to contact the provider by telephone, in order to discuss appointment times and for other advice.

- The premises should have good disabled access in line with current legislation.
- The national waiting time standards in force at the time will be met.
- Assessment of referral will be done on receipt. This will ascertain whether the patient should appropriately receive treatment under this service.
- The patient should be seen for counselling within 6 weeks of receipt of referral. Treatment will be carried out within the target wait time set out by the CCG unless the patient needs more time in which case within 6 months of counselling.
- In the event of an unexpected complication occurring, with care provided by the provider, there must be an agreed clear pathway of referral into secondary care and, if appropriate, information shared with the patients GP.

Patients can be referred directly through to the provider of their choice ensuring a Pre Vasectomy Counselling session has been completed and they understand that this is a

permanent sterilisation procedure.

3.2.7 Consent

Written consent should be obtained from the patient and include explanation of other contraception methods available, failure rate of vasectomy, discussion regarding vasectomy and tubal ligation as methods of sterilisation, understanding that procedure is permanent and informed of success rates of reversibility, that reversals of sterilisation are unlikely to be funded on the NHS, the couple (particularly) the woman should be informed that vasectomy carries a lower failure rate and lower risks than sterilisation, extra care given to patients who are young (under 30) and/or without children or going through a stressful period in life (if mental capacity to consent is in doubt then the opinion of a high court judge should be sought), reassurance given that there is no increased risk of testicular cancer of heart disease, they will be told about the risk of chronic testicular pain, advised to use other appropriate contraception prior to the procedure and after the procedure until azoospermia confirmed. The patient will be provided with printed information leaflets regarding all aspects of the procedure including complication rates, and the couple given adequate time to read and carefully consider. They will be given time to fully understand the information provided and give an informed written consent prior to the procedure.

3.2.8 Documentation

The Provider must ensure that all information given to the patient is recorded and retrievable by other health professionals. Sharing details of what documentation has been shared and where documentation is stored.

The procedure documentation should include:

- Evidence of counselling to include explanation of risks
- Information given to the patient and in which format the information is given
- Date of operation
- Type and amount of local anaesthetic used
- Type of procedure carried out
- Type of diathermy if used
- Type of closure used
- Any operative or post-operative problems experienced by the patient
- Any adverse incidents or near misses
- Any Serious Incidents should be reported in line with the National Serious Incident Framework

3.2.9 Service Monitoring and Evaluation

Service The provider will need to demonstrate the effectiveness of the service to commissioners possibly at regular times during the year and, at the least, on an annual basis. This will need to be provided to the commissioners in an annual report, which will inform any annual review process or meeting.

The process by which this evaluation is achieved can also be used to show the outcomes of the service to other interested stakeholders such as patients and other joint The provider.

Service evaluation should cover, as a minimum, the following areas:

Service activity – Volume of work undertaken, capacity, needs and demand analyses, workforce arrangements, real time referral data.

Clinical Outcomes - Regular analysis and interpretation of service data.

Quality and Governance – Quality criteria will need to be established (in agreement with commissioners) and measured with standards needing to be met on a continual basis. Results of clinical audits will be used to inform service provision during the year.

Patient Experience – Patients views on their experiences and satisfaction levels will need to be measured through an on-going, systematic process to test whether the service is engaging with patients in a way that supports them. Patient, GP and consultant satisfaction

questionnaires are an important tool in evaluating the service.

This process should be stratified where possible to show any differential impact on disadvantaged groups (e.g. Black and Minority Ethnic groups, deprived groups, males, etc.) and any resultant service changes (planned or achieved) should be highlighted.

Value for Money – Cost effectiveness or best value analyses of the primary service outcomes in relation to comparative costs of hospital activity or those services providing equivalent quality of care.

3.2.10 Service Performance

The provider will be required to:

a) Identify and record those individuals who book an appointment for pre-vasectomy counselling further identifying those who both attend and fail to attend.

b) Provide a service within the local community taking account of the equality and diversity issues relevant to that service.

c) Provide the service described in this specification to patients who will have been referred locally through agreed primary care referral pathways.

d) Involve partners, where possible, in the counselling and decision to proceed and where possible acquiring joint consent or confirmation of understanding.

e) As a part of the counselling process provide up-to-date, comprehensive and non-discriminatory sexual health advice and information through a variety of media which is specific to patient's needs, to ensure that patients and partners are aware of all contraceptive options available to them.

f) Where appropriate where vasectomy is declined, discuss and provide (or signposting to) the full range contraceptive methods including reversible, emergency and long-acting reversible contraceptive (LARC) methods with follow up.

g) Refer to an appropriate primary care or other care pathway where alternative treatments are identified. E.g. counselling services, GUM clinic screening and management services for STI.s and HIV, psycho-sexual health within local networks.

h) A letter will be sent to the referring GP within 5 working days following vasectomy surgery and following the final outcome. Practice records should be kept and include Patients NHS number DOB, postcode, referring GP code.

3.2.11 Patient, Public and Staff Safety

Evidence based clinical protocols should be used.

a) Appropriate health and safety and risk management systems and premises that are safe and patient friendly must be in place.

b) Risk assessments and significant events must be audited regularly, learning outcomes identified and changes implemented in a timely manner.

c) Services should comply with national requirements for recording, reporting investigation and implementation of learning from incidents.

3.2.12 Supervision, Training & Education

The provider delivering this service is responsible for ensuring that their staff are adequately trained and competent to deliver the service safely for patients.

a) Operators performing vasectomies in primary care settings will be required demonstrate appropriate training or experience and planned appropriate access to secondary care advice and services when necessary.

b) Staff appraisal on an annual basis and at an appropriate level will also be required.

c) Commissioners may wish The provider to hold one or more of the following:

- Competency certificate gained following training with a
- General Surgeon or other specialist training provision

- Diploma of the Faculty of Family Planning form the Faculty of Family Planning and Reproductive Healthcare www.ffprhc.org.uk and have a certificate in Local Anaesthetic Vasectomy surgery, issued by the FFPRHC
- Diploma from the Royal College of Obstetricians and
- Gynaecologists (DRCOG) www.rcog.org.uk
- Certificate from the British Association of Sexual Health
- (BASHH) STIF course www.bashh.org
- Member of British Association of Non-Scalpel Vasectomy
- (BANSV) www.bansv.org

d) Doctors with no prior experience should be supervised for ten operating sessions or 40 procedures, while doctors with relevant prior surgical experience should perform eight supervised procedures.

e) The provider should ensure optimum staffing capacity is available to sustain service delivery. Staff should be able to demonstrate that they have participated in organisational mandatory and update training, for example resuscitation, infection control, manual handling, and risk assessment as required.

3.2.13 Facilities

Although there are no explicit standards for the facilities required for vasectomy at general practice or other sites away from hospital, there are general guidelines for minor surgery in these situations and these should be adhered to.

As a minimum the provision of adequate equipment should include an appropriate room fitted with a couch and with adequate space and equipment for resuscitation.

The Provider will be expected to provide evidence that the facility is fit for purpose in that it complies with national guidelines for minor surgery. The operating theatre will need to have the following in place:

- Oxygen supply for emergencies including necessary tubing and masks
- Suction appliance
- Patient Monitoring equipment i.e. pulse oximeter, blood pressure monitoring
- A selection of appropriate Guedel airways
- A panic alarm (All staff to be aware of procedure if bell sounds)
- Additional resuscitation equipment

In addition, to the above, the Provider must undertake annual infection control audits and provide evidence of any actions taken as a result of completed audits.

3.2.14 Referral Criteria

It should be made clear to patients that the NHS, other than in exceptional individual circumstances, will NOT fund reversal of the procedure. Marital breakdown, change of partner or remarriage is not unusual. Such events would not be considered sufficient grounds to give an individual priority for funding a sterilisation reversal. Vasectomy reversals have only been agreed to date when patients have clearly demonstrated that the vasectomy procedure was undertaken under duress or inadequate counselling. The death of a child although rare and tragic would also be considered sufficient grounds for a reversal.

Contraindications to treatment include:

- Cryptorchidism
- Mental instability
- A history of an allergy to local anaesthetic
- Patient refusal of local anaesthesia
- Those deemed unsuitable for local anaesthetic
- Specialist referral with availability of general anaesthesia may be necessary.
- Surgery should be delayed if the following conditions are present.
- Scrotal skin infection

- Active sexually transmitted disease
- Balanitis
- Epididymitis
- Orchitis

3.2.15 Referral Route

Referral route for any patient or temporary resident registered with a GP in Bristol, North Somerset or South Gloucestershire is through the GP who will submit a GP Standard Referral letter.

Referrers should indicate why sterilisation is required and provide evidence of previous obstetric history and use of contraception and give reasons and explanation of any intolerance.

The provider should provide pathways of care from receipt of GP referral to discharge of patient including pathways if complications arise including a clear pathway of referral into secondary care that is agreed.

3.3 Population covered

Any patient or temporary residents registered with a GP in Bristol, North Somerset or South Gloucestershire.

The service is open to all male patients currently registered to a general medical practice responsible to NHS South Gloucestershire, NHS Bristol, and North Somerset CCGs.

In general the service will be located in an area that is accessible by all members of the community and should have good public transport links – 20 minutes by car, 40 mins by public transport

3.4 Any acceptance and exclusion criteria and thresholds

Vasectomy is commissioned in a primary or community care setting for patients meeting the criteria set out below. Vasectomy should only be carried out in men **who meet all of the following criteria:**

- The patient understands that the sterilisation procedure is permanent and irreversible and the reversal of sterilisation operation would not be routinely funded by the CCG,
- The patient is certain that his family is complete,
- The patient is of sound mental capacity for making the decision as emotional instability or equivocal feelings about permanent sterilization are contraindications to vasectomy (M David Stockton & Chief Editor: Edward David Kim),
- The patient has received counselling about the availability of alternative, long-term and highly effective contraceptive methods and these are either contra-indicated or unacceptable to the patient,
- The patient understands that sterilisation does not prevent or reduce the risk of sexually transmitted infections,
- The procedure will be carried out in a primary or community care setting under a local anaesthetic (Faculty of Sexual and Reproductive Healthcare, 2014).

Vasectomy Policy – Criteria Based Access BNSSG Website https://bnssgccg.nhs.uk

Exclusion Criteria

This is outlined in the BNSSG CCG Vasectomy Policy – Criteria Based Access policy on the BNSSG CCG website. https://**bnssgccg**.nhs.uk

3.5 Interdependence with other services/providers

Interdependencies with other organisations should be clearly documented in the submission.

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

The applicable national standards are as follows:

The provider should deliver a service where the National waiting time targets are adhered to which are currently 13 weeks from referral to being seen within outpatients/GP clinic and 18 weeks from referral to procedure/treatment being undertaken.

The provider is responsible for ensuring that their staff are adequately trained and competent to deliver the service safely for patients.

The service provider will be responsible for ensuring that all aspects of the service are compliant with;

- NICE "Infection Control – Prevention of health-associated infection in primary and community care" 2003
- BMA "Healthcare associated infections, a guide for healthcare professionals" 2006
- "Infection Control Policy & Guidelines for South Gloucestershire Primary care Trust" with particular regard to:
  - Minor surgery
  - Correct Disposal of waste including sharps
  - Decontamination of equipment
  - Specimen handling
- And appropriate policies will be produced that are in line with national and CCG guidance.

Accreditation of facilities as suitable for delivering the service may be required by prospective provider/s prior to awarding of contracts.

Unannounced audits may take place of all provider sites to monitor compliance and patient safety, as required, through the year.

4.1.1 Operators performing vasectomies in primary care settings will be required demonstrate appropriate training or experience and planned appropriate access to secondary care advice and services when necessary.

4.1.2 The provider should comply with national standards for recording, reporting, investigation and implementation of learning from incidents. See National Patient Safety Agency www.npsa.nhs.uk

4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

The provider will need to ensure that staff have appropriate clinical audit skills and identify a programme of clinical audit to support the delivery of the service.

An annual review will include an audit of:

(a) the register of patients who have undergone surgery
(b) postoperative complication rate
(c) postoperative infections
(d) postoperative pregnancy rates
(f) Post vas pain syndrome

It is regarded as good medical practice (RCOG), and the CCG will require the provider to conduct a retrospective audit of an individual operator's procedure

outcome, if more than 1 pregnancy is noted within a short separation in either time or number of procedures.

4.3Applicable local standards

Responsive protocols and procedures should be in place for managing patient complaints (in line with national requirements).

Complaints should be reviewed at regular intervals and learning from these shared and applied as appropriate to ensure that services are continually improved.

5. Applicable quality requirements and CQUIN goals

5.1 Applicable CQUIN goals (See Schedule 4D)

6. Location of Provider Premises

The Provider's Premises are located at:

Hanham Health,
33 Whittucks Road
Hanham
Bristol BS15 3HY

7. Individual Service User Placement