CLINICAL STANDARDS

Advice on Planning the Service in Obstetrics and Gynaecology

Royal College of Obstetricians and Gynaecologists

Setting standards to improve women's health

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ABBREVIATIONS USED IN THIS REPORT

BSCCP	British Society for Colposcopy and Cervical Pathology
CCST	Certificate of Completion of Specialist Training
CHI	Commission for Health Improvement
CNORIS	Clinical Negligence and Other Risks Indemnity Scheme for Trusts
CNST	Clinical Negligence Scheme for Trusts
CSBS	Clinical Standards Board for Scotland
GMC	General Medical Council
HFEA	Human Fertilisation and Embryology Authority
NCC-WCH	National Collaborating Centre for Women and Children's Health
NHSLA	National Health Service Litigation Authority
NICE	National Institute for Clinical Excellence
WHO	World Health Organization

1. INTRODUCTION

In recent years there has been an unprecedented emphasis on quality issues in relation to the provision of medical care. Recent initiatives were described and summarised in the RCOG document *Clinical Governance*[1] and since then the College has published further documents of relevance to training,[2–4] lifelong learning,[5] maintaining fitness to practise,[6,7] medical workforce issues,[8] policy for assisting trusts and doctors in cases in concern,[9] and further training for doctors in difficulty.[10] All of these documents are concerned with setting and maintaining standards for individual doctors practising in obstetrics and gynaecology.

At the same time, through the work of the Standards Board, the College has continued to publish a series of working party reports and clinical guidelines of direct relevance to clinical teams. For example, since 1999, working party reports have been published on labour ward care,[11] colposcopy,[12] vulval cancer,[13] storage of ovarian tissue,[14] ultrasound screening in pregnancy (supplement),[15] uterine artery embolisation in the management of fibroids,[16] and fetal and perinatal pathology.[17] In addition, during the same period, 21 internal (green-top) guidelines have been published on topics varying from trophoblastic disease to peritoneal closure (see Appendix 1). The guidelines are based on systematic assessment of evidence, use robust methodology and are extensively peer reviewed. This rigorous approach has resulted in improved relevance and applicability to everyday clinical practice.

Furthermore, through the work of the Clinical Effectiveness Support Unit, and now the National Collaborating Centre for Women and Children's Health (NCC-WCH), national evidence-based guidelines have been published covering male and female sterilisation, menorrhagia, infertility, induced abortion, electronic fetal monitoring and induction of labour, as well as national audits on uptake of RCOG clinical guidelines, induced abortion and caesarean section. The NCC-WCH, funded by the National Institute for Clinical Excellence (NICE), will continue to produce national evidence-based guidelines of relevance to the practice of obstetrics and gynaecology.

Patient involvement is integral to the planning of health service provision and to build on this philosophy the College established its Consumers Forum in early 1993. All guidelines now, whether national or internal, have consumer input, especially at the peer review stage. Advice to Fellows and Members on how they might involve users in organising and providing their services is given in Clinical Governance Advice No. 4 *Patient involvement in enhancing service provision.*[18]

The College perceives setting standards, in consultation with service users, as a major responsibility that has been placed high on its agenda. A considerable internal reorganisation supports these and associated developments, emphasised also by the adoption by the College of the 'strap line' *"Setting standards to improve women's health"*.

Thus, the RCOG together with other organisations has provided practitioners with a wide range of evidence-based recommendations covering most areas of

service provision and clinical practice. Clinical directors and other interested parties have now indicated that they would welcome guidance from the College on how to prioritise these various recommendations and standards. Clinical directors particularly have requested a set of attainable clinical standards, endorsed by the College, which would allow them to prioritise service developments and clinical governance issues.

This document summarises the sources and purposes of the various types of standards already set, by a range of bodies, for the guidance of individual clinicians and healthcare organisations. It then describes a set of 12 key clinical standards covering the practice of obstetrics and gynaecology. These have been developed by the Standards Board of the RCOG and approved by College Council. These clinical standards are derived from existing RCOG guidance documents and represent, in the view of the College, essential minimum requirements of an obstetrics and gynaecology service. They are provided for clinical directors, and others with responsibility for service planning, as a guide to service developments that should be prioritised in order to meet an organisation's clinical governance responsibilities. The proposed standards are compatible with, and complementary to, the standards set by other bodies such as the Clinical Negligence Scheme for Trusts (CNST) and the Clinical Standards Board for Scotland (CSBS).

2. GOOD MEDICAL PRACTICE

Existing standards can be summarised in the following categories:

- professional standards
- institutional standards
- training standards.

2.1 Professional standards

The general professional standards that apply to all doctors are those published by the General Medical Council (GMC) and on a specialty basis by the Royal Colleges, as well as by specialist societies and associations. The GMC guidance *Good Medical Practice*[19] includes 14 key principles, and emphasises that every doctor must be professionally competent, perform consistently well, practise efficiently, do patients no harm, be an effective team player and take action if poor practice places patients at unnecessary risk. *Maintaining Good Medical Practice*[20] emphasises the importance of being committed to providing a good quality service and effective clinical practice. Maintaining quality is dependent upon the standards set by professional organisations, the implementation of clinical guidelines and regular review of procedures and individual clinical performance. It is intended that the guidance provided within this document and the clinical standards set by the RCOG will assist Fellows and Members in meeting these basic professional standards.

2.2. Institutional standards

All trusts and trust chief executives now have a statutory responsibility in relation to clinical governance. Relevant standards include those produced by the NHS Litigation Authority (NHSLA) – a special health authority that

indemnifies NHS bodies in England in respect of clinical negligence and non-clinical risks. The NHSLA administers four separate schemes for different categories of claims; the scheme for managing current and recent clinical negligence claims is the CNST, which has in place risk management programmes against which trusts are assessed. Meeting the various standards set in these programmes qualifies trusts for discounts on the indemnity premiums payable. CNST has developed specific clinical risk management standards for maternity services[21] and all trusts providing maternity services will be assessed specifically against these standards, as well as against existing CNST clinical risk management standards for the trust as a whole. The RCOG supports the standards set out by CNST, which have been derived to a great extent from RCOG documents, and clinical directors are encouraged to work towards these. In Wales, the Welsh Risk Pool administers the risk management standards, which include specific standards for maternity services.[22] In Scotland, the Clinical Negligence and Other Risks Indemnity Scheme for Trusts (CNORIS),[23] serves a similar function and operates in a similar way, although the organisation has not yet developed specific standards for maternity services.

In England and Wales, the Commission for Health Improvement (CHI)[24] has an over-arching responsibility for ensuring the quality of health services. It conducts clinical governance reviews of trusts based on direct observation at site visits. To date, CHI has not published explicit standards against which obstetric and gynaecological services will be assessed. We envisage that compliance with the RCOG standards presented here would serve as good evidence of a trust's commitment to meeting its clinical governance responsibilities. In Scotland, the CSBS[25] – a special health board – serves a function similar to that of CHI. This organisation has developed sets of explicit standards for different healthcare areas, including generic standards, and like CHI, assesses trusts through a process of site visits. The development of explicit standards for maternity services is now scheduled in the CSBS's work plan.

The RCOG welcomes the initiatives by these national bodies in contributing rigorously developed sets of standards to guide the provision of reproductive health services. In view of the availability of this carefully developed set of standards for maternity services, as well as the availability of national guidance in gynaecological cancer care, the College has focused on other aspects of the service in the set of 12 clinical standards presented here. It is hoped that the College's own standards, presented here, will serve as a guide to members, particularly clinical directors, in prioritising their own service developments. These standards may be of particular use in service areas for which explicit standards have not yet been set by other organisations.

2.3. Training standards

The RCOG is responsible for overseeing, maintaining and developing the highest possible standards of education and training in obstetrics and gynaecology.

The implementation of structured (Calman) training included clear standards to be achieved by both trainee and trainer. The development of training

agreements, with regular formative and summative assessments based on identified criteria and targets has, combined with the RCOG's logbooks and personal development files, produced an incremental and structured progression to the award of the Certificate of Completion of Specialist Training (CCST).

To attain the CCST trainees must progress satisfactorily through the necessary education and training, while also gaining sufficient experience to be able to practise as an independent specialist. Implicit in this training is the arrangement of rotations through training centres that are both able and willing to provide quality education.

The shorter time of training to specialist level demands a more concentrated education with an inevitable impact on service provision. The necessary consultant expansion required to implement Calman training, as intended, has not yet been fully realised.

Those centres involved in training must make provision for protected time for both trainees and trainers. Formal teaching arrangements across rotations and within deaneries must be agreed. Hospitals must set aside time for both outpatient teaching and training operating lists. College tutors, programme directors and deanery college advisors require fixed sessions devoted to training.

Standards of training will continue to be reviewed by hospital recognition visits, planned in the future to occur at four yearly intervals. The recently adopted scoring system, developed by the Hospital Recognition Committee, should help the continuing development and improvement in training while aiding those trusts facing difficulties with facilities and delivery of education.

The impact of the Postgraduate Medical Education and Training Board on training and training recognition is yet to be fully appraised. However it is anticipated that the maintenance and development of training standards will be closely related to the introduction and assessment of clinical standards, and it is likely that they will feature in the evolving hospital recognition and accreditation system.

2.4. Impact on working practices

Inevitably, these issues will have a major impact on individual consultants. Job plans may need to change to reflect that time has been allocated and that responsibility has been accepted to address issues pertinent to the development of quality issues. Such developments may impinge on individual clinical practice or on an individual's contribution to the provision of clinical services as a member of a team.

At the same time, there will have to be an increasing recognition of the need for protected sessions of relevance to clinical governance, such as individual study, attending educational meetings, reviewing local and national outcome data and pursuing risk management.

There will be conflict and tension between these essential, quality activities and the day-to-day provision of service. It is likely that this tension, which is already

a very real issue in most units, will be felt more acutely as the service deficit in obstetrics and gynaecology, associated with the reduction in training posts, increases and continues to lag behind the recognised need for more specialists.

Patients will continue to be seen and treated but it is inevitable that the development of quality issues of relevance to the maintenance of good medical practice and the provision of the service will be inhibited until such time as the tension can be resolved. The College is committed to keeping these workforce issues to the forefront until some resolution is in sight. Thus, workforce numbers and practice remain at the very top of the quality agenda.

3. PROPOSALS FOR RCOG CLINICAL STANDARDS

As indicated in the introduction, clinical directors have indicated the need to develop a list of clinical priorities and have requested a set of attainable clinical standards that would allow them to prioritise developments. In response, the College has developed, in the first instance, a set of 12 key clinical standards covering the practice of obstetrics and gynaecology. Because of national maternity service standards (CNST) and national cancer guidance (Department of Health), the emphasis is on other aspects of obstetrics and gynaecology.

Clinical standards are **defined** as standards of clinical care which the College would expect units and hospitals to adopt in relation to the quality of patient services, training opportunities and participation in national data gathering of relevance to clinical accountability and effectiveness.

Accreditation of training will continue to focus on the range of services and hence clinical experience available to trainees, while clinical standards will focus on the quality of individual aspects of the service.

The clinical standards are intended to be:

- clear, evidence-based where relevant, and derived from clinical guidelines and RCOG recommendations
- revisited frequently and updated where necessary
- measurable or at least assessable
- available to all
- focused on improving the outcome of care.

The standards here are specific to obstetrics and gynaecology, but the College also endorses standards that are **generic** to all specialties, such as those set by the GMC. In particular, the College supports generic standards related to patient expectations:

- to be treated politely and considerately
- to be involved in and informed about decisions
- to receive care based on clinical effectiveness
- to receive care provided by trained and revalidated team members
- to know that privacy, dignity and confidentiality will be respected
- to receive information about their care, where appropriate, in writing and in the relevant language.

The College also supports previously published standards that are generic to broad areas of care. For example, in relation to cancer care:

- the care to be provided by an identified lead consultant and multidisciplinary teams
- communication to be clear and care documented
- patients to be partners in their own care
- professionals to be appropriately trained, including in palliative care
- participation in audit and trials.

The RCOG clinical standards are focused on important areas of practice and have sought to determine which key statements are likely to reflect the fact that due consideration has been given to the development of quality issues within that aspect of the service. There has been a major attempt to ensure consistency with current standards where they exist.

Twelve basic clinical standards are proposed here. Clinical directors are asked to ensure, as a priority, that these 12 standards are met in their own services. Meeting these standards will serve to demonstrate a unit's commitment to clinical governance, and this will prove useful in CHI reviews and other assessments. In the immediate future, accreditation of units for training purposes will continue to focus on the range and skills of services provided. However we anticipate the assessment of the quality of the services will feature increasingly in the evolving hospital recognition system.

Where units have achieved the key standard, suggestions for further standards are offered in each section. In addition, suggestions for **patient focus** in the quality of services are provided. A list of patient support groups is now available on the College website (www.rcog.org.uk). It is important that clinical standards are not viewed as static, but as part of a rolling programme of improvement in the quality of clinical care.

4. FUTURE WORK

It is proposed that implementation will be assessed by questionnaire in due course and there will be further discussions at our annual meetings with the clinical directors. It would appear that these standards will continue to feature in the developing quality agenda, and we will continue to discuss the relevance and development with other parties, particularly CHI, NICE and the NHS Confederation.

We also need to consider whether additional standards should be developed in other areas of clinical practice, as well as other aspects of clinical governance work, including patient involvement and referral between primary and secondary care.

It is important that all aspects of clinical governance, including audit, patient participation and risk assessment, should underpin developing clinical care.

5. THE PROPOSED 12 KEY STANDARDS

KEY STANDARD 1: LABOUR WARD

- All labour wards should have a designated lead consultant obstetrician and clinical midwife manager.

KEY STANDARD 2: ANTENATAL ULTRASOUND SCREENING

- The performance of the 20-week anomaly scan should be to the minimum standard defined in the RCOG report. If a unit cannot deliver to this standard the woman should be referred to an appropriate unit.

KEY STANDARD 3: EARLY PREGNANCY LOSS

- All units should provide an early pregnancy assessment service with direct access for general practitioners and patients.

KEY STANDARD 4: COLPOSCOPY

- The colposcopy service should have a designated lead clinician and lead nurse.

KEY STANDARD 5: GYNAECOLOGICAL CANCER

- Women with gynaecological cancer should receive their care in cancer centres and be managed by the relevant multidisciplinary team.

KEY STANDARD 6: UROGYNAECOLOGY

- All units providing urogynaecology services should have local protocols in place for the initial management of patients in primary care.

KEY STANDARD 7: MENORRHAGIA

- The initial investigation of menorrhagia should be according to a locally available protocol derived from the RCOG national evidence-based guideline.

KEY STANDARD 8: INDUCED ABORTION

- Services should offer arrangements that minimise delay in referral, either by telephone or direct access, because this is important in terms of morbidity and choice of method.

KEY STANDARD 9: STERILISATION

- Verbal and written information must be provided to those requesting sterilisation, advising them of the consequences, risks, failure rate and sequelae.

KEY STANDARD 10: INFERTILITY

- The secondary and tertiary management of infertility should take place in dedicated clinics that facilitate a structured clinical management process and have access to an appropriately trained multiprofessional team.

KEY STANDARD 11: GYNAECOLOGICAL EXAMINATION

- A chaperone should be available to assist with gynaecological examinations irrespective of the gender of the gynaecologist.

KEY STANDARD 12: OUTPATIENT TIMES

- Antenatal clinics: each unit should allow at least 15 minutes for each new and return visit. Thus during a three-hour clinic session an experienced doctor, with no other commitments, might expect to see a maximum of 12 patients.

- Gynaecology clinics: each unit should allow at least 20 minutes for each new and ten minutes for each return visit. There should be approximately the same proportion of new and returning patients. Thus, during a three-hour clinic session an experienced doctor, with no other commitments, might expect to see six new and six returning patients.

KEY STANDARD 1: LABOUR WARD

All labour wards should have a designated lead consultant obstetrician and clinical midwife manager.

FURTHER STANDARDS

- Consultant cover should be available in a supervisory capacity for a minimum of 40 hours during the working week, unless the unit is small and where the majority of women who give birth have had a normal pregnancy.
- There should be a clinical midwife leader available on each shift.
- The consultant on call for the labour ward should conduct labour ward rounds at least twice during the day, with an actual or telephone round during the evening.
- There should be a multidisciplinary labour ward forum comprising, at a minimum, the lead obstetrician, the clinical midwife manager, an obstetric anaesthetist, a neonatal paediatrician, a risk manager, representatives from junior medical and midwifery staff and a consumer representative to review labour ward activity and develop guidelines.
- All labour wards should have available a set of evidence-based guidelines which should be dated and reviewed every one to three years.
- Education sessions on the management of 'high risk' labours and cardiotocograph interpretation should be organised every six months and attended by all clinicians. A logbook of attendances should also be kept.

PATIENT FOCUS

- While a pleasant environment is an important element in creating the right atmosphere, the attitude of staff is of greater value. All personnel on the labour ward should work towards creating a pleasant and relaxed atmosphere in which couples can share in the experience of childbirth.
- Facilities should be available to accommodate bereaved parents, preferably so that all their care can be given in a separate room, from which they can be discharged.

SOURCES

Clinical Negligence Scheme for Trusts. *Clinical Risk Management Standards for Maternity Units*, 2002 [www.nhsla.com].

Royal College of Obstetricians and Gynaecologists. *A Blueprint for the Future: A Working Party Report on the Future Structure of the Medical Workforce and Service Delivery in Obstetrics and Gynaecology.* London: RCOG Press; 2000.

Royal College of Obstetricians and Gynaecologists, Royal College of Midwives. *Towards Safer Childbirth: Minimum Standards for the Organisation of Labour Wards*. London: RCOG Press; 1999.

KEY STANDARD 2: ANTENATAL ULTRASOUND SCREENING

The performance of the 20-week anomaly scan should be to the minimum standard defined in the RCOG report. If a unit cannot deliver to this standard the woman should be referred to an appropriate unit.

FURTHER STANDARDS

- Each woman should have at least one routine scan in pregnancy to confirm gestational age.
- Ultrasound equipment should only be conducted by appropriately trained personnel using equipment that had been upgraded no more than five years before.
- When an abnormality is detected on any scan, a full discussion of its implications should ensue. Parents should have the benefit of discussion with a multidisciplinary group comprising, where appropriate, a paediatrician, geneticist and paediatric surgeon, in addition to the ultrasonographer and obstetrician. If such a team is not available, referral to a tertiary centre should be arranged.
- After the termination of a pregnancy in which an abnormality has been diagnosed, arrangements should be made for the parents to return to discuss the outcome, whether or not autopsy information is available. A plan for care in the next pregnancy should be devised.
- Medical staff who undertake ultrasound scanning for fetal abnormalities should ideally hold the Advanced Certificate of Ultrasound Training.

PATIENT FOCUS

- Minimum standards should be made clear in a patient information leaflet, which should include the results of any relevant audits.
- Women should receive written details of their scan result and whenever possible, information concerning the type of fetal abnormality present.

SOURCE

Royal College of Obstetricians and Gynaecologists. *Routine Ultrasound Screening in Pregnancy: Supplement to Ultrasound Screening for Fetal Abnormalities*. London: RCOG Press; 2000.

KEY STANDARD 3: EARLY PREGNANCY LOSS

All units should provide an early pregnancy assessment service with direct access for general practitioners and patients.

FURTHER STANDARDS

- Ideally, the service should be sited in a dedicated area with appropriate staffing. It should be available on a daily basis, at least during the normal working week.
- Medical and expectant methods are effective in the management of confirmed miscarriage and should be available in all early pregnancy assessment units.
- A policy for the administration of anti-D immunoglobulin should be available in all early pregnancy assessment units.
- All at risk women (usually women under the age of 25 years) undergoing surgical evacuation for miscarriage should be screened for *Chlamydia trachomatis*.

PATIENT FOCUS

- Women should be made aware of the psychological sequelae associated with miscarriage, and should be provided with support and follow-up, as well as access to formal counselling when necessary.
- Women undergoing medical and expectant management at home should have direct access to the ward for advice and support.

SOURCES

Royal College of Obstetricians and Gynaecologists. *The Management of Early Pregnancy Loss*. Guideline No. 25. London: RCOG Press; 2000.
Royal College of Obstetricians and Gynaecologists. *Problems in Early Pregnancy: Advances in Diagnosis and Management*. London: RCOG Press; 1997. Recommendations of the 33rd RCOG Study Group.

KEY STANDARD 4: COLPOSCOPY

The colposcopy service should have a designated lead clinician and lead nurse.

FURTHER STANDARDS

- The service should aim to minimise intervention in women who do not have cervical intraepithelial neoplasia (CIN).
- Colposcopists must be trained according to the British Society for Colposcopy and Cervical Pathology/Royal College of Obstetricians and Gynaecologists (BSCCP/RCOG) training programme.
- Clinics should record the waiting times for both new patients and treatments.
- All clinics should adhere to local written protocols that should reflect published national practice guidelines and quality standards.
- Clinics should ensure adequate data collection for quality assurance annual reviews.

PATIENT FOCUS

- All patients should have their results communicated to them in writing.
- There should be adequate facilities in the clinic to provide privacy and a safe working environment.

SOURCE

Royal College of Obstetricians and Gynaecologists. *Recommendations for Service Provision and Standards in Colposcopy.* London: RCOG Press; 1999.

KEY STANDARD 5: GYNAECOLOGICAL CANCER

Women with gynaecological cancer should receive their care in cancer centres and be managed by the relevant multidisciplinary team.

FURTHER STANDARDS

- There should be an agreed **urgent referral pathway** to the local gynaecological department with a stated maximum time to hospital appointment.
- Ovarian cancer: investigations at the first appointment should include serum CA125 levels, ultrasound and/or computed tomography scan with the results available within ten days. The decision to operate to operation time should be less than 14 days.
- Cervical cancer: decisions regarding surgery, radiation or chemoradiation should only be made by the multidisciplinary team. This will help to minimise the use of both surgery and radiotherapy and maximise cure rates.
- Vulval cancer: with the rare exceptions, radical treatment should not be undertaken without prior biopsy confirmation of malignancy.
- All women diagnosed with endometrial cancer should be carefully investigated to assess the degree of myometrial invasion and tumour histopathology, including degree of differentiation.

PATIENT FOCUS

- Written and verbal information should be provided to all patients, together with advice regarding support agencies.
- Each patient must be aware of the named medical coordinator for any given part of their care.
- Women should be encouraged to make their preferred priorities clear to clinicians, who should always respect patients' views.
- Women who have undergone radical treatment should be informed about possible long-term adverse effects and should have a clear access route to specialist help if symptoms develop.
- Women should be encouraged to bring a partner, close friend or relative with them to clinic appointments, particularly when they could be told of a cancer diagnosis.

SOURCES

Clinical Standards Board for Scotland. *Clinical Standards for Gynaecological (Ovarian) Cancer 2001* [www.clinicalstandards.org/introduction.html].

Department of Health. *Guidance on Commissioning Cancer Services: Improving Outcomes in Gynaecological Cancer – The Manual.* London: Department of Health; 1999.

National Assembly for Wales. *Gynaecological Cancer Services: All Wales Minimum Standards*. Cardiff: Cancer Services Coordinating Group, National Assembly for Wales; 2000.

Royal College of Obstetricians and Gynaecologists. *Clinical Recommendations for the Management of Vulval Cancer*. London: RCOG Press; 1999.

KEY STANDARD 6: UROGYNAECOLOGY

All units providing urogynaecology services should have local protocols in place for the initial management of patients in primary care.

FURTHER STANDARDS

- The service should only be provided by those who have undergone appropriate training.
- A management plan should be discussed and agreed with every patient who has been assessed, and a copy should be given to the patient.
- Urodynamic studies should be undertaken prior to surgery in all cases.
- Trained individuals should be available who can provide advice on bladder training and pelvic floor exercises.
- A continence adviser should be available for the non-surgical management of urinary incontinence.
- Surgical cure and complication rates should be discussed with the patient prior to surgery.
- Specialist surgeons should have a sufficient volume of cases to improve their expertise.
- Recurrent surgery should be focused on a small number of individuals in each geographical area

PATIENT FOCUS

- All patients should have access to written information about their investigations and surgical treatments.

SOURCE

Department of Health. *Good Practice in Continence Services*. London: Department of Health; 2000 [www.doh.gov.uk/continenceservices.htm].

KEY STANDARD 7: MENORRHAGIA

The initial investigation of menorrhagia should be according to a locally available protocol derived from the RCOG national evidence-based guideline.

FURTHER STANDARDS

- A progestogen releasing intrauterine device is an effective treatment for reducing heavy menstrual blood loss and should be considered as an alternative to surgical treatment.
- A choice of surgical approaches for the management of menorrhagia needs to be available, and there needs to be awareness of local hysterectomy rates.
- There should be local protocols for prophylaxis against infection and venous thromboembolism for women undergoing major surgical treatment.

PATIENT FOCUS

- Patients must be involved in the decision-making process regarding their treatment and be provided with appropriate information to enable them to do this.
- If definitive surgical treatment is intended, the likely outcomes and complications should be discussed with the woman beforehand. These discussions should be backed up with appropriate written information.

SOURCE

Royal College of Obstetricians and Gynaecologists. *The Initial Management of Menorrhagia. National Evidence-based Guideline No. 1.* London: RCOG Press; 1998.

KEY STANDARDS 8: INDUCED ABORTION

Services should offer arrangements that minimise delay in referral, either by telephone or direct access, because this is important in terms of morbidity and choices of method.

FURTHER STANDARDS

- Local protocols should be in place for facilities for counselling, including access to social services.
- As a minimum, all services must be able to offer abortion by one of the recommended methods for each gestation band.
- Abortion care should encompass a strategy for minimising the risk of post-abortion infective morbidity.
- Anti-D immunoglobulin should be given to all non-sensitised rhesus-negative women following abortion, whether by surgical or medical methods and regardless of gestational age.
- In cases of suspected uterine perforation, laparoscopy should be the investigation of choice.
- On discharge, each patient should be given a letter that gives sufficient information about the procedure to allow another practitioner elsewhere to deal with any complications.

PATIENT FOCUS

- Written information about the relevant abortion method, as well as possible complications and sequelae, should be given to each woman.
- When ultrasound scanning is undertaken, it should be done in a setting and manner that are sensitive to the woman's situation. It is inappropriate for pre-abortion scanning to be undertaken in an antenatal department alongside women with wanted pregnancies.
- Women having second-trimester terminations by medical means should be cared for by an appropriately experienced midwife or nurse. Ideally they should have the privacy of a single room.

SOURCE

Royal College of Obstetricians and Gynaecologists. *The Care of Women Requesting Induced Abortion. National Evidence-based Guideline No. 7*. London: RCOG Press; 2000.

KEY STANDARD 9: STERILISATION

Verbal and written information must be provided to those requesting sterilisation, advising them of the consequences, risks, failure rate and sequelae.

FURTHER STANDARDS

- Additional care must be taken when counselling those under the age of 25 years or those without children who request sterilisation. In all instances this decision should be sanctioned by a consultant who has talked with the patient.
- Mechanical occlusion of the tubes by either clips or rings should be the method of choice for tubal occlusion at laparoscopy. Diathermy should not be used as the primary method of tubal occlusion, but could be used if tubal occlusion is technically difficult and mechanical methods have failed.
- Tubal occlusion can be performed at any time within the menstrual cycle but the woman must be advised to use effective contraception up until her next period in order to avoid a luteal-phase pregnancy.
- Routine curettage at the time of tubal occlusion, in order to prevent luteal phase pregnancy, is not recommended.
- If tubal occlusion is to be performed at the same time as a caesarean section, counselling and agreement should have taken place at least one week prior to the procedure.

PATIENT FOCUS

- All verbal counselling advice must be supported by written information, which the woman may take away and read before the operation.
- Women should be informed of the method of access and tubal occlusion being recommended in their case, the reasons for preferring it to other methods, and the method that would be used if the intended method fails for any reason.
- Women should be informed that tubal occlusion is associated with a failure rate and that pregnancies can occur several years after the procedure. The rate should be quoted as approximately one in 200 lifetime risk.
- Women should be informed that if tubal occlusion fails, the resulting pregnancy may be an ectopic pregnancy.

SOURCE

Royal College of Obstetricians and Gynaecologists. *Male and Female Sterilisation. National Evidence-based Guideline No. 4.* London: RCOG Press; 1999.

KEY STANDARD 10: INFERTILITY

The secondary and tertiary management of infertility should take place in dedicated clinics that facilitate a structured clinical management process and have access to an appropriately trained multiprofessional team.

FURTHER STANDARDS

- Local protocols based on the RCOG guidelines should be agreed for the management of the infertile couple in general practice, as well as referral to secondary care.
- Ovulation induction, tubal surgery and surgical sperm recovery should be carried out only in centres where there are appropriate facilities and trained staff.
- In undertaking ovulation induction, centres should adopt protocols that minimise the risk of multiple pregnancy and ovarian hyperstimulation.
- Ovulation induction with gonadotrophins should only be performed in circumstances that permit daily monitoring of ovarian response.
- In couples with unexplained infertility, expectant management (no treatment) for up to three years of trying should be considered, taking into consideration the woman's age.
- Anti-oestrogens, androgens, bromocriptine and kinin-enhancing drugs have not been shown to be effective in the treatment of men with abnormalities of semen quality.
- Medical treatment of minimal and mild endometriosis does not enhance fertility in subfertile women.
- The medical treatment of moderate and severe endometriosis, either alone or as an adjunct to surgery, does not improve fertility.
- Semen analysis should be undertaken according to recognised WHO methodology and in laboratories that practise internal quality control and belong to an external quality control scheme.
- The British Andrology Society guidelines for the selection, screening and recruitment of semen donors should be followed.

PATIENT FOCUS

- Written information should be provided for the investigation and management of infertility, including pregnancy rates and risks of treatment.
- Patients undergoing ovulation induction must be given information about the risks of multiple pregnancy, ovarian hyperstimulation and the possibility of fetal reduction.

- Counselling should be made available throughout all stages of infertility investigations and treatment and also after the treatment process is complete.

- Patients also need to be made aware of the HFEA guidelines in relation to the assessment of the welfare of the child.

SOURCE

Human Fertilisation and Embryology Authority. *Code of Practice,* 5th ed. London: HFEA; 2001.
Royal College of Obstetricians and Gynaecologists.*The Management of Infertility in Secondary Care. National Evidence-based Guideline No. 3*. London: RCOG Press; 1998.

KEY STANDARD 11: GYNAECOLOGICAL EXAMINATION

A chaperone should be available to assist with gynaecological examinations irrespective of the gender of the gynaecologist.

FURTHER STANDARDS

- Verbal consent should be obtained prior to all pelvic examinations.

- Where pelvic examination under anaesthesia is regarded as being of educational value, fully informed written consent must be obtained for a named medical student.

- There is no clinical evidence to support the use of rectal examination as means of assessing the cervix in pregnancy or labour and as most women find it more distressing than vaginal examination it cannot be recommended.

PATIENT FOCUS

- Patients should be provided with private, warm and comfortable changing facilities. After undressing there should be no undue delay prior to examination. Every effort must be made to ensure that such examinations take place in a closed room that cannot be entered while the examination is in progress and without interruption.

- Easily understood literature and diagrams should be provided for women undergoing invasive procedures such as colposcopy and urodynamic investigations.

SOURCE

Royal College of Obstetricians and Gynaecologists. *Gynaecological Examinations: Guidelines for Specialist Practice.* London: RCOG Press; 2002.

KEY STANDARD 12: OUTPATIENT TIMES

Antenatal clinics: Each unit should allow at least 15 minutes for each new and return visit. Thus during a three-hour clinic session an experienced doctor, with no other commitments, might expect to see a maximum of 12 patients.

Gynaecology clinics: Each unit should allow at least 20 minutes for each new and ten minutes for each return visit. There should be approximately the same proportion of new and returning patients. Thus, during a three-hour clinic session an experienced doctor, with no other commitments, might expect to see six new and six returning patients.

FURTHER STANDARDS

- Maternal and fetal medicine: during a three-hour clinic session an experienced subspecialist should see a maximum of between two and six new patients or six returning patients.
- Gynaecological oncology: during a three-hour clinic session an experienced subspecialist should see a maximum of four new or 12 returning patients.
- Reproductive medicine: during a three-hour clinic session an experienced subspecialist should see between three and six new referrals or six couples for follow-up.
- Urogynaecology: during a three-hour clinic session an experienced subspecialist should see between three and nine new or 12 returning patients.

PATIENT FOCUS

- Patients should be provided with information on the purpose of the visit, as well as the maximum and minimum allocated time.

SOURCE

Royal College of Obstetricians and Gynaecologists. *A Blueprint for the Future: A Working Party Report on the Future Structure of the Medical Workforce and Service Delivery in Obstetrics and Gynaecology.* London: RCOG Press; 2000.

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APPENDIX 1

RCOG GUIDELINES PUBLISHED FROM 1999

1. National evidence-based guidelines

Male and Female Sterilisation (No. 4)

The Management of Menorrhagia in Secondary Care (No. 5)

The Management of Infertility in Tertiary Care (No. 6)

The Care of Women Requesting Induced Abortion (No. 7)

The Use of Electronic Fetal Monitoring (No. 8)

Induction of Labour (No. 9)

2. Internal (green-top) guidelines

Adverse Pregnancy Outcome Associated with the Use of Visual Display Units in Pregnancy (No. 6) September 1999 (revision)

Antenatal Corticosteroids to Prevent Respiratory Distress Syndrome (No. 7) December 1999 (revision)

Alcohol Consumption in Pregnancy (No. 9) December 1999 (revision)

Management of Eclampsia (No. 10) July 1999 (reviewed but no change)

The Management of Gestational Trophoblastic Disease (No. 18) April 1999

Hormone Replacement Therapy/Venous Thromboembolism (No. 19) April 1999

The Management of Tubal Pregnancies (No. 21) October 1999

Use of Anti-D Immunoglobulin for Rh Prophylaxis (No. 22) October 1999

Methods and Materials Used in Perineal Repair (No. 23) January 2000

Amniocentesis (No. 8) February 2000 (revision)

The Investigation and Management of Endometriosis (No. 24) July 2000

Management of Early Pregnancy Loss (No. 25) October 2000

Instrumental Vaginal Delivery (No. 26) October 2000

Placenta Praevia: Diagnosis and Management (No. 27) January 2001

The Management of Breech Presentation (No. 20) April 2001 (revision)

Pelvimetry (No. 14) April 2001 (revision)

Thromboembolic Disease in Pregnancy and the Puerperium: Acute Management (No. 28) April 2001

Chickenpox in Pregnancy (No. 13) July 2001 (revision)

Management of Third and Fourth Degree Perineal Tears Following Vaginal Delivery (No. 29) July 2001

Management of Genital Herpes in Pregnancy (No. 30) March 2002

Peritoneal Closure (No. 15) July 2002 (revision)

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