Service Specification No.	
Service	Non-Scalpel Community Vasectomy Service
Commissioner Lead	
Provider Lead	
Period	
Date of Review	

1. Population Needs

1.1 National/local context and evidence base

Vasectomy is indicated when a man wishes to make permanent and irreversible his and his partner's decision that they should never subsequently conceive a child of their own. A recommendation to consider sterilisation by a Professional should generally be part of a range of options offered for information or as a result of particular circumstances or opportunities. However, the onus is on the health care practitioners involved to ensure that the patient has all the information required in order to make an informed choice.

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	✓
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	✓

2.2 Local defined outcomes

- Patients will receive an effective, quality vasectomy procedure in a community location
- Minimal infection and/or complications rates
- Compliance with Good Surgical Practice
- Value for money through reduced costs and better quality outcomes

3. Scope

3.1 Aims and objectives of service

The service will provide a quality and safe no-scalpel technique vasectomy under local anaesthetic, in accordance with the FSRH Clinical Guidance on Male and Female Sterilisation in a community setting. The service is available to all adult males who request it, are of sound mind and not acting under external duress and are

registered with a General Practitioner within NHS Cornwall and Isles of Scilly Integrated Care Board Clinical Commissioning Group.

The FSRH clinical guidelines were jointly produced with the Royal College of Obstetricians and Gynaecologists (RCOG) and can be found at: https://www.fsrh.org/documents/cec-ceu-guidance-sterilisation-cpd-sep-2014/

The Service will provide:

- High quality and safe care
- Good access to services
- Equity and fairness
- Responsive and patient-centred care
- Efficient and effective use of resources
- An environment to support collaboration between providers and achieve seamless services to the patient
- Achieve all local and national waiting time targets and expectations

The service will promote a culture of encouraging informed decisions regarding healthcare. The aim will be to facilitate self-care and patient/carer empowerment. The Provider should ensure that patients are equipped with appropriate information and resources to facilitate this.

3.2 Service description/care pathway

Access to the service

The Provider of the service will define their service on NHS E-referrals service and will have an on-going responsibility to ensure that the information in the Directory of Service is accurate and kept up-to-date. Referrals which are not appropriate for a community service will be returned to the referrer within a timely manner. All clinically appropriate referrals must be accepted. The Provider will offer a one-stop approach with minimal follow ups.

Support, Advice and Informed Consent

This will normally be undertaken by the patient's General Practitioner prior to referral.

Where this has not happened, the Provider will provide counselling and advice on sterilisation in accordance with the recommendations of FSRH Clinical Guidance on Male and Female Sterilisation. Obtaining and giving consent should be regarded as a process and not a one-off event.

The operating clinician will ensure that the counselling, information exchange, history and examinations have been completed and be satisfied that the patient does not suffer from concurrent conditions that may require an additional procedure or precaution.

Due to the permanency of the procedure, if there are concerns about a person's mental capacity to give informed consent, guidance from the Mental Health Act (2007) and Making Decisions – Guide for people who work in Health and Social Care (2005) must be adhered to.

Vasectomy Procedure

The clinician who performs or supervises a trainee performing a vasectomy takes responsibility for the procedure even when discussion, examination and consent were undertaken by other healthcare professionals.

All practitioners must have been trained to the standard advocated by the Faculty of Family Planning and Reproductive Health Care (FFPRHC) and evidence of this must be seen by the commissioner.

All vasectomies will be performed under local anaesthetic. Except when technical considerations dictate otherwise, a no-scalpel approach should be used to identify the vas as this is known to result in a lower rate of early complications.

Division of the vas on its own is not an acceptable technique because of its failure rate. It should be accompanied by fascial interposition or diathermy. Clips will not be used for occluding the vas as failure rates are unacceptably high.

Excised portions of the vas will only be sent to histological examination if there is any doubt about their identity.

Post-procedure Care
The Provider will ensure that post-vasectomy care including emergency contact numbers (when and who to contact), pain relief, wound care, resuming normal activities including sexual intercourse, contraception prior to clearance and semenology testing is given to all patients.

The Provider is responsible for ensuring the provision of post vasectomy testing and ensuring that seminal analysis is carried out at a recognised laboratory.

The Provider will advise patients on how to comply with semenology testing, supply all necessary equipment in advance of the required testing date and inform patients that they will require further testing if the first test is not clear of sperm. Clearance is defined as fewer than 10,000 non-motile sperm per ml.

The Provider shall forward semenology results to the patient and their GP, emphasising at each stage of the pathway that it is the patient's responsibility to arrange semenology testing.

The Provider will maintain a register of failed vasectomies and post-operative complications.

Patient Safety
The Provider will comply with policies and procedures on:

- Infection Prevention and Control
- Complaints and Compliments
- Managing and reporting of all incidents, including Serious Incidents Requiring Investigation (SIRIs) and near misses
- Never Events occurrences
- Risk assessment and risk management
- Information governance
- Meeting the duties of equality legislation
- Safeguarding Adults
- Data protection
- Quality assurance/maintaining good practice
- Faculty of Family Planning and Re-productive Health Care Standards
- Clinical Professional Development, supervision and training
- Commissioner's GPwER Accreditation process

- Practitioners should ensure that their training conforms to that advocated by the Faculty of Family Planning and Re-productive Health Care.

The Provider will be able to demonstrate appropriate training or experience and planned appropriate access to secondary care advice and services when necessary.

The Provider will be able to demonstrate the regularity of the personal development proposed for all staff on an annual basis.

Providers must ensure that they have sufficient and relevant indemnity and insurance cover including clinical/medical and malpractice. (See contract for further details).

Confidentiality
The service shall be, and be known to be, strictly confidential. A written Confidentiality Policy shall be made available to patients upon request. Staff should be able to demonstrate full understanding of the policy and be able to communicate this to patients using the service. Confidentiality shall be maintained throughout the patients' visit including the minimal use of names in public areas such as the reception or waiting areas.

In order to maintain confidentiality no information should be sent to the patient's home address unless the patient expressly wishes this. The Provider must ensure that the information is not shared with anyone else including the patients GP without consent. Issues of child protection overrule the right to confidentiality; however, the patient should be informed if other agencies are to be involved.

The Provider shall be expected to demonstrate that the collection, storage, and transfer of information to other services including that in electronic format is secure and complies with any data protection requirements.

Consent
The Provider will operate a policy for obtaining consent that complies in all respects with the requirements of National Minimum Standards and the Private and Voluntary Healthcare (England) Regulations 2001 and any other relevant guidelines. (See contract for further details).

Consent is understood in terms of the patient's ability to understand the choices and their consequences, including the nature, purpose, and possible risk of any treatment (or non-treatment). In assessing competence, the Provider needs to refer to the Department of Health (DoH) Reference Guide to Consent for Examination or Treatment (2009)

Discharge processes
Patients should be discharged back to the care of their GP with information which explains the likely course of recovery, including pain and bleeding and with sufficient information to allow another practitioner elsewhere to deal with any complications.

The Provider will give information on symptoms indicating deviations from the normal course of recovery and will explain to the patient how and when to seek medical help.

Response times and prioritisation
Referrals not appropriate for a community service should be returned to the source of referrals within one week. Patients who self-refer should be advised to see their GP.

Patients are to be seen within a maximum waiting time of 11 weeks.

3.3 Population covered

The service will be available for the population of Cornwall and Isles of Scilly Integrated Care Board areas.

3.4 Any acceptance and exclusion criteria and thresholds

All adult males who request it, are of sound mind, not acting under external duress and do not have any of the exclusion criteria. It should be made clear to patients that the NHS, other than in exceptional circumstances, will NOT fund reversal of the procedure.

The referral route into this service is via a GP referral to e-RS
Referral suitability will be ascertained via an initial Telephone Assessment, and the patient will be able to choose the location for their first appointment/operation. The patient will then be contacted by the Provider to book their first appointment/operation.

Exclusion Criteria

- Previous scrotal surgery
- Hydrocele/varicocele
- Inguinal hernia
- Cryptoorchidism
- Gross obesity: BMI>35
- Anticoagulant therapy
- Coagulation disorders
- Drug or alcohol misuse
- Mental instability
- A history of allergy to local anaesthetic
- Patient refusal of anaesthesia
- Those deemed unsuitable for local anaesthetic

Surgery should be delayed if the following conditions are present:

- Active sexually transmitted disease
- Scrotal skin infection
- Balanitis
- Epidiymitis
- Orchitis

3.5 Interdependence with other services/providers

Key professions that the Provider will be expected to develop effective links with include:

- General Practitioners
- Secondary care vasectomy service providers
- Contraception and Sexual Health
- Genito-Urinary Medicine (GUM)
- Any other appropriate service

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

The Service will work to the following policy and guidance documents, each as amended and replaced form time to time:

- FSRH Clinical Guidance on Male and Female Sterilisation, 2014
- Department of Health (DoH) Reference Guide to Consent for Examination or Treatment, 2009
- Our Health, Our Care, Our Say: A New Direction for Community Services, DH 2006
- The current Operating Framework for the NHS in England
- Good Surgical Practice, Royal College of Surgeons 2014
- Moving Care Closer to Home, 2015
- High Quality Care for All, DH 2008
- Implementation Manual Surgical Safety Checklist, WHO (First edition) 2008
- WHO Safe Surgery Saves Lives, 2009
- Code of Professional Conduct
- Health Protection Agency and DH guidelines for Infection Control including MRSA and C Difficile
- NHS Records Management, NHS Code of Practice 2006
- Confidentiality: NHS Code of Practice 2003
- Quality, Innovation, Productivity and Prevention (QIPP)
- Other Best Practice Policy and Guidance relevant to the service not specifically listed above

4.2 Applicable local standards

Patients are seen within a maximum waiting time of 11 weeks

5. Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements (See Schedule 4)

General practitioners with extended roles (GPwER)

The provider must comply with the requirements as set out in the RCGP Framework for GPs with Extended Roles 2021.

The provider should also:-

- Ensure that the GP has the additional or separate medical indemnity for assessment and treatment outside of their immediate practice.
- Report in a timely manner recommendations to revalidate, to defer, or of non-engagement.
- Provide any clinical governance information collected by the organisation for the GP to reflect on.
- Where possible, an annual performance development review should be facilitated by a specialist working in the relevant extended role area, preferably your clinical guide. This information and review should be reflected on in the whole scope of practice annual medical appraisal.

Commented [MC1]: This was varied into other GPwER contracts in April 2024, so have added this in.

6. Location of Provider Premises

The Provider's Premises are located at:

- Provider to add details here.

Commented [A2]: Veor - please add details here.

7. Individual Service User Placement

N/A

Appendix 1 Patient Pathway

