NHS
Somerset
Clinical Commissioning Group

Service Specification No.	11X-10 v3
Service	Vasectomy
Commissioner Lead	Sheryl Vincent, Commissioning Manager
Provider Lead	
Period	1 April 2018- 31 March 2019
Date of Review	TBC

1. Population Needs

National/local context and evidence base

1.1 A vasectomy is an operation to cut or tie the vas deferens, the tube which delivers sperm from the testicles.[1] The operation aims to provide permanent sterilisation (permanent contraception) and is recommended by the Royal College of Obstetricians and Gynaecologists[2] (RCOG) as the preferred method of sterilisation. This service specification details the procedure undertaken under a local anaesthetic.

1.2 Evidence shows that vasectomy is a safe and cost-effective form of permanent contraception.[3] The RCOG Clinical Guideline[4] states (and evidences) that vasectomy carries a lower failure rate in terms of post-procedure pregnancies than female sterilisation and there is less risk related to the procedure. The failure rate for vasectomy is at least one order of magnitude lower than that of tubal occlusion. There are also fewer operation-related risks with vasectomy as it avoids a laparoscopy and usually avoids general anaesthetic.

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

Not applicable

3. Scope

[1] See Reference 4.4
[2] See Reference 4.1
[3] See Reference 4.5
[4] See Reference 4.6

Aims and Objectives of Service

3.1 The aim of this specification is to equip commissioners, providers and practitioners with the necessary background knowledge, service and implementation details to safely deliver a high quality vasectomy service. The specification is a means of improving Service Users' health and quality of life by providing Service User centred, systematic and on-going support.

3.2 Primary care and commissioners have a responsibility to improve access for Service User s by providing alternatives to traditional hospital-based services. In line with the principles of Implementing Care Closer to Home[5] (timely, efficient, effective, equitable, Service User - centred and safe care) in Somerset, the service can be accessed via referral from a general practitioner (from within the county) to a choice of local providers.

3.3 Somerset Clinical Commissioning Group has a priority to bring all sexual health services closer to Service User s and communities through increasing the role of primary care and community based services. This vasectomy service is an integral part of this strategy.

3.4 The service outlined includes; booking, assessment, counselling, procedure, information provision to the Service User to ensure informed consent is sought, post-operative follow-up, record keeping and clinical governance activities.

Service Description/Care Pathway

Referrals/booking of appointments

3.5 Upon receipt of the referral (via Choose and Book or paper referral through the Referral Management Centre), the Provider will review the referral for any information which may indicate that the procedure is not appropriate, either for this setting or for the Service User (see 3.8 if Service User is unsuitable for local anaesthetic).

3.6 If the referral is received from an out-of-county GP practice, then the Provider will notify Somerset Clinical Commissioning Group immediately (SCCG). The SCCG will need to liaise with their commissioning colleagues in the respective Clinical Commissioning Group to ensure that this is agreed and a funding process is put in place. The Service User cannot be booked for the counselling/procedure until this has been confirmed – the Provider should advise the referring GP that this process is being undertaken.

3.7 If appropriate, confirmation in writing of the appointment booked, enclosing relevant information (see Appendix A for a sample leaflet) should be sent to the Service User. Appointments should be booked as far as possible, according to Service User choice. The Service User should be contacted within two weeks of the referral to arrange the first appointment, with the aim of completing the procedure within eight weeks, subject to Service User choice, i.e., ten weeks from referral. This is in line with local surgical referral to treatment targets. If a Service User choses to undergo the procedure at a time outside of the ten week target, then it may be reasonable to suggest the Service User is referred at a time when he is ready.

[5] See reference 4.6

3.8 If the Service User is not a suitable candidate for surgery under a local anaesthetic, the Provider should make an onward referral to secondary care or, alternatively, the referring doctor should be notified in order that s/he may discuss the options with the Service User. If there is a query with regard to the Service User's suitability for the procedure, the Provider may need to liaise with the referring doctor.

3.9 It is assumed that the referring doctor will have had an initial conversation with the Service User regarding the options relating to permanent contraception.

Assessment and counselling

3.10 The Provider will need to assess the Service User 's suitability for surgery, particularly:

- any relevant medical history, including current or recent medication
- history of allergy to local anaesthesia
- active sexually transmitted infections
- inguinal or scrotal condition
- whether coercion is suspected
- whether the Service User has few or no children or is in an unstable relationship
- awareness of other forms of contraception

3.11 Please refer to 3.8 above if there is a clinical reason for not doing the procedure under local anaesthetic. More detailed information regarding contra-indications to vasectomy under local anaesthesia can be sought from the Royal College of Obstetricians and Gynaecologists Guideline on Male and Female Sterilisation.[6]

3.12 In addition, the counselling session should inform the Service User of the purpose of vasectomy and determine the Service User's understanding of the procedure and the decision which is being taken. It should cover:

- irreversibility
- details of the procedure and the arrangements that the Service User should make on the day of the operation
- details of post-operative testing and precautions that should be undertaken following the procedure until testing confirms sterilisation is complete
- failure rates
- recanalisation
- acute and chronic complications (including infection, bleeding and acute/chronic scrotal pain).

3.13 The Provider needs to ensure that the Service User is competent to make a choice to have this method of permanent contraception and is aware of the alternative methods of contraception via the written information provided to the Service User (see 3.9 above) and counselling. Please refer to the new General Medical Council guidance regarding consent[7]. Please also refer to paragraphs 3.34 – 0.

[6] See Reference 4.6
[7] See Reference 4.7

3.14 Counselling should be provided by either the operating practitioner or a fully trained registered nurse with a 15-30 minute appointment, at least a week prior to the intended procedure date and no earlier than six months in advance of the procedure. The Service User's partner (where relevant) should be encouraged to attend for the counselling session.

3.15 A sample checklist documenting the key areas that should be covered, including a Service User consent form, is included at Appendix B.

3.16 Information sent to the Service User when the initial appointment is booked should be followed up during the counselling session to ensure the key points are understood and the Service User is ready to give consent to the procedure. Samples of information provided to Service Users are included at Appendix A and, as a minimum, must cover details listed in paragraph 3.13.

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

3.18 Refer to an appropriate primary care or other care pathway where alternative treatments are identified as required, eg, counselling services, GUM clinic, screening and management services for STIs and HIV and psycho-sexual health within local networks.

Procedure

3.19 Prior to the procedure, the operating practitioner (vasectomy surgeon) should re-check that the Service User has received all the necessary information and has provided written consent to the procedure using the relevant documentation (especially where the counselling has not been provided by the operating practitioner). In addition, the practitioner should confirm that the Service User has organised suitable transport to return home following the procedure.

3.20 A reminder should be provided to the Service User about the need for continuing contraception until the final samples have been provided and the operation deemed to be successful (information regarding samples and where to take them should already have been provided in the initial pack – see Appendix A). In addition, the Service User should be made aware that the provider will ask for their feedback on the service once they have provided the final samples. A copy of the Service User survey is detailed in Appendix C.

3.21 The procedure will be delivered under a local anaesthetic by scalpel or non-scalpel (diathermy) method, to cut the vas deferens in order to achieve a permanent method of contraception in men. 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 should not be used for occluding the vas as failure rates are unacceptably high.[8]

3.22 Where the procedure involves re-section of the vas, then this should be sent to histology at the local Acute Trust where the vasectomy surgeon considers this to be appropriate.[8]

[8] See Reference 4.6

3.23 The operating practitioner should remind the Service User about what they can and cannot do immediately following the procedure and what to expect with regard to the wound/common problems and how to deal with them. The Service User should receive advice about post-operative semen analysis (see 3.26 below). Finally, some brief advice should be given about when the Service User should be able to return to work.

3.24 The Service User must be provided with a contact number to access the Provider (not their registered GP) should they have any questions or post-operative symptoms (noting contact for out of hours period for any acute problem when the Provider is not contracted to be open).

3.25 Where the operating practitioner is away from the Provider premises for a week or longer, arrangements with another colleague providing this service should be made to ensure there is appropriate cover for any queries that are raised, which cannot wait for the practitioner to return.

Follow-up/Completion

3.26 Providers will be required to provide Service User s with appropriate information about post vasectomy semen analysis and how to access the service. The information should include the rules for provision of samples and how to ensure they arrive at the correct laboratory.

3.27 Post-vasectomy semen samples should be sent to the appropriate Acute Trust in line with the Trust protocols. The first sample should be provided at least both 20-weeks and 25 ejaculations post-vasectomy, the second sample should be provided no sooner than 2 weeks after the first.

3.28 Results will be provided to the Provider of the vasectomy service who will inform the Service User of the results and whether any further samples are necessary.

REPORTING

Activity Reporting

3.29 Activity data shall be submitted using the enhanced services monitoring return which should be submitted by the 10th working day of the following month after the end of a quarter. The months for submission are therefore July; October; January; and April.

Reporting of Significant / Adverse Events

3.30 The Department of Health emphasises the importance of collected incidents nationally to ensure that lessons are learned across the NHS. A proactive approach to the prevention of recurrence is fundamental to making improvements in patient safety.

3.31 The Provider should be aware of (and use as appropriate) the various reporting systems such as:

- the NHS England National Reporting and Learning System https://report.nrls.nhs.uk/nrlsreporting/

- the Medicines and Healthcare products Regulatory Agency reporting systems for adverse reactions to medication (yellow card system), and accidents involving medical devices; and

- the legal obligation to report certain incidents to the Health and Safety Executive under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)

3.32 In addition to their statutory obligations, the Provider will notify the Commissioner within 72 hours of being aware of the hospital admission or death of a patient being treated by the Provider under this enhanced service where the Provider believes that the treatment was a significant contributor to the cause of admission or death.

3.33 In addition to any regulatory requirements the CCG wishes the Provider to use a Significant Event Audit system (agreed with the Clinical Commissioning Group) to facilitate the dissemination of learning, minimising risk and improving patient care and safety. Providers shall:

- Report all significant events to the CCG within 2 working days of being brought to the attention of the Provider, via the Incident Reporting System http://wyndatix.xdshc.nhs.uk/Datix/GGC/index.php or via the Medications Incident Report icon  situated on the GP desktop and on the pathway navigator, or via the CCG Feedback icon on your desktop.

- Undertake a significant event audit (SEA) using a tool approved by the CCG and forward the completed SEA report to the CCG within one month of the event

Consent

3.34 The service user shall be fully informed of the treatment options, risks and the treatment being proposed, consented in writing and willing to participate.

3.35 Providers must ensure valid consent is obtained from the patient in accordance with the provider's local consent policy. For guidance on developing a consent policy providers should refer to the current Department of Health Guidance.

Record Keeping

3.36 The Provider should maintain records of:

- all referrals received recorded by Service User name, referring practice and where serving military personnel, where that service user is stationed
- details of any onward referrals and the reason for referring
- the Service User 's medical history, including consent received from the Service User
- evidence of counselling to include the explanation of risks
- procedures completed
- any procedure or post-operative complications
- any adverse incidents or near misses.

3.37 The referring practice should be notified when the procedure is complete (after final sperm testing, so that this can be added to their lifelong medical record).

3.38 Records should be kept by the Provider for a minimum of eight years.

Monitoring

3.39 The Provider shall undertake continuous monitoring of the Service and have processes in place to respond to any identified issues.

Key Performance Indicators

3.40 100% of vasectomy procedures, where motile sperm are identified in the second post vasectomy sample, are to be reviewed to understand the cause of failure.

100% of patients to be requested to complete post vasectomy patient survey with results reviewed and acted upon (Refer to Schedule 2 Part G of the Contract Particulars).

Clinical Governance Sessions, Audit and Service User Surveys

3.41 Providers will undertake three clinical governance sessions per annum. These will comprise different elements of performance review and Continuing Professional Development (CPD) as detailed in paragraphs 3.42-3.44 below.

3.42 A performance review of activity, at least annually. The Commissioner may request a copy of the review which will include the following:

-
- number of operations undertaken in the period
- number of Service Users 'completed' (i.e., have provided their two samples satisfactorily)
- any procedural or post-operative complications and whether these were preventable (including infection rates)
- Service User survey results (see 3.45 below)
- failure rates
- Service User complaints

3.43 Annual peer review with representatives of other Service Providers which may be undertaken virtually with the assistance of information technology.

3.44 One session dedicated to CPD, ensuring new evidence is reviewed and skills refreshed as necessary.

3.45 Providers will survey all Service Users annually who have provided their two post-operative samples satisfactorily for a range of areas (sample survey included at Appendix C). This survey should include, as a minimum, infections reported, information provided and the medical care provided.

Accreditation/Training/CPD

3.46 Doctors providing the vasectomy service are expected to:

- have current minor surgery experience

- have specific training regarding vasectomy provision, conforming to that advocated by the Faculty of Family Planning and Reproductive Health Care (FFPRHC).[9]
- have undertaken 40 vasectomy procedures within the most recent 12 months and provided a minimum of one vasectomy operating list per month.[10]
- keep up-to-date with current best practice and guidance
- undertake audits of own complication and failure rates.

3.47 Evidence of the above requirements shall be provided to Somerset CCG prior to initial commencement of the service. Where a new Provider/practitioner is looking to provide the service, the Somerset CCG retains discretion to accredit if the volume of procedures is less than detailed in 3.46.

3.48 Where existing Providers/practitioners have been accredited by previous health organisations, Somerset CCG will retain discretion to accredit on the consideration of that information provided by the Provider in line with the FFPRHC recommendations (including complication/failure rates).

3.49 Doctors providing this service should have annual basic life support training and be competent in resuscitation and, as for other areas of clinical practice, have a responsibility for ensuring that their skills are regularly updated. Evidence of training and updating will be required as part of the review process.

3.50 Nurses assisting in providing this service should be appropriately trained and competent, taking into consideration their professional accountability and the Nursing and Midwifery Council (NMC) guideline on the scope of professional practice. This will include training associated with anaphylaxis and basic life support as a minimum.

Premises

3.51 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.

3.52 Facilities should be self-assessed using the tool at Appendix D. As a minimum, there should be:

- disabled access to the premises, operating room and waiting area
- the treatment room should have space to enable movement around the operating table/couch, ie, adequate space and equipment for the procedure and resuscitation
- resuscitation equipment and drugs (check this against Appendix D)
- a sink for hand washing
- workspace for instruments
- clinical waste bin (pedal operated)
- an area of recovery if the treatment room is not available

Infection Control

3.53 Providers must have infection control policies that are compliant with national and local guidelines and current handling protocols, including but not limited to The Health and Social

[9] See Reference 4.6
[10] See Reference 4.8

Care Act 2008 Hygiene Code[6] and which takes into account:

- disposal of clinical waste
- needle stick incidents
- environmental cleanliness
- standard precautions, including hand washing

3.54 The Provider should use single use equipment for any part of the procedure where the skin is broken.

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

3.56 Service Users should be involved in the decisions about their treatment and given high-quality information to enable them to make fully informed decisions regarding their care.

3.57 Practices should encourage, consider and report any Service User feedback (positive and negative) on the service which they provide and use it to improve the care provided to Service Users, particularly if there are plans to alter the way a service is delivered or accessed.

Population Covered

3.58 The service is open to all male Service Users currently registered to a general medical practice responsible to the Somerset Clinical Commissioning Group (SCCG) and to all service military personnel, based in Somerset.

Any acceptance and exclusion criteria and thresholds

3.59 See above.

Interdependence with other services/providers

3.60 Andrology Services

4. Applicable Service Standards

Applicable National Standards (eg NICE)

4.1 Department of Health (DH). April 2007 – Implementing care closer to home: Convenient quality care for Service User s. Available via www.dh.gov.uk, gateway reference 7954

4.2 Department of Health (England) Guidance on Consent for Examination or Treatment

4.3 The Health and Social Care Act 2008 Hygiene Code. Available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216227/dh_1

23923.pdf

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

4.4 Cook LAA, Van Vliet HHAAM, Lopez LM, Pun A, Gallo MF. *Vasectomy Occlusion Techniques for Male Sterilisation.* Cochrane Database of Systematic Reviews 2007, Issue 2. Art No: CD003991. DOI: 10.1002/14651858.CD003991.pub3.

4.5 Greek, G. 2000. Vasectomy – a safe and effective, economical means of sterilisation. Journal of Postgraduate Medicine. Vol. 108/No 2

4.6 Royal College of Obstetricians and Gynaecologists (2004) – Clinical Guideline 4 – Male and Female Sterilisation.

4.7 General Medical Council (GMC) 2008. Consent: Service User s and doctors making decisions together. Report published 2008. Available at www.gmc-uk.org/guidance/ethical_guidance/consent_guidance/

4.8 Faculty of Sexual Reproductive Healthcare. (Revised May 2008). Syllabus and logbook for the Certificate in Local Anaesthetic Vasectomy – www.fsrh.org

4.9 Sharlip ID, Belker AM, Honig S, Labrecque, M, Marmar JL, Ross LS, Sandlow JI, Sokal DC. Vasectomy: AUA guideline. The Journal of Urology. Volume 188, 2482-2491, December 2012. 2. Available at www.auanet.org/common/pdf/education/clinical-guidance/Vasectomy.pdf

4.10 Dohle, GR, Diemer T, Kopa Z, Krausc C, Giwercman A, Jungwirth A. European Association Guidelines on Vasectomy. European Urology 61 (2012), 159 -163. Available at www.ncbi.nlm.nih.gov/pubmed/22033172

Applicable local standards

4.11 Not applicable

5. Applicable quality requirements and CQUIN goals

5.1 Applicable quality requirements (See Schedule 4 Parts A-D)

5.2 Applicable CQUIN goals (See Schedule 4 Part E)

Not applicable

6. Location of Provider Premises

6.1 **The Provider's Premises are located at:**

As defined in Schedule 5 Part A

7. Individual Service User Placement

Not applicable

APPENDIX A

VASECTOMY

Vasectomy is a permanent method of contraception for men. It is safe, simple and effective.

What is vasectomy?

Vasectomy is a surgical procedure, which cuts the sperm-carrying tubes. It prevents the sperms made by the testicles joining the fluid at ejaculation. The sperm only form 2% of this fluid – the rest of which comes from other glands, such as the prostate.

Who chooses vasectomy?

…any man who feels that his family is complete, or who is certain he will never want children. He does not have to be married, or have children already. We would advise anyone considering undertaking this procedure to discuss this fully with his GP in the first instance (preferably accompanied by his partner). Any further issues or concerns can be discussed when you see the *PRACTICE TO CLARIFY WHO WILL CARRY OUT THE COUNSELLING* for counselling at our surgery at least 2 weeks before going through with vasectomy. Please telephone *PRACTICE NAME AND TELEPHONE NUMBER*. You will also have the opportunity to ask the doctor questions before the operation. We will be asking you to sign a consent form to ensure you understand this leaflet and the consequences of the operation.

We want you to read this information leaflet and be certain in your own mind that vasectomy is right for you. Vasectomy does not help anyone who is going through sexual difficulties within a relationship, in which case specific counselling should be sought.

Vasectomy should always be thought of as a permanent, irreversible form of contraception.

How effective is vasectomy?

Vasectomy is the safest form of contraception available, but even so there is a chance of failure which can be up to 2 in 100 in the earlier stages, but just 1 in 1,000 thereafter. This can occur because the sperm-carrying tubes can re-join. This may happen soon after the procedure, and will be detected. However, this may happen in rare cases some years after the operation and the only way of knowing would be if your partner became pregnant. A few men have more than one sperm carrying tube that may be another reason for early failure. In cases of failure, a further operation can be arranged.

What can go wrong?

Vasectomy is safe and the risk of long-term problems is small. Any surgical procedure carries a small risk of bleeding and infection. Immediately after a vasectomy some men can get excessive bruising and swelling. As with any operation, the wound can become infected, very occasionally this can spread to involve the tubes and testicles. These complications are unlikely if you follow instructions and rest with your feet up, for the first 48 hours. You should also avoid heavy work and sports for a further week. Contact sports, riding a bicycle or motorbike should be avoided for three weeks. Later on a small nodule sometimes develops around the cut end of the tube; this is harmless, but occasionally causes discomfort. Chronic (long term) post-vasectomy testicular pain is a recognised complication after vasectomy. Studies working at how often this occurs are of poor quality and give greatly differing estimates. However, for most people who suffer this problem, the pain is mild, intermittent and little trouble.

Does vasectomy increase the risk of cancer?

There is no conclusive evidence of a link between vasectomy with testicular or prostatic cancer. *However, we would recommend that all men regularly check their testicles for any lumps.*

Is vasectomy permanent?

A vasectomy operation must be considered final. If you have any doubts about being sterilised, you should not go ahead with the operation. It can be possible to surgically rejoin the cut ends of the sperm-carrying tubes. However, the sperm are often damaged and unable to function normally and so infertility persists.

How is it done?

A vasectomy is generally a straightforward operation, which takes about 10 - 15 minutes. It involves injecting a small amount of local anaesthetic into the skin of your scrotum (bag of skin over the testicles), at the front, in the middle. The anaesthetic is also injected around the tubes, the vas deferens, which carry the sperm up from each testicle. These tubes lie beneath the skin of your scrotum where they are relatively easy to reach.

Diathermy (a probe that uses an electrical current to heat the tissue) is used to remove two centimetres from the tubes. The wound is then reduced in size to 2-3 mm, again with the diathermy probe. This means there will be no stitches, only a dry dressing over a small open wound.

When will I be sterile?

You will not be sterile immediately after your vasectomy. It takes some time – usually 3-4 months – for all the sperm in the storage system ahead of where your tubes have been blocked to work their way through. After your operation, you will be given 2 pots and instructions for collection of 2 samples of seminal fluid. ***This should be done at 20 weeks and 22 weeks after your operation.***

Only when you have produced 2 consecutive, completely sperm free samples, can you be considered sterile.

You will need to continue to use contraception until we have confirmed that you are sterile. Once your sperm counts are negative, you undoubtedly have the safest method of contraception available. However, though the chance of sperm finding their way back and functioning years later is extremely rare, it is still possible.

Will vasectomy affect my sex life?

Orgasm and ejaculation are not affected by vasectomy and nor are the male hormones. Sperm are still produced, but their way into the ejaculate is blocked, and so the body reabsorbs them. Some couples find new sexual freedom when they no longer have to worry about pregnancy.

What do I have to do before my vasectomy?

You do not need to starve and can eat and drink normally. Just before your operation, shower or bathe. Shaving the area is not required.

Arrange for someone to accompany you as you will need to be driven home. You will need to have two days off work following your vasectomy, longer if you do manual work.

After your vasectomy

A vasectomy is performed under local anaesthetic, which takes about two to four hours to completely wear off. Take some simple painkillers, such as paracetamol, 30 minutes before the vasectomy, and repeat this four hours later once you get home. You should expect some discomfort but this varies from person to person. You will be able to pass water normally.

Spend the next two days off work, with your feet up, doing very little. This is very important and helps reduce the discomfort. You will experience a variable amount of swelling and bruising. You should wear tight fitting pants for support, rather than boxer shorts.

48 hours after your vasectomy have a shower or a quick bath and soak off the dressing carefully. Dry the cut afterwards with a clean towel. If it is dry, leave it open to the air, it is still oozing, cover it with a clean dry dressing.

After the first 48 hours, do what is comfortable, and gradually return to normal activity. Do not do any heavy work during the first week. Sexual activity can be resumed whenever you are comfortable, usually at about one week. Avoid any contact sports and do not ride a bike or motorcycle for at least 3 weeks. If you are worried please consult your own doctor.
At your operation, you will be given 2 sample pots, forms and instructions for post-op sample checks.

Continue to use contraception until you have heard from us that your vasectomy has proved successful.

If you have any concerns or problems following the operation please contact your own GP in the first instance.

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At

PRACTICE NAME

Patient Information

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APPENDIX B

Assessment, Counselling and Consent Proforma for Vasectomy

Patients Surname: …….. Forename(s): ……

Date of Birth: …… Telephone: ……..

Address: ……...

…….. Postcode: …….

Date counselled: ……

Medical History

Please tick the box if the patient has any of the following:

Jaundice / hepatitis:	☐
Any heart problem:	☐
A cardiac pacemaker:	☐
Hernia surgery:	☐
Surgery for undescended testicle (at any age):	☐
Other testicular surgery (at any age):	☐
Bleeding / clotting problems:	☐
Any other serious illness:	☐
Any problems with local anaesthetic (inc.dental):	☐
Allergies (inc.local anaesthetic & adrenaline):	☐

Further details, if yes to any of the above:

……

……

……

……

Medication History

Is the patient taking aspirin or warfarin?	Yes☐	No☐
Is the patient taking any other medication?	Yes☐	No☐

Further details, if yes to either of the above:

……

……

Family History

If applicable, age of any children the patient and his current partner have by this or previous relationships

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……

Counsellor's Checklist and Notes

I confirm that I have discussed the following issues with the patient:

Pre-vasectomy leaflet	☐	Alternatives to vasectomy	☐
Medical/drug history & allergies:	☐	Arrangements to be made on the day of the	
Contraception post-vasectomy:	☐	operation	☐
Early and late failure:	☐	Semen test procedures:	☐
Infection & haematoma risk:	☐	Acute & chronic testicular pain:	☐
Reversibility of vasectomy:	☐	The cost/success of reversal surgery:	☐
Sexual function	☐	Post-vasectomy advice	☐

Notes: ……..

……..

……..

……..

……..

I have counselled this man about vasectomy. In my opinion he understands completely the operation, its complications, limitations and risks. Therefore, I believe his consent, given below, is fully informed.

Signed (counsellor): …… Date: ……

Patient's Consent

I, ……...

of……

…… Date of birth: ……..…..

consent to undergo vasectomy, with the use of local anaesthetic, in the knowledge that:

- The purpose of vasectomy is to make me sterile and thus unable to father any children.
- I consider this to be a permanent, irreversible form of contraception.
- No assurance has been given that it will be 100% safe or successful.
- There is a risk of bleeding, bruising, infection and early and late testicular pain
- There is a risk of both early and late failure of the operation.
- Two consecutive negative sperm counts must be obtained before I can stop using other contraception
- The NHS does not fund reversal of sterilisation except in rare circumstances

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Signature(s):

Patient: …….. Date: ……..

Partner: (not compulsory)……..... Date: ……

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APPENDIX C

Vasectomy Service Patient Survey

A patient survey as outlined in the service specification will include an audit of:

The register of patients who have undergone surgery

The demographic profile of all initial referrals received.

The number and percentage of patients who have had a counselling appointment and then proceeded to having the vasectomy procedure

Average and range of waiting times .

Number and % appointments not attended (DNA).

Report on Significant Adverse Events, including numbers, type and lessons learnt

Number of complaints (written and verbal) and lessons learnt.

Complication rates by clinician

Postoperative complication rate by clinician

Postoperative infections rate by clinician

Return rate for second sample

The number and percentage of patients achieving a negative semen result (evidence of successful procedure) with an agreed timescale post operatively

The number and percentage of patients not producing samples therefore no confirmed negative results

The number and percentage of patients who require a second procedure

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Vasectomy Satisfaction Survey

To help us to continue to provide the best vasectomy service possible, feedback from you is essential.

Now that you have had two consecutive semen samples clear of sperm, I would be grateful if you would spend a few minutes completing the following questionnaire:

Please circle your answers or comment where appropriate.

Please rate the following in the range of one (poor) and five (excellent):

Ease of getting a convenient appointment	1	2	3	4	5
Information in your appointment letter	1	2	3	4	5
Reception when you arrived at the surgery	1	2	3	4	5
The counselling	1	2	3	4	5
The medical care	1	2	3	4	5
The information pack for after the vasectomy	1	2	3	4	5

Would you have preferred the counselling and the vasectomy to be on the same day?

Yes No

Please rate any pain/discomfort you felt during or soon after the vasectomy; using a scale of one (severe pain) to five (minimal pain):

During the vasectomy	1	2	3	4	5
In the first few days after the vasectomy	1	2	3	4	5

Please rate any problems arising after the vasectomy: using a scale of one (severe) to five (minimal):

Bruising	1	2	3	4	5
Bleeding	1	2	3	4	5

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Other problems (please specify)

Did you see your GP for any reason arising from the vasectomy?
Yes No

If yes, please give details

Did you develop a wound infection needing antibiotic treatment? Yes No

How many semen samples did you provide before two consecutive samples were clear?

Overall, please rate the vasectomy service, using the rate one (poor) to five (excellent)

1 2 3 4 5

Please use the space below for any additional comments you may have about this service, and/or any suggestions for improving it.

Thank you for taking the time to complete this questionnaire. Your feedback will be treated confidentially and will help improve services to our patients.

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APPENDIX D

DRAFT FACILITIES AND EQUIPMENT SELF ASSESSMENT

Practice Name:

Items to check	
Do you have sole use of the room? Is the room fit for Minor Surgery use i.e. dedicated space / access around operating table?	Yes / No / Not applicable
Do you have sole use of the patient waiting area?	Yes / No / Not applicable
Do you have recovery facilities? (number of spaces)	Yes / No / Not applicable
Do you have:	
Hand washing facilities?	Yes / No / Not applicable
Liquid Soap?	Yes / No / Not applicable
Alcohol hand gel?	Yes / No / Not applicable
Paper Towels?	Yes / No / Not applicable
Gloves – sterile?	Yes / No / Not applicable
Gloves – non-sterile?	Yes / No / Not applicable
Aprons?	Yes / No / Not applicable
Masks?	Yes / No / Not applicable
Eye protection?	Yes / No / Not applicable
Latex free products?	Yes / No / Not applicable
Use of single use items where appropriate	Yes / No / Not applicable
Are trolleys/work surfaces appropriate for their use?	Yes / No / Not applicable
Ample, safe storage facilities?	Yes / No / Not applicable
Foot operated bins?	Yes / No / Not applicable
Regular Waste Collection?	Yes / No / Not applicable
Sharps Containers labelled and signed?	Yes / No / Not applicable
Linen Disposal?	Yes / No / Not applicable
Washable working surfaces?	Yes / No / Not applicable
Resuscitation equipment, Oxygen/Defibrillator/ Emergency Drugs/Ambi-bag or venti mask?	Yes / No / Not applicable
Floor & Wall Coverings are washable, durable, clean?	Yes / No / Not applicable
Cleanable lighting (if manually operated)?	Yes / No / Not applicable
Is there a suction machine/suction tube available?	Yes / No / Not applicable
Where appropriate privacy screens/curtains in place?	Yes / No / Not applicable
Cleaning schedule for clinical areas?	Yes / No / Not applicable
COSHH reports for all hazardous substances?	Yes / No / Not applicable
Specimen storage (fridge) not stored with other products?	Yes / No / Not applicable
Staff vaccinations?	Yes / No / Not applicable
Equipment maintenance contract?	Yes / No / Not applicable

This list is not intended to be the sole requirements for facilities, please refer to the specification. If any questions are answered negatively the Primary Care

Trust may wish to discuss any necessary changes to facilitate the continued commissioning of this service.