Service Specification No.	
Service	**Vasectomy Service**
Commissioner Lead	**Jayne Mellor, Director of Transformation & Delivery**
Provider Lead	
Period	**1st April 2023 to 31st March 2024**
Date of Review	**Annually**

1. Population Needs

1.1 National/local context and evidence base

This specification is for the provision of a community-based vasectomy service.

Vasectomy is a procedure that stops sperm from travelling to the testis through the cutting of the vas. It is recommended by the Royal College of Obstetricians and Gynaecologists as the preferred method of sterilisation.

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

Sterilisation has become increasingly popular since the late 1960s and it is now the principal method of contraception used worldwide. Approximately 190 million couples use tubal occlusion while 42 million men have had a vasectomy.

In 2001, 44% of women aged 45–49 years in Great Britain were using sterilisation of themselves or their partner as their method of contraception.

Of women aged 16–49 years, 10% had been sterilised, and of men aged 16–64 years, 15% had undergone vasectomy. A study of the General Practice Research Database data suggests that in 1999 an estimated 47, 268 tubal occlusions and 64, 422 vasectomies were performed in England by the NHS and charitable sectors.

The lifetime failure rate is about 1 in 2,000. This means that one out of 2,000 men who are sterilised will get a woman pregnant during the rest of his lifetime.

Vasectomy carries a lower failure rate in terms of post-procedure pregnancies and that there is less risk related to the procedure than sterilisation of women.

Sterilisation procedures, both male and female are frequently the subject of litigation. The most important influencing factor appears to be the competence of the practitioner surrounding sterilisation provision – this was partly the reason why National Guidance was deemed necessary

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 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

3. Scope

3.1 Aims and objectives of service

The aims of the vasectomy service are to:

- ensure that the full range of contraceptive options is offered by local providers to patients.
- provide an effective accessible and appropriate vasectomy service within a local Primary Care setting
- provide a vasectomy service in accordance with the Royal College of Obstetricians and Gynaecologist guidelines, as another means of reducing unwanted pregnancies
- provide more choice for patients: value for money through reduced costs: increase in quality outcomes: assist in achieving the national and local targets (e.g., waiting times.)

3.2 Service description/care pathway

The vasectomy service will be delivered in line with the Royal College of Obstetricians and Gynaecologists (RCOG) Male and Female Sterilisation Evidence –evidence base clinical guideline number 4 2004. The service is set out in three stages

Stage One - Pre-Vasectomy Counselling

a) Men should be informed that reversal operations or intracytoplasmic sperm injections are rarely provided within the National Health Service.
b) Providers will be required to offer counselling appointments at various times to meet the needs of patients who may wish to access the service. The provider must ensure that counselling appointments are available up to 14 days in advance. Ideally the counselling sessions should be delivered to both the patient and their partner.
c) The counselling session should inform the patient of the purpose of vasectomy and determine the patients understanding of the procedure and decision that is being taken within the context of a service providing a full range of information about and access to other long-term reversible methods of contraception. This should include information on the advantages, disadvantages and relative failure rates of each method.
d) All verbal counselling must be supported by accurate, impartial printed or recorded information (in translation, where appropriate and possible), which the person requesting sterilisation may take away and read before the operation.
e) As a precaution against the risk of later regret, additional care must be taken when counselling people under the age of 30 years or people without children.
f) Care should also be exercised in discussions with people taking decisions during pregnancy, or in reaction to a loss of relationship, or who may be at risk of coercion by their partner or family or health or social welfare professionals.
g) Counsellors and advisers should also be aware and take account of cultural, religious, psychosocial, psychosexual and other psychological issues, some of which may have implications beyond fertility.
h) If there is any question of a person not having the mental capacity to consent to a procedure that will permanently remove their fertility, guidelines from the Official Solicitor make it clear that the case should be referred to court for judgment.
I) Men should be informed that vasectomy has an associated failure rate and that pregnancies can occur several years after vasectomy. The rate should be quoted as approximately one in 2000 after clearance has been given.

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

a) that undertaking this procedure is viewed as a permanent form of contraceptive. That if circumstances change there is no automatic right to seek a reversal which are rarely funded within the NHS and reversals are rarely successful
b) details of the procedure to be undertaken and the arrangements that the patient should make on the day of the operation
c) details of the post-operative testing required and precautions that should be undertaken following the procedure until such time as the testing confirms sterilisation is complete
d) details of any contra indications or complications that may occur as a result of this operation and how to access the provider (not their registered GP) for advice or actions on any complications that may occur including those complications requiring urgent medical attention.
e) The information should also include the agreed date of the operation (within 4 weeks of the counselling appointment). Where a patient wishes to further consider their options, details of how to access the service for an operation date when a decision to proceed is made, should be provided. (The open arrangement should not be offered more than 6 months after the initial counselling appointment)
f) A complete history and examination should be taken to rule out any conditions that may complicate the procedure or result in complications (re: RCOG guidelines) should be performed on all men requesting vasectomy.
g) Records should be made regarding the history, counselling process, and any problems with the vasectomy and follow-up arrangements.
h) Written consent should be obtained for the operation and the documentation should clearly demonstrate that the patient has received all of the information in the pre-counselling requirements

Stage Two - Surgical Operation

a) The operating doctor will need to ensure that the counselling, information exchange, history, examination, and written consent have been completed and be satisfied that the patient does not suffer from concurrent conditions which may require an additional or alternative procedure or precaution.
b) Providers should deliver a service where 85% patients operation appointments are seen on time and 100% should be seen within 15 minutes of their operation time
c) Vasectomy should be performed under local anaesthetic wherever possible. Where there are contraindications to vasectomy under local anaesthesia a general anaesthetic may be necessary in which case the patient should be referred to secondary care for the procedure.
d) Pathology: Excised portions of the vas should only be sent for histological examination if there is any doubt about their identity.
e) Patients should receive written advice about post-operative care and post-operative semen analysis including the use of effective contraception until azoospermia has been confirmed and should include how to access the provider (not their registered GP) for advice or actions on any complications that may occur.

Stage Three - Post Vasectomy testing

Patients will be provided with appropriate information about post vasectomy semen analysis and how to access the service to undertake a sperm count 16 weeks after the procedure to check for azoospermia and proceed accordingly.

In the event of sperm being present a fresh sample 7 month after the procedure should be provided, a special clearance can be considered when <10,000 non motile sperms are present in a fresh sample

3.3 Equipment / Premises

The provider is required to ensure that all premises and equipment meet the required standards for delivery of an invasive vasectomy service.

Adequate and appropriate equipment should be available for the doctor to undertake resuscitation.

3.4 Minimum Required Activity

Clinicians taking part in this service should be able to demonstrate a continuing sustained level of activity (i.e., at least 6 vasectomies be performed within the previous 12 months)

3.5 Activity Reporting

Method of Reporting	Frequency	Consequence if Report Not Received
Numbers to be included on the Commissioning Support Unit (CSU) claims spreadsheet	Monthly	Non-payment

The provider is required to submit a claim to the Commissioning Support Unit, via the services spreadsheet to enhancedserviceslcsu@nhs.net by 10th of each month for processing.

3.6 Audit

Full records of all procedures should be maintained in such a way that data and details of individual patients are readily accessible. Practices should regularly audit and peer-review the procedures carried out. Possible topics for audit could include clinical outcomes or rates of infection.

3.8 Fraud

In the event of suspected fraud or other illegality being uncovered at any stage the ICB will implement the ICB Fraud Policy and will investigate.

Information supporting reported activity and monitoring information must be made available to the ICB or its representatives upon request. Failure to provide this information, or the provision of incomplete or inaccurate information, may result in suspension of payments or clawback, as well as further investigation by the ICB and its representatives.

3.9 Eligibility / Criteria and Accreditation

Doctors performing vasectomies in primary care settings should be able to demonstrate appropriate training or experience.

3.10 Any acceptance and exclusion criteria

All patients requesting a vasectomy, not requiring a general anaesthetic

3.11 Interdependencies with other services

GP Practices referring into the service
Pathology Laboratories
Secondary care vasectomy service provider
Accredited Andrology Services
Contraception and Sexual Health (CASH)
Genito-Urinary Medicine (GUM)

4. Applicable Service Standards

4.1 Applicable national standards (e.g., NICE)

4.1.1 Infection Prevention
The service provider is required to adhere to all current infection prevention guidance including the Health and Social Care Act 2012 and NICE Guidance CG139 or relevant guidance which supersedes these detailed.

4.2 Applicable standards set out in Guidance and/or issued by a competent body

4.3 Applicable local standards

5. Applicable quality requirements and CQUIN goals

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

Detail	Evidence Required to Meet Indicator	Source of Evidence	Consequence of Breach	Frequency of Indicator
Pre-vasectomy counselling	Signed consent form	Practice	Agree timescale to rectify breach	Annually
History and Examination	Notes	Practice	Agree timescale to rectify breach	Annually
Written post-operative advice	Copy of information	Practice	Agree timescale to rectify breach	Annually

5.2 Applicable CQUIN goals (See Schedule 4 Part E)

6. Location of Provider Premises

The Provider’s Premises are located at the GP practice whose address has been supplied previously.

7. Individual Service User Placement