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Gynaecology



Standards of Care for Women's Health in Europe

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Foreword

Over the past decade there has been an unprecedented emphasis on enhancing the quality of clinical care. This has been supported by the publication of a large number of clinical guidelines, protocols and policy documents by countries and institutions in Europe. However, there is still an evident disparity in accessibility to sexual and reproductive health services, in the quality of care across the countries and even in regions within the same country and in clinical outcomes. The significant variations in survival following cancer surgery and indeed the inequity in the treatment of common gynaecological conditions, such as heavy menstrual bleeding has a huge impact on women's lives and on their families. Such inequitable access to the delivery of healthcare systems has an economic and societal impact and therefore, there is a compelling need to improve delivery of care.

The European Board and College of Obstetrics and Gynaecology (EBCOG), being a representative body of the obstetricians and gynaecologists in its thirty six member countries, has set up a working party to look at various models of health service delivery, both within EU28 and beyond in order to address these issues. Following extensive discussion and consultation with stakeholders, including input from European organisations representing women's interests, the Working Party has now produced this document outlining the standards of care for various clinical conditions which affect women throughout their lives, from childhood to post-reproductive age.

These standards define a roadmap of quality service underpinned by clinical governance, safety and patient experience. The standards cover 25 key clinical areas such as sexual and reproductive health, fertility regulation, the prevention and treatment of female cancers, benign gynaecology and access to emergency gynaecology treatment, to cite a few. Each standard is set on the best available evidence and supported by a set of quality outcome indicators to benchmark services. The standards address the necessary requirements for training and support for doctors and healthcare professionals.

We are confident that these standards of care will be adopted by the Ministries of Health and also be used by healthcare professionals to deliver the best possible health care. This would be the only way to fulfil our inspiration of providing equitable and safe services with the best possible outcomes for women seeking gynaecological care anywhere in EU28 and beyond.



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Glossary of Terms Used In The Document

Clinical guideline	A systematically developed, evidence based guidance that assists in decision making about the appropriate healthcare for a specific clinical condition
Clinical protocol	A list of things that must be done in specific situations to achieve a specific outcome and no deviations are allowed
Standard operating procedure (SOP)	A set of written instructions applied to an activity undertaken at an organisational level
Care pathway	A list of steps which are taken for the care of a patient over time for a specific clinical problem with expected progress and outcomes. It may include referral arrangements between different health care providers/clinicians and organisations, instructions for investigations required at different levels of care and treatments recommended
Clinical practice standards	A specific and measurable target presenting the minimum care that is effective, safe and provides a good patient experience
Clinical audit	A process of quality improvement which involves a systematic review of care against clearly defined criteria. The ultimate objective is to improve patient care
Stakeholder	A person, group or organisation who may be affected by the guidance given for service development
Primary care	This describes the first level of care in the healthcare system. It is usually a General Practitioner or a family doctor but may be another healthcare provider, such as a specialist nurse or midwife who may be the patient's first point of contact. This is sometimes referred to as community care
Secondary care	Care which is provided by medical specialists with access to a range of investigations and treatment in a specialist setting. Some of these may take place as in-patient care, often hospital based but not always
Consumer	A woman, her family, or other representatives, who are currently or have previously utilised the healthcare services being described
Clinical governance	A framework through which health organisations create an environment to ensure continuous improvement in the quality of

their services and safeguard high standards of care

Educational Supervisor	A senior clinician responsible for one or more trainees overseeing their training programme and progression, sometimes referred to as a tutor or trainer.
Risk management	An approach for improving the quality of care and involving various methods for the early identification of adverse events, by using either staff reports, patient complaints, local or national alerts or a systematic review of patient records
Route cause analysis	A formal group review of the chronology of the events of cases with adverse outcomes to look at case management, why it happened and possibly offer suggestions for the alternative management of similar clinical scenarios in future
Multi-disciplinary	Involves a combination of two or more clinical departments/clinicians developing a clinical care package for a patient. It is about crossing boundaries and thinking across different disciplines
Open access clinic	An out-patient or ambulatory care clinic/facility primarily devoted to care in an out-patient setting. This clinic is staffed by appropriately trained staff, equipped with diagnostics offering specialised tests and treatments. Quite often the patient can call in or make an appointment to be seen
General out-patient clinic	Offers general diagnosis or treatments without an overnight stay
Specialist clinic	Provides advanced diagnostic or treatment for specific disease or parts of the body such as sexual health clinics, fertility clinics, etc
Ambulatory surgery clinic	Offers out-patient based, usually same day surgery services, for minor surgical procedures not requiring hospitalisation
Healthcare provider	An individual or organisation (hospital or clinic) that provides preventive, therapeutic or rehabilitative healthcare services in a systematic way to individuals, families or communities
Specialist nurses	Nurses who have specialist clinical experience and training and involved in the care of patients in defined clinical areas

1.0: Background

The Maastricht Treaty (1992)¹ forms the basis of a dedicated common public health strategy of the European Union (EU) and its Article 219 specifies that “The member states of the EU decided to co-ordinate their health policies and programmes with the co-operation of the European Commission to ensure a high level of health protection and to prevent widespread severe illness”. Subsequently, Article 152 of the Treaty of Amsterdam (1997)² enlarged the healthcare duties of the EU, clearly stating that EU action should complement national health policies to improve public health, prevent human illness and diseases and to obviate sources of danger to human health, thus encouraging a common approach to clearly defined public health problems. Currently, considerable inequalities in access to women’s health care exist among the member states of the EU and beyond.

There is a strong connection between perinatal health and chronic disease in adulthood; hence this was addressed in the EBCOG's Standards for Obstetric and Neonatal Services³. Here EBCOG continues with their strategy in setting standards of clinical care provided to women to ensure improvement of quality of care, accessibility and equality.

There is also a considerable gap in life expectancy at birth in the EU member states⁴. There are more than 5 million births each year in the EU and about 2 million women have failed pregnancies (spontaneous and induced abortion, as well as Ectopic pregnancies)^{5,6}. Cancer is the second most common cause of death in Europe and 1.3 million cancer deaths occurred (just 25% of total deaths) in 2008 in the 27 EU member states. Of these, approximately 500,000-600,000 deaths were due to cancers in females.

Although cancer survival rates are improving overall across Europe, the most up to date EU comparisons show that countries from central and eastern Europe still have worse cancer survival rates than many other countries, including Norway, Sweden, Germany, The Netherlands, Finland and France. The gap appears to be narrowing in breast cancer but the gap has not narrowed for ovarian, cervical and lung cancers. The five year relative survival improvement rate varies widely across these countries. There remain huge variations in breast and cervical cancer screening and human papilloma virus immunisation programmes across all European Countries.⁷⁻¹⁰

Variations in outcome can only be addressed by setting unified standards of care and by monitoring individual providers’ performance by using high quality data related to process and outcome indicators. This document will hopefully make an important contribution to achieving that goal.¹¹⁻¹⁵

The promotion of sexual health is closely tied to the promotion of fundamental human rights, such as non-discrimination, privacy, protection from violence, access to information and the rights to expression and association as well as the rights that support meaningful participation in society and politics.¹⁶⁻¹⁷

There is a regional and country level diversity as regards teenage pregnancy rates, the age at which sexual intercourse first takes place, contraceptive use at first intercourse, availability of contraception and access to abortion. HIV knowledge and STI rates also vary

widely. This situation is further complicated by a failure to collect standardised reproductive indicators and age specific data. Furthermore, the migrant/refugee population in Europe is also at risk.¹⁸⁻²⁰

Furthermore there remains inequitable access with variable outcomes to non-cancerous clinical conditions such as infertility, urinary incontinence and menstrual disorders across all countries in Europe. Such disparities in health care provision require urgent attention.

EBCOG Process of Developing Standards of Care for Gynaecology

The Council of EBCOG agreed, in May 2012, that a Working Party be established to oversee the development of core standards of care in Gynaecology. In order to facilitate this exercise, it was decided to gather information from the representatives of the member countries and also to review published reports from different sources in order to establish a baseline which could support the developmental process of Standards of care.

The Working Party

The EBCOG Standards Working Party was set with the aim of developing Europe-wide Standards of care for women's health services. Its remit was firstly to review current evidence based published Standards of care in the member states of the European Union.

Secondly, to develop Standards of gynaecological care for benign and malignant conditions affecting the health of women from childhood to the post-reproductive era.

The Working Party, Chaired by Dr Tahir Mahmood, included the EBCOG Officers Group, representatives of European Subspecialist Societies and Special Interest Groups and an invited external expert. In addition, the Editors were responsible for collating the reviews and editing and finalising the document. The Working Party met four times and the Editors communicated electronically on a regular basis in addition to two meetings.

Situation Analysis of the EBCOG Member Countries

All the members of Council were sent a questionnaire to ascertain from the individual member states whether they had up to date clinical guidelines and standards of care developed by their own National Societies. About 50% of the member countries responded that they had guidelines available but that it was not possible to quality assure them or to ascertain whether all the health care providers were using them. There was a clear misunderstanding among the clinicians about the definition of a guideline, protocol or standard and they are using these terms interchangeably. The United Kingdom was the only country where a document, describing standards of care had been published.

The Review of the Published Literature

The European Perinatal Health Report - Europeristat Project 2013 - has provided data on indicators such as overall pregnancy loss, multiple pregnancy rates and pointing out that in some EU countries, a high multiple pregnancy rate is due to poor regulation of infertility treatment. Websites of the European Union (Brussels and Luxembourg), the WHO website and PubMed were searched for key policy documents and publications providing comparative EU-wide outcome data. The two documents published by the Royal College of Obstetricians and Gynaecologists (RCOG) of the United Kingdom (UK) detailing standards of care for Maternity and Gynaecology²¹ and the relevant Guidelines published by The National Institute of Clinical Excellence and Healthcare (NICE) were considered.

Authorship and Consultation

Each specialist society represented was allocated and produced the relevant standard(s) and manuscripts were discussed, reviewed and revised by the Working Party in the presence of the representative. Each standard was circulated to the relevant stakeholders including the respective specialist society, UEMS, European public health organisations and stakeholders before being submitted to the EBCOG Executive and Council. Input from consumer representatives was invited and comments included. Finally, all the standards were subjected to the final editorial process.

The Purpose and Layout of this Document

The purpose of developing this document is to set common standards of care in gynaecology in order to harmonise the care of women in Europe and beyond. This document sets out issues related to the equitable access to services for women's health and demonstrates that outcomes differ between similar countries in Europe and how unified standards of care can influence national policies and service delivery. Tackling health inequalities in the wider social determinants of health, smoking and obesity rates and in earlier stage diagnosis and access to the best available evidence based treatment are all likely to improve overall health outcomes.

This document will provide guidance for the development of equitable and high quality services, so that a similar standard of healthcare can be expected in all member states of the EU. The standards should act as incentives to implement clinical guidelines and be used as a valuable tool to quality assure women's services.

The standards described here address various areas of service provision, ranging from benign conditions to the treatment of cancers. Each clinical service standard is comprised of a mixture of clinical and organisational standards, dealing with: patient focus, accessibility and the process of service provision and the competency of the staff providing this service. Each set of Standards is supported by a list of auditable indicators which should act as a benchmark for improvement.

This document also encompasses the generic dimension required for the support and overall quality assurance of women's health services.

EBCOG Standards: Towards Enhancing Postgraduate Training

One of the fundamental concerns of EBCOG relates to issues around the quality of training for our future generation of "doctors in training" in order to sustain high quality services in Europe. This is especially important as "European integration allows free movement of persons, services, capital and goods". Therefore, a separate set of standards to facilitate a uniform quality of training is also desirable.

The purpose of accrediting a training unit is that over time it will seek to drive up quality and consider developing more complex outputs to satisfy the needs of all the stakeholders.

Currently, EBCOG operates a voluntary system of hospital visiting to accredit the training programmes against an agreed template, overseeing the structure and process of delivering PG training. It is envisaged that the implementation of European-wide standards of care will ultimately lead to the effective delivery of not only clinical services but indeed provide excellent training in these units. Therefore, by setting these professional standards, EBCOG is in effect facilitating the work of the national regulatory bodies to ensure that appropriate data is collected.

EBCOG Standards: Towards Improving Quality of Care

It is envisaged that the standards will provide equitable, safe, effective clinical care with good patient experience and best outcomes for women and their families. They should serve the following purposes:

- Providers may use the standards for the quality assurance of local services, to identify gaps and develop a local risk management strategy
- The Ministry of Health may consider using the standards to inform service contracts and the performance management of women's services.
- Trainers should consider using these standards to streamline postgraduate training and the supervision of doctors in training. They are encouraged to develop local clinical audits using these quality indicators to inform their own practice.
- The EBCOG Standing Committee on Training Recognition can use these standards to quality assure systems for post graduate training.
- The EU Public Health Committee should consider developing a unified "data system" to accurately capture clinical activities across the EU member states in order to promote EU-wide national audits of maternal wellbeing, maternal morbidity, mortality and patient related outcomes.

There is no overall timescale for their implementation but it is anticipated that the standards will be an integral part of the audit and commissioning process. Where high standards are not achieved, data from audits may provide evidence to support a business case for additional resources.

Women's services should be working towards achieving the standards contained in this document to ensure a contemporary, safe service meeting the needs of women and families.

We are confident that the adoption and implementation of these standards of care across Europe, would not only address inconsistencies of care across the EU, but also enable the most cost-effective clinical care to be delivered.

STANDARD 1

Generic Standards for the Provision of Gynaecology Services

Rationale

Women's health services must be accessible so that women are able to receive the most appropriate care to meet their needs.

A good clinician must fulfil his or her role in the clinician – patient partnership by being polite, empathetic and honest, treating patients with dignity, treating each patient as an individual, and respecting patients' privacy and right to confidentiality. It is important to take time to listen and understand patients's specific needs and issues and use these standards as a guide for best practise.

Gynaecology services must comply with the best available scientific evidence for the provision of high quality care. Patient related outcomes should be regularly benchmarked with other units providing similar services.

A multidisciplinary approach should be adopted where appropriate to ensure effective delivery of service in specialised areas.

Each gynaecology unit should have a clinical governance programme incorporating: risk management, clinical audit according to national requirements, continuing professional development and training, complaints handling, and a policy of continual service improvement should be in place, in order to offer safe, high quality care that is in the best interest of the patient.²²

1. Patient focus

1.1 Communication

1.1.1 A clearly defined referral pathway should be in place from the primary care to the specialist services.

1.1.2 The pre-appointment communication (letter, text/SMS, telephone call, fax, e-mail) for clinic attendance should provide clear information about the patient's first visit to the clinic and give information on what to expect and how to prepare for the appointment.

1.1.3 A summary of the woman's care should be available to her primary care physician within an agreed timeframe. Information should only be shared among professionals with the consent of the woman. If there are public health issues, then they should be dealt with according to national legislation.

1.1.4 Each unit should have a patient-centred mechanism in place to communicate urgent results to the woman and her doctor and also to deal with treatment related queries.

1.2 Patient Information

1.2.1 There should be clear, up to date verbal and written information on relevant aspects of treatment available in different languages. There should be visible open access to written information/web based leaflets, guidelines and relevant websites, including contact details of patient support groups. Dates of updates should be included in materials and written in plain language.

1.2.2 Local strategies on information sharing should be reviewed regularly to reflect the needs of the local population and advances in communication technology.

1.2.3 Local protocols should be developed and support equal access to healthcare needs for all vulnerable groups including the migrant population and those who do not speak the host country's language. They should respect cultural differences relating to women's health and modesty.

1.2.4 Interpreting services should be used whenever appropriate for patients who do not speak the local language. Members of the family should not be used as translators. Units need to be aware that in some cultures women are reluctant to share information relating to women's health with males. Where possible units should be sensitive to this issue and identify a way to communicate that builds trust.

1.3 Patient Protection Issues and Confidentiality

1.3.1 There should be a clear pathway for referral to local child protection teams, including the management of young people who are sexually active. Guidelines should be in place in all relevant clinical areas.

1.3.2 A policy should be in place to support and refer potential victims of domestic and sexual abuse.

1.3.3 Health professionals should be appropriately trained to recognise vulnerable individuals.

1.3.4 Migrants in an irregular situation seeking medical assistance should not be apprehended at or next to medical facilities.

1.4 Well-being of Women Services

1.4.1 All units should consider providing facilities for patient-led support groups.

1.4.2 Local arrangements should be in place for prompt access to a dietician, drugs and alcohol misuse, and smoking cessation services. The referral pathways should be well publicised to clinicians and patients.

1.5 Environment

1.5.1 The environment should meet all national standards in relation to health and safety.

1.5.2 There should be an interview room to allow discreet consultation.

1.5.3 Seats of various heights and widths should be provided in the clinics, as low chairs may be unsuitable for women with mobility problems. Clinics should be accessible and provide facilities for all patients with disabilities.

1.5.4 Each unit should have Standard Operating Procedures (SOPs) and policies in place and should be regularly updated.

1.5.5 All laboratory facilities which are linked to gynaecological services should be in full compliance with the European Union Tissue and Cell Directives.

1.5.6 There should be a designated examination room to provide privacy. Facilities must be provided to give the woman privacy to undress and dress. A garment should be available to ensure dignity while awaiting the clinical examination. Drapes must be available to maintain dignity.

1.5.7 Equipment should be regularly maintained and tools and reagents should be checked for expiry and replaced on time.

1.6 Gynaecological Examination

1.6.1 An explanation must be provided as to what the examination will involve so the woman has a clear idea of what to expect, including any potential pain or discomfort. She must be given an opportunity to ask questions.

1.6.2 Verbal consent should be obtained before all pelvic examinations. A chaperone should be available, irrespective of the gender of the gynaecologist.

1.7 Record Keeping

1.7.1 Accuracy of record keeping is an integral part of clinical care as poor record keeping is a common contributing factor in many medical negligence claims.

1.7.2 Patient records must be written legibly and indelibly, ideally in black ink and have the patient's name and hospital number or date of birth on each page. Every entry (whether conventional or electronic) deletion or alteration in the case notes should be dated, timed and signed by the clinician. Any abbreviations used in the case notes should conform to agreed terminology.

1.7.3 The reports of investigations and laboratory results and letters must be signed and dated before being filed in the notes. Any appropriate action and follow-up required should be taken and clearly recorded before being filed. The development of an electronic records system is encouraged.

1.7.4 Processes should be in place to ensure that patients' health and other sensitive information is safeguarded against loss, damage or unauthorised access and kept confidential in accordance with legislation and guidance.

1.7.5 Procedures should be in place to facilitate the transfer of records for those whose residence status may cause them to move frequently.

2. Staffing

2.1 Each Gynaecology unit should have a head with an overall responsibility for clinical service and training.

2.2 Staff must be competent, up-to-date with their continuing professional development and able to establish and maintain good professional relationships with patients and colleagues.

2.3 All new professional staff should have appropriate introduction to the working of the unit and should be offered a mentor when appropriate.

2.4 Arrangements must be in place to ensure that temporary staff employed on short term contracts (locum trainees, bank or agency staff) receive an appropriate introduction to the working of the unit and are provided with appropriate supervision. If possible, patients' requests for a specific health professional should be supported.

2.5 Staff should receive regular training in health and safety, communication skills and consumer service.

2.6 Appropriate administrative support should be given to the service.

3. Clinical Governance Structure

3.1 There should be nominated responsible personnel for risk management in each clinical area e.g., clinic, ward, operating theatre, endoscopy suite, general practice, to deal with risk issues timely.

3.2 Risk management strategy should be in place. The risk management strategy should include:

- Identification, monitoring and control of risks;
- Embedding continual risk assessment in all clinical areas;
- Promoting awareness and understanding of patient safety issues within the unit and providing feedback;
- Developing risk management manual containing policies, protocols and clinical practice guidelines.

3.3 Each unit should have easily accessible referenced, protocols derived from the best scientific evidence and adapted to local use. These should be reviewed and updated at regular intervals.

3.4 All units should have a patient safety risk register to identify all incidents and corrective actions taken. A local 'trigger list' should be developed to encourage reporting.

3.5 All units should have a process for root cause analysis in place to investigate unexpected severe incident or death. Each report should include learning points and an action plan.

3.6 All units should have policies and processes in place that protect patient safety when new technologies are introduced.

3.7 Each unit should have a multidisciplinary programme of clinical audit that monitors local practice against disease-specific/service standards of care.

3.8 Each unit should ensure that protocols operate to best practise, are patient-centred and position the patient as an individual.

4. Training Standards

4.1 All doctors in training should have a named educational supervisor.

4.2 All units should ensure that postgraduate trainees are observed by their supervisors performing clinical/pelvic examinations and procedures as part of their formative assessment of skills.

4.3 All units should have written advice for doctors in training on seeking advice and on procedures they may perform without direct supervision.

4.4 All units should have a Postgraduate Educational Programme.

4.5 All units should have established audit programme where doctors in training are encouraged to present their audit projects.

5. Auditable Standards

5.1 All the standards described in this chapter may be subject to regular audit. The ideal target for the achievement all of the auditable standards is 100%. There should be evidence of progressive improvement.

5.2 An audit of a small number of randomly selected medical records should be undertaken to ensure that the content of the notes are in line with the standards described in this chapter.

5.3 Patient satisfaction questionnaires, focus groups and feedback sessions are needed to ascertain what proportion of women patients received appropriate information prior to their visit to the clinic.

5.4 There should be an audit programme that both responds to clinical incidents and demonstrates excellence in following the agreed care pathways.

5.5 Evidence of a risk management strategy.

STANDARD 2

Emergency Gynaecology, Acute Abdominal Pain in Women

Rationale

Acute abdominal pain is a major reason for emergency referral of women. Prompt diagnosis and management is essential and could be life-saving in cases of ectopic pregnancy and has major implications for women's reproductive potential.²³

Women presenting with acute abdominal pain may require a multi-disciplinary approach and prompt access to a dedicated emergency gynaecological service.

1. Patient Focus

1.1 Women who are at increased risk of ectopic pregnancy (e.g. previous ectopic, tubal surgery etc.) and those at other risks (e.g., cyst torsion, Pelvic Inflammatory Disease (PID)) should be informed to consult at the earliest.

1.2 Timely and clear information should be provided on the diagnostic procedures, clinical findings, the results of investigations and the treatment options.

1.3 Women should be counselled regarding possible implications on their future fertility and their understanding should be ensured.

1.4 Consideration should be given to patients' family and employment needs and commitments.

1.5 Women should have the opportunity to make informed decisions about their care and treatment.

2. Accessibility

2.1 Women should have direct access to emergency services.

2.2 All emergency services should have access to gynaecological input on a 24 hour basis.

2.3 All emergency services accepting women should have access to laboratory, imaging facilities, blood transfusion services, emergency surgery and intensive care.

3. Environment

3.1 Services should provide a setting allowing for the appropriate privacy.

3.2 Services should have the facilities for triage.

4. Process

4.1 Complicated pregnancy in all women of reproductive age should be considered and ectopic pregnancy should be excluded.

4.2 All emergency services should have facilities for urgent β -hCG measurement.

4.3 The service should be based on a multi-disciplinary approach encompassing anaesthesiologists, general surgeons, urologists etc.

4.4 The service should have protocols for the investigation and management of the patient presenting with pelvic pain. The protocol should have a clear algorithm for the management of acute abdominal pain in women; one for pregnant and another for non-pregnant women.

4.5 Pregnant Women with Acute Abdominal Pain

4.5.1 Ectopic pregnancy should be diagnosed by clinical assessment, trans-vaginal ultrasound scanning and quantitative β -hCG estimation.

4.5.2 Haemodynamically unstable patients should be urgently assessed and managed by a senior gynaecologist together with a senior anaesthesiologist to expedite the surgery and ensure patient safety.

4.5.3 Haemodynamically stable women should be reviewed by a senior gynaecologist to decide on management and treatment options.

4.5.4 The laparoscopic approach is the standard surgical intervention for haemodynamically stable tubal ectopic pregnancy.

4.5.5 The laparoscopic approach may be considered for haemodynamically unstable tubal ectopic pregnancy provided that surgical expertise is available.

4.5.6 Medical or conservative management should be decided by a senior clinician.

4.5.7 Supportive facilities for quantitative β -hCG, close follow-up arrangements should be in place and patient compliance should be ensured.

4.6 Non-Pregnant Women with Acute Abdominal Pain

4.6.1 Once pregnancy has been excluded, other gynaecological emergency conditions, such as complicated ovarian pathologies and PID must be considered and a management plan made by a senior gynaecologist.

4.6.2 Women with acute abdominal pain often need a multi-disciplinary diagnostic approach once gynaecological conditions are excluded.

4.6.3 In case a decision is taken to proceed with surgery, a laparoscopic approach is the preferred option.

4.6.4 Patients (guardians/parents/carers as appropriate) who are discharged following the management of their acute abdominal pain should be given detailed discharge instructions and follow-up arrangements as appropriate and contact details given in case of an emergency.

5. Staffing and Competence

5.1 There should be a lead obstetrician/gynaecologist with responsibility for emergency gynaecology services.

5.2 There should be dedicated nurses/midwives and named (rostered) medical staff in the emergency service on a twenty four hour basis.

5.3 All staff should be competent and receive regular updates and training on basic life support and managing emergency gynaecology.

5.4 Ultrasound sonography should be performed by experienced and well-trained staff in pelvic scanning for women.

6. Training Standards

6.1 All trainees should have regular training to ensure competency in dealing with acute emergencies, including basic life support.

6.2 Training in transvaginal ultrasound scanning is essential for all staff required to provide a scanning service in the provision of emergency gynaecology.

6.3 Training should be provided to ensure that all gynaecologists involved in emergency services are proficient in the laparoscopic management of patients with ectopic pregnancy.

6.4 Regular training in communication skills, breaking bad news, cultural/gender awareness, equality and diversity, safeguarding children and vulnerable individuals should be provided.

7. Auditable Standards

7.1 Waiting times between arrival at the emergency unit, triage, diagnosis, initiation of treatment and/or discharge should be benchmarked against best practise.

7.2 Rate of unsuspected and suspected ectopic pregnancies re-admitted as ruptured ectopics - each case to be audited, discussed and analysed.

7.3 Rate of negative laparoscopies in women presenting with acute abdominal pain - each case to be audited.

7.4 Rate of successful outcome of ectopic pregnancy following medical or conservative management - Unsuccessful cases should be audited.

7.5 Rate of re-admissions within 24 and 48 hours after discharge from emergency gynaecology service.

7.6 Annual patient satisfaction survey about service usage.

STANDARD 3

Early Pregnancy Loss

Rationale

Women suffering from miscarriage are usually distressed and particularly vulnerable at this time in their lives. They are anxious to find an explanation and cause of their problem and the prognosis of achieving a successful pregnancy. Management of this clinical condition requires an holistic approach based on the best available evidence. The clinic should provide timely diagnosis, information, counselling and management.²⁴

1. Patient Focus

1.1 Information on the physiology of pregnancy and pregnancy loss should be available to women and their families.

1.2 Women should also be offered a range of management options for early pregnancy loss and opportunities to discuss possible management in a subsequent pregnancy.

1.3 Emotional support should be also offered to the women with early pregnancy loss in the context of specialist counselling.

1.4 Written information should be provided with regard to tests and the sensitive disposal of pregnancy material.

2. Accessibility

2.1 An open access service with appropriate expertise and support should be available as a seven day service with minimum waiting time.

3. Environment

3.1 The clinics should have a designated reception area and should also provide a supportive environment with the appropriate level of privacy.

3.2 There should be an appropriately furnished room for breaking bad news and to discuss future management options.

3.3 A professional counsellor should be available.

3.4 Information materials of various kinds should be available.

4. Process

4.1 There should be clearly defined and evidence based protocols in place, offering a full range of options for managing women with early pregnancy loss including Conservative, Medical and Surgical management.

4.2 Patients should be provided with verbal and written information about the investigation and treatment options.

4.3. All services should have written protocols for the management of women with pregnancy of unknown location and suspected ectopic pregnancy and pregnancy of unknown viability.

4.4 Cases of recurrent miscarriages should be referred to the appropriate clinic for investigation and further management.

4.5 Multi-disciplinary working arrangements should be in place especially with radiology, genetics, immunology , microbiology , endocrinology and haematology departments.

5. Staffing and Competence

5.1 Each unit should have a lead consultant with special expertise in managing early pregnancy problems.

5.2 All staff providing pelvic ultrasound scanning should be appropriately trained and preferably be certified.

5.3 All units must be adequately staffed in order to provide multidisciplinary support to the women for full clinical and laboratory investigations.

6. Training Standards

6.1 All trainees in Obstetrics and Gynaecology should acquire competence in the management of women with early pregnancy loss to fulfil the requirements of the EBCOG Log Book.

6.2 Doctors in training should maintain a log book to demonstrate their competence in early pregnancy ultrasound scanning especially fetal viability, twinning and ectopic pregnancy.

6.3 Training should be provided on the basic consultation, effective and sensitive communication and to initiate the appropriate investigations and management according to the departmental protocols.

6.4 Regular training in communication skills, breaking bad news, cultural/gender awareness, equality and diversity, safeguarding children and vulnerable individuals should be provided.

7. Auditable Standards

7.1 Rate of patient choice and uptake of different method of management together with success rates and failure rates

7.2 Annual patient satisfaction survey about service usage.

STANDARD 4

Recurrent Miscarriage

Rationale

Women suffering from recurrent first trimester miscarriage are frequently distressed and anxious to find a cause and possible solution to their problem in order to allow them to achieve a successful pregnancy in the future. Management of this condition requires specialised services which provide management based on the best available evidence.²⁵

1. Patient Focus

1.1 Information and support on pregnancy physiology and losses should be accessible to women and their families.

1.2 Women should also be offered follow up visits at a specialised clinic to discuss possible management in a subsequent pregnancy. A high risk pregnancy care plan should be provided to such patients during their future pregnancy.

2. Accessibility

2.1 Specialised clinics with appropriate expertise should be available.

2.2 Multi-disciplinary working arrangements should be in place, especially with radiology, genetics, immunology, microbiology, endocrinology and haematology departments.

3. Environment

3.1 The clinics should provide a supportive environment with the appropriate level of privacy.

3.2 A professional counsellor should be available.

3.3 Information materials of various kinds should be available.

4. Process

4.1 Couples with recurrent miscarriages should be referred to the appropriate clinic. Personal, social and environmental risk factors should be taken into account at the initial assessment and during investigations and counselling.

4.2 Management should be based on the best available evidence with clear guidelines and protocols.

4.3 Patients should be provided with written information about the investigation and treatment options.

4.4 Laboratories with the appropriate facilities must provide all the investigations, including karyotyping and screening tests that will exclude thrombophilia and other related conditions according to the protocols.

4.5 Other tests including hysteroscopy and imaging such as two and three-dimensional ultrasound scanning for the exclusion of uterine abnormalities should be available.

4.6 Patients who may require uterine surgery should be referred to a specialised gynaecologist with an interest in this area for evaluation and further management.

4.7 Medical management of recurrent miscarriage should be based on protocols derived from best available evidence and regularly updated.

4.8 Aspirin and/or heparin, in the case of anti-phospholipid syndrome or thrombophilia, should be given starting from the time an intrauterine pregnancy is diagnosed. An individualised venous thrombotic disease risk assessment is also made in early pregnancy. Heparin administration should continue during the first 6 postnatal weeks.

4.9 Patients (and their partners) should be regularly updated on the process, given an indication of the time-frame and counselled regarding the potential impact on work and family life.

5. Staffing and Competence

5.1 Each unit should have a lead consultant with special expertise in managing recurrent miscarriages.

5.2 All units must be adequately staffed in order to provide multidisciplinary support to the women for full clinical and laboratory investigations.

5.3 Emotional support should be also offered to the women with early pregnancy loss in the context of specialist counselling. All staff should attend induction and refresher courses on breaking bad news and providing emotional support.

5.4 A policy on how to communicate effectively throughout the time a patient is under the team's care should be in place.

6. Training Standards

6.1 According to the EBCOG training programme, trainees in Obstetrics and Gynaecology should attend the recurrent miscarriage unit to fulfil the requirements of the Log Book.

6.2 Training should be provided on the basic consultation and to initiate the appropriate investigations leading to possible referral to specialised units.

6.3 Regular training in communication skills, breaking bad news, cultural/gender awareness and equality and diversity should be provided.

7. Auditable Standards

7.1 Rate of successful pregnancy outcome in patients attending the service

7.2 Rate of successful pregnancy outcome for each treatment modality

7.3 Patient satisfaction survey with the service.

STANDARD 5

Pelvic Inflammatory Disease (PID)

Rationale

Pelvic inflammatory Disease is an infection of the upper genital tract. It can be life threatening and frequently has serious long-term sequelae like infertility, chronic pelvic pain and ectopic pregnancy.

The diagnosis is not always simple and straightforward. Many women suffer from it subclinically. Prevention, early diagnosis and appropriate management are essential to prevent adverse sequelae.

1. Patient Focus

- 1.1 Information should be widely available on primary and secondary prevention strategies.
- 1.2 Women with lower abdominal pain and/or unexplained fever deserve a proper diagnostic and treatment advice given by a trained and competent health care provider.
- 1.3 Women should get up to date information about the natural course of the disease, its cause, mode of transmission, treatment options, side effects and limits of treatment regimens.
- 1.4 Psychological, sexual and partner-related aspects should be addressed.
- 1.5 Counselling should take into account and respect the lifestyle of the women.
- 1.6 Partner notification and/or treatment should be discussed. Contact tracing and partner testing should be arranged.

2. Accessibility

- 2.1 There should be open and free access in the community setting to preventive measures.
- 2.2 Emergency services should be available for patients with acute symptoms.

3. Environment

- 3.1 Primary and secondary care settings should all provide discrete, confidential, patient-centred and non-judgemental care.
- 3.2 There should be facilities available to perform testing for haematology and microbiology.

3.3 All gynaecologists offering specific care should operate within a multi-professional environment with access to surgery, anaesthesiology, radiology, urology and internal medicine.

3.4 All units should have facilities for gynaecology examination, pH testing, KOH solution in water, microscopy, different collection tools for cultures and cervical cytology.

3.5 All units should be equipped with an abdominal as well as a trans-vaginal ultrasound scanning facility.

4. Process

4.1 There should be well defined care pathways in place to ensure appropriate initial treatment and later specialised management.

4.2 All units should have diagnostic and treatment guidelines derived from the best available scientific evidence in place.

4.3 There should be proper facilities, trained personnel and equipment to perform a diagnostic and operative laparoscopy, also in emergency situations.

4.4 For patients with uncertain diagnosis, or not responding to treatment within 24 hours, multidisciplinary consultation(s) should be considered.

4.5 Patients with PID should be risk-assessed and HIV testing offered when appropriate.

5. Staffing and Competence

5.1 All health care professionals in primary care should be well informed about preventive care measures.

5.2 All gynaecologists should be trained and competent in diagnosing suspicious cases of PID infections.

5.3 Further diagnostic workout and treatment should be led by a gynaecologist with a special interest in benign gynaecology and/or infectious disease.

5.4 The treating gynaecologist should be acquainted in dealing with sexual and reproductive health in general.

6. Training Standards

6.1 All health care professionals working dealing with primary prevention should have appropriate and up-to-date training.

6.2 Doctors in training should attend theoretical courses to learn prevention, diagnosis, differential diagnosis and management of PID.

6.3. All gynaecologists treating this condition should be capable of undertaking laparoscopy at ESGE level 1 & 2.

6.4 All gynaecologists taking care of women with PID should be up to date with their CPD.

6.5 Regular training in communication skills, cultural/gender awareness, equality and diversity and in safeguarding children and vulnerable adults should be provided.

7. Auditable Standards

7.1 Percentage adherence to national or (if not available) recognised international recommendations and guidelines

7.2 Number of admissions, treatments and days of admission.

7.3 Documentation of notifiable diseases like gonorrhoea, chlamydia and other STI according to the national policies.

7.4 Annual patient satisfaction survey.

STANDARD 6

Vulvovaginitis

Rationale

Vulvovaginitis is associated with distressing symptoms, impaired sexual function and has psychological implications. It is one of the most frequent reasons why women consult a gynaecologist.

In addition, during pregnancy vulvovaginitis may be linked to obstetric complications such as chorioamnionitis, preterm delivery and preterm rupture of the membranes.

Furthermore, the extensive use of prescribed and self-medication, complementary therapies and repeated consultations lead to a high financial burden.

1. Patient Focus

1.1 Women with vulvovaginal complaints deserve proper diagnostic and treatment advice given by a trained and competent health care provider.

1.2 Psychological, sexual and partner-related aspects should be addressed.

1.3 Counselling should take into account and respect the lifestyle of the women.

1.4 Women should get up to date information about the natural course of the disease, its cause, mode of transmission, treatment options, side effects and limits of treatment approaches.

1.5 In specific cases partner notification and/or treatment should be discussed.

1.6 In the case of vulvovaginal complaints in children, sexual abuse must also be considered. These children should be referred to a specialist with special focus and training.

2. Accessibility

2.1. All women should have easy access to gynaecologists or other health care providers who are appropriately trained in providing basic diagnostic workup and treatment according to the best available evidence.

3. Environment

3.1 Community, primary and secondary care settings should all provide discrete, confidential, patient-centred, non-judgemental care.

3.2 Children should be seen in an appropriate environment.

3.3 Units should have or be connected to a local service to deal with diagnostic investigations of vulvovaginal samples.

2.4.2. All units should have facilities for examination, including phase-contrast microscopy, pH testing, KOH solution, different collection tools for cultures, cervical and vulvar cytology and access to colposcopy and biopsy tools.

4. Process

4.1 There should be well defined care pathways in place to ensure appropriate initial treatment and later specialised management.²⁶

4.2 All units should have diagnostic and treatment guidelines available and regularly updated.

4.3 A list of referral contact details must be at hand for expert advice if needed including a genito-urinary infection specialist, dermatologist, paediatric gynaecologist, microbiologist, psychologist and sexologist.

5. Staffing and Competence

5.1. All gynaecologists should be trained in best available evidence in managing vulvovaginitis.

5.2. Women with chronic recurrent diseases require a specialised workup and treatment regimen and should be referred to a gynaecologist with a special interest in lower genital tract disease.

5.3 All professionals involved in managing children with vulvovaginal symptoms should be competent in child protection policies and procedures and the safeguarding of children is paramount.

6. Training Standards

6.1 Doctors in training should attend courses that include diagnosis and management of vulvovaginitis.

6.2 All gynaecologists taking care of women with vulvovaginitis should be up to date with their CPD.

6.3 Regular training in communication skills, cultural/gender awareness, equality and diversity and in safeguarding children and vulnerable adults should be provided.

7. Auditable Standards

7.1 Prevalence data of various STI in the screened population .

7.2 Percentage of women correctly diagnosed and treated for vulvovaginitis using best available guidelines

7.3 Number of children seen and appropriate referral and management according to the local protocol.

7.5 Annual patient satisfaction survey.

STANDARD 7

Ultrasound Scanning in Gynaecological Practice

Rationale

Ultrasound scanning is an integral part of the investigation for a wide range of gynaecological conditions such as early pregnancy monitoring, management of infertility as well as diagnosis of benign and malignant gynaecological conditions. The standardisation and accuracy of scanning and its reporting are fundamental to formulating the appropriate clinical management plan.

1. Patient Focus

1.1 Women should be provided with detailed verbal and written information with respect to the procedure of ultrasound scanning, and in particular transvaginal scanning and their understanding ensured.

1.2 Counselling should be available prior to the procedure and explanation given with respect to the level of invasiveness and the expected degree of discomfort/pain.

1.3 The results of ultrasound scans should be communicated to the patient by the lead clinician to provide the required reassurance and explanation regarding the findings and the possible diagnosis.

1.4 Women undergoing ultrasound scans, particularly transvaginal ones, should be treated with a high standard of privacy and dignity, ensuring minimal exposure.

1.5 Women's choice of scanning approach should be discussed provided that a full explanation is given with respect to the advantages and disadvantages of both the abdominal and transvaginal approaches.

1.6 A husband, partner or designated friend should be allowed to join the woman during the investigation if she so wishes.

1.7 A chaperone should be offered and made available if requested.

2. Accessibility

2.1 Readily accessible for women presenting with early pregnancy complications in order to promptly check for viability and to exclude ectopic pregnancy.

2.2 Access to ultrasound scanning should be available at all levels of care including primary, secondary and tertiary.

2.3 Access to more sophisticated imaging services should be made available upon suspicion of high grade pathology by ultrasound scanning.

3. Environment

3.1 Ultrasound scan units should ensure the appropriate privacy and well-equipped with the appropriate changing and toilet facilities.

3.2 The unit should have the appropriate examination couches for patients as well as appropriate stools for the examiners.

3.3 Units should follow the standard health and safety policy.

3.4 Ultrasound scan machines should be regularly updated, calibrated and maintained.

3.5 A standard operating procedure (SOP) should be in place.

4. Process

4.1 The choice of vaginal or abdominal approach should be available, depending on suspected pathology and taking into account the patient's wishes.

4.2 Vaginal ultrasound scan approach is the preferred option for early pregnancy complication.

4.3 Protocols should be in place and relative to different gynaecological conditions e.g., early pregnancy, adenexal masses, fibroids etc.

4.4 Failure to demonstrate viability should be confirmed by two observers.

4.5 Pregnancy of unknown location should be considered carefully and a protocol in place for diagnosis and management.

4.6 Diagnosis of ovarian cyst should follow the standard agreed classification of ovarian masses of cysts.

4.7 Accurate reporting of the findings is essential to inform the clinical interpretation and management.

4.8 A copy of the report should be sent to the referring clinician and the result communicated to the family doctor.

4.9 Appropriate image archiving facilities should be in place to allow quality assurance auditing and formulating management plans.

4.10 The result of the scan and its clinical interpretation should remain the responsibility of the referring doctor to avoid any misinterpretation or confusion to the patient.

5. Staffing and Competence

5.1 The unit providing early pregnancy scanning should have a named, lead clinician to oversee clinical and administrative management and ensure standards are applied.

5.2 Units providing ultrasound scanning for gynaecology should have a lead clinician and lead sonographer with the above mentioned responsibilities.

5.3 Personnel providing gynaecological scanning should be appropriately trained and certified by their national professional bodies, regularly updated in knowledge and practice and have the relevant CPD.

6. Training Standards

6.1 All trainees should attend theoretical and practical basic skill courses in ultrasound scan.

6.2 The unit should provide the appropriate supervised, hands on training to fulfil the requirements of the EBCOG postgraduate curriculum.

6.3 Trainees should maintain a log book of their experience and demonstrate skills in case mix management.

6.4 The unit should provide regular training updates to ensure the maintenance of skills.

6.5 Clinicians providing gynaecological ultrasound scanning in special categories, e.g., fertility scans, early pregnancy scans etc., should have an adequate case load to ensure maintenance of skills.

6.6 Regular training in communication skills, cultural/gender awareness, equality and diversity and in safeguarding children and vulnerable adults should be provided.

7. Auditable Standards

7.1 Annual audit for failed diagnosis of ectopic pregnancy.

7.2 Rate of pregnancy of unknown location.

7.4 Audit and case review for special categories such as fetal demise, ovarian cyst and endometrial thickness in post menopausal women.

7.5 Patient satisfaction surveys should be carried out annually.

Standard 8

Contraception and Sexual Health

Rationale

Global maternal mortality and morbidity could be decreased by reducing unintended pregnancies and providing good contraception services for both women and men.

Prevention of unintended pregnancies is therefore one of the most important objectives of women's preventive health care and a key element of women's empowerment.¹⁷⁻²⁰

Male sexual behaviour and contraception have an important impact on women's health, such as sexually transmitted infections (STI), unintended pregnancy, spread of HIV, sexual assault and violence. This impact is not fully addressed in many European countries. There is a need for services addressing these issues.

1. Patient Focus

1.1. The contraceptive needs of each individual should be assessed taking into account her/his priorities, values and attitudes, her/his biological and medical condition and psychosocial profiles.

1.2. All women and men have the right to evidence-based information on all available contraceptive methods, and myths and misconceptions should be dispelled, as a form of education and to ensure informed choice.

1.3. Both women and men should have the opportunity to address sexual health problems (screening for sexually transmitted infections, violence, sexual dysfunction etc.), in view of the close link between contraception and sexual health.

1.4 Multi-agency partnership approach would support the development of integrated sexual and reproductive healthcare services.

2. Accessibility

2.1. All services should be easily accessible, offer a five day service and be complemented by the provision of emergency contraception.

2.2. All services should provide information in different languages, according to the population it serves.

2.3 All services should have a wide range of contraceptive methods available.

2.4 All services should have antibiotics, emergency contraception and post-exposure HIV prophylaxis available.

2.5 All services should have on-site urine tests for pregnancy and access to trans-vaginal ultrasound scanning.

2.6 With due regard to national legislation, all services should have access to referral for safe termination of pregnancy.

3. Environment

3.1. All services should have a designated reception area, constantly staffed during working hours.

3.2 The service should provide a setting allowing for the appropriate privacy and confidentiality.

3.3 All services should have a link with providers of termination of pregnancy, outpatient and emergency gynaecology, sexually transmitted infections, urology and social services.

4. Process

4.1 History taking and clinical examination are essential. Gynaecological examination and genital examination of men may be indicated.

4.2 All services should provide counselling on evidence-based efficacy, advantages and disadvantages of the available methods of hormonal, non-hormonal, including long acting and permanent contraception as well as on sexual health.

4.3 Medical eligibility criteria as described for contraception by WHO should be applied.

4.4 Both men and women should be informed of sexually transmitted infections (STI), the additional protection of male condoms, the different condom types and instructions about appropriate use, including management of broken and slipped condoms and the possible need for emergency contraception and STI prevention.

4.5 Services should provide counselling regarding vasectomy and female sterilisation when appropriate and an appropriate referral process should be established.

4.6 All services should provide balanced and detailed educational materials for patients regarding the different methods.

4.7 The insertion and removal of Intra Uterine Contraceptive Devices (IUDs) and implants should be performed by well trained health care professionals.

4.8 Protocols for the use of emergency contraception should be followed.

4.9 There should be an integrated outreach programme in the community.

4.10 All services should offer, or offer referral for, screening and diagnostic methods and treatment for STIs including care for HIV positive women or men.

5. Staffing and Competence

5.1 All services should have a lead clinician with an interest and expertise in contraception and sexual health.

5.2 Staff members should be trained to perform female and male genital examinations, pap smears, STI screening or ultrasound scanning when indicated.

5.3. Staff members should be able to insert and remove IUDs and implants.

5.4 All staff members should be formally trained in contraceptive and sexual health counselling.

5.5 All staff members should be able to educate, inform and counsel women and men of all sexual orientations and those from migrant or ethnic groups in a non-judgemental and empathic way.

6. Training Standards

6.1 Doctors in training in Obstetrics and Gynaecology should have access to contraceptive services to fulfil the requirements of the EBCOG curriculum.

6.2 Doctors providing the service should be trained and achieve competence in counselling, insertion and removal of IUDs and implants.

6.3 Doctors in training should maintain a log book to demonstrate their competence in various aspects of contraception counselling and care and communicating their benefits.

6.4 Regular training in communication skills, cultural/gender awareness, equality and diversity and in safeguarding children and vulnerable adults should be provided.

7. Auditable Standards

7.1. All services should audit their practice against Medical Eligibility Criteria.

7.2. Each service should have systems for ensuring identification and notification of serious untoward incidents.

7.3 Uptake for various methods of contraception.

7.4 Annual patient satisfaction survey.

STANDARD 9

Male Contraception

Rationale

Male sexual behaviour and contraception have an important impact on women's health, such as STI, unintended pregnancy, spread of HIV, sexual assault and violence. This impact is not fully addressed in many European countries. There is a need for services addressing these issues.

1. Patient Focus

1.1 Men's concerns and needs should be assessed taking into account their psychosocial and cultural background.

1.2. Non judgemental and non directive communication and counselling should be provided.

1.3. Confidentiality should be assured.

1.4. Due to the close link between contraception and sexual health, the patients should have the possibility to address and get help with sexual health problems.

1.5 A multi-agency partnership approach would support the development of integrated sexual and reproductive healthcare services.

1.6 The contraceptive needs of each individual man should be assessed taking into account his priorities, values and his biomedical and psychosocial profiles.

1.7 The individual man has the right to evidence based information and addressing myths and misconceptions on all available contraceptive methods in an individually adapted way to allow education and ensure informed choice.

1.8 Men should have the opportunity to address sexual health problems.

2. Accessibility

2.1 All services should be easily accessible, offer a 5 day service and be complemented by the provision of emergency contraception.

2.2 All services should provide information in different languages according to the population it serves.

2.3 All services should have condoms, antibiotics and postexposure HIV prophylaxis available.

3. Environment

3.1 All services should have links with urology, dermatology and STI services.

3.2 All services should have a designated reception area constantly staffed during working hours.

3.3 The service should provide a setting allowing for the appropriate privacy and confidentiality.

4. Process

4.1 All services should provide counselling on the best evidence-based methods of male contraception available including their efficacy, advantages and disadvantages.

4.2 Men should be informed about different types of condoms, get instructions about use, including management of broken and slipped condoms (emergency contraception).

4.3 Services should provide counselling regarding vasectomy when appropriate and an appropriate referral process should be established.

4.4 All services should offer, or offer referral for, screening and diagnostic methods and treatment for STIs including care for HIV positive men.

4.5 All services should provide balanced and detailed educational materials for patients regarding the different methods.

5. Staffing and Competence

5.1. All services should have a lead clinician with an interest and expertise in sexual and reproductive health.

5.2. All staff members should be formally trained in contraceptive and sexual health counselling and have undergone communication training

5.3 Staff members should be able to perform a physical examination and STI screening.

5.4 All staff members should be able to inform and counsel men of all sexual orientation in a non-judgemental and empathic way.

5.5 All staff members should get regular updates on evidence regarding contraception and STIs.

6. Training Standards

6.1 Doctors in training should have access to contraceptive services to fulfil the requirements of their curriculum.

6.2 Doctors in training should maintain a log book to demonstrate their competence in various aspects of contraception prescribing.

6.3 All services should have regular clinical governance meetings (training and education, risk management, communication issues, areas for improvement, review of protocols and research).

6.4 Regular training in communication skills, cultural/gender awareness, equality and diversity and in safeguarding children and vulnerable adults should be provided.

7. Auditable Standards

7.1 Each service should have in place systems for ensuring identification and notification of serious untoward incidents.

7.2 Percentage of males presenting and counselled by the service as regards various methods of contraception and STIs.

7.3 Percentage of females presenting and counselled by the service as regards various methods of contraception and STIs.

7.4 Annual patient satisfaction survey.

STANDARD 10

Safe Termination of Pregnancy

Rationale

With due regard to national legislation, access to the safe termination of pregnancy is an important part of women's sexual and reproductive rights and empowerment.¹⁹⁻²⁰

Women seeking termination of pregnancy are frequently in emotional distress. They need support and non-directive counselling with unbiased information to help them come to a decision.

1. Patient Focus

1.1. Women seeking a termination of pregnancy should be treated with respect and acceptance in a non-judgemental way.

1.2. Women should have ample opportunity to express any ambivalence and ask any questions they may have regarding their decision. In case of persistent ambivalence or unresolved issues around the decision making, social problems or others, specialised counselling should be readily available.

1.3 Women from different backgrounds should have culture sensitive counselling and interpreters should be available.

1.4 Women should get non-directive counselling and balanced information about the different methods of termination of pregnancy available in the country (medical and surgical) and possible complications.

1.5 Adolescents, women with coexisting physical and psychiatric disorders and women at risk of partner violence or abuse or severe family disruption should be offered specific counselling.

2. Accessibility

2.1 Services for termination of pregnancy should be easily accessible five days a week during office hours.

2.2. Fast track appointments should be available when appropriate.

2.3 Services should be provided by teams based on national guidance that are clear about legal restrictions and should be responsive to the needs of women and offer choices and preferences for method of management of termination of pregnancy.

3. Environment

3.1 A welcoming, safe feeling environment is essential where women are able to express their concerns easily.

3.2 All services should have a special reception area ensuring confidentiality and privacy.

3.3 All services should have easily accessible information and educational material about medical and surgical termination of pregnancy should be made available.

3.4 All services should have relevant translation services.

3.5 All services should have facilities for gynaecological examination, STI Screening, basic laboratory testing including blood grouping and β hCG measurements, ultrasound scans to determine location, viability and gestational age.

3.6 The service delivery facilities (operating room, anaesthesia, equipment) should meet the national requirements.

3.7 Intra-operative ultrasound scanning should be available.

3.8 All services should have a formal arrangement with local emergency gynaecology services.

4. Process

4.1 All women seeking termination of pregnancy should be seen as soon as possible, at least within 5 days.

4.2 Between the decision and the actual termination of pregnancy, reflection for a limited period of time is advised according to the needs of the individual patient.

4.3 All methods of contraception should be discussed before the intervention. The option of long acting methods should be mentioned including immediate placement of an IUD or an implant.

4.4 All services should provide non-directive counselling.

4.5 All services should have local protocols according to national guidelines, regarding early and late medical and surgical terminations of pregnancy.

4.6 All services should have local protocols for the prevention of infections and rhesus immunisation.

4.7 There should be written guidelines on the management of women using the service who are under the legal age of consent.

5. Staffing and Competence

5.1 All services should have a lead clinician with an interest and expertise in termination of pregnancy, contraception and sexual health.

5.2 Staff members should be competent to counsel women in a non-directive way, make time to listen and respond to the emotional needs of women (and their partners).

5.3 Staff members should be able to perform the procedures offered by the service.

6. Training Standards

6.1 Doctors in training should attend theoretical courses to learn about the legal status as regards termination of pregnancy in their countries.

6.2 Doctors in training should have access to the local termination of pregnancy services to fulfil the requirements of their curriculum.

6.3 Doctors providing the service should be trained and achieve competence in counselling in various methods of termination of pregnancy.

6.4 Doctors in training should maintain a log book to demonstrate their competence in various methods of termination of pregnancy and contraception offered following termination of pregnancy.

6.5 Regular training in communication skills, cultural/gender awareness, equality and diversity and in safeguarding adolescents and vulnerable adults should be provided.

7. Auditable Standards

7.1. Uptake and documentation of surgical and medical termination of pregnancy and the incidence of complications.

7.2 Frequency of women with repetitive terminations of pregnancy in the same service.

7.3 Documentation of the application, prescription or advice on contraception post termination.

7.4 Another standard could be the % of women who are screened or treated for Chlamydia prior to the procedure.

7.5 Annual patient satisfaction survey.

STANDARD 11

Paediatric and Adolescent Gynaecology (PAG)

Rationale

The physical and psychological wellbeing of children and adolescents is crucial for their future general and reproductive health. Gynaecological conditions can be common and disruptive, with rare conditions requiring specialist multidisciplinary management. Inappropriate provision of care can result in poor outcomes and adverse long term consequences.²⁷

1. Patient Focus

1.1 Children and adolescents should receive the best evidence based specialist treatment in order to preserve their future reproductive potential.

1.2 Surgical procedures for PAG conditions should primarily be based on minimal invasive techniques.

1.3 Female genital mutilation (FGM) is unacceptable under any circumstances. Legislation should be encouraged in those countries where such practices are not already classified as being illegal.

1.4 Appropriate information for children, their parents or guardians should be available.

2. Accessibility

2.1 An easy access, non-judgemental service should be available where the welfare of the child is the primary focus.

2.2 Age-appropriate sex and contraceptive education should be available.

2.3 Vaccination against human papilloma virus should be promoted and offered to all adolescents. National prevention programmes should be encouraged.

3. Environment

3.1 Children and adolescents with gynaecological problems should be seen in appropriate and designated clinical environments.

3.2 All services should have a non-threatening reception area.

3.3 All services should have age appropriate displays and posters to provide patient information.

4. Process

4.1 Clinical networks should be established to allow for the multidisciplinary management of rare and complex conditions, the setting of standards and the development of clinical, educational and referral pathways

4.2 Disorders of sex development should be classified and managed according to the 2006 Consensus Document

4.3 Processes should be put in place to ensure a comprehensive and seamless transition of care of adolescents with gynaecological conditions to adult care.

5. Staffing and Competence

5.1 There should be a named clinical lead for PAG.

5.2 All professionals involved in managing children with gynaecological problems should be competent in child protection procedures. The safeguarding of children is paramount.

5.3 Clinicians providing this service should be competent in medical and surgical interventions required.

6. Training Standards

6.1 Training to be provided in PAG recognised centres (outreach programme to ensure referrals are timely and appropriate).

6.2 Trainers to be members of or work in close collaboration with national PAG Societies.

6.3 Training should be based on well established curriculum and training programme such as the RCOG PAG training curriculum.

6.4 Regular training in age appropriate communication skills, cultural/gender awareness and the safeguarding of children and adolescents should be provided.

7. Auditable Standards

- 7.1 Evidence of defined PAG health networks including multidisciplinary working.
- 7.2 Staff trained in child protection procedures.
- 7.3 Audit of surgical PAG procedures and outcomes in children.
- 7.4 Prevalence and supportive management of cases of FGM.
- 7.5 Proportion of adolescents able to access vaccination for human papilloma virus when available.

Standard 12

Menstrual Bleeding Disorders

Rationale

Menstrual disorders are the commonest presentation to gynaecological clinics which interfere with a woman's physical, social, emotional wellbeing and negatively impacts on quality of life. Women's health services should clearly set out management strategies for excessive menstrual bleeding.²⁸

Women with menstrual disorders should have access to services both in the community and hospital care which provide efficient management, appropriate counselling and support to make informed choices about their management.

1. Patient Focus

1.1 The term heavy menstrual bleeding needs to be clearly defined and articulated so that patients know when to seek support.

1.2 Women should have access to clear and unbiased information which includes all diagnostic and treatment options, their outcomes and complications.

1.3 Women with heavy menstrual loss should have the opportunity to make an informed decision about their management with a primary aim of improving quality of life.

1.4 Services should be customised to meet the needs for special groups such as adolescents and peri-menopausal women and those from different ethnic background.

1.5 Treatment should be based on a woman's own subjective evaluation and the impact on her quality of life. Professionals should listen to the needs of the patient and recommend timely interventions based on the facts the patient presents. (i.e. impact on quality of life).

2. Accessibility

2.1 Referral pathways from primary to hospital care should be agreed locally to ensure appropriate initial assessment and management of heavy menstrual bleeding in primary care.

2.2 Local protocols, derived from the best available evidence, should be agreed and incorporated into the referral care pathways. A time-frame should be set to manage the problem effectively.

2.3 Women should have access to all modalities of managing excessive menstrual loss and appropriate referral to a specialist centre may be required.

2.4 Care and referral pathways should be designed to ensure appropriate and speedy management of women who have results suspicious of cancer.

3. Environment

3.1 Development of “one stop” services, with facilities for ultrasound scanning and outpatient hysteroscopy should be encouraged.

3.2 Facilities for insertion of Levonorgestrel-releasing Intrauterine System (LNG-IUS), should be available in both primary and hospital care settings.

4. Process

4.1 Following exclusion of associated pathology and management of associated anaemia, medical treatment should be given according to the best available evidence. Acceptable haemoglobin levels should be agreed upon in the protocols as differences in initiating treatment for anaemia exist in different countries.

4.2 If there is a history of irregular vaginal bleeding, inter-menstrual bleeding and post-coital bleeding, cervical pathology should be considered. If cervical pathology is suspected, guidelines should be in place for further investigation and diagnosis.

4.3 Continuity of care is essential for teams to deliver ongoing care for menstrual problems.

4.4 A multidisciplinary approach including haematological advice should be sought for the management of adolescents without obvious pathology suffering from heavy menstrual bleeding particularly if presenting since menarche.

4.5 Ultrasound scanning is the first line investigation to exclude abnormality.

4.6 Failures to respond to first line medical treatment, persistent inter-menstrual bleeding are indications for outpatient endometrial sampling possibly obtained by hysteroscopy.

4.7 Services should be able to provide a range of therapeutic modalities including least invasive ones such as LNG-IUS, second generation endometrial ablation techniques and hysteroscopic surgery. Uterine Artery Embolisation (UAE) is an option when available.

4.8 Hysterectomy should be considered only if the woman has not responded to other treatments or declines other options after appropriate counselling for the least invasive available approach.

4.9 Healthy ovaries should not be routinely removed and appropriate counselling and consent is an essential requirement, whereas, removal of the fallopian tubes should be considered.

4.10 Management of associated iron deficiency anaemia should be an integral part of the care pathway and should take place prior to carrying out major surgery for heavy menstrual bleeding.

4.11 Protocols should be in place for thrombo-prophylaxis and infection prophylaxis for women undergoing major surgery.

5. Staffing and Competence

5.1 Gynaecology units should ensure competency/accreditation of staff involved in the management and those providing treatment modalities for heavy menstrual bleeding including insertion of LNG-IUS, Laparoscopic surgery and imaging and radiological procedures.

5.2 Referral to another unit should be considered if the woman's choice falls beyond the area of expertise which exists in local service.

5.3 Maintenance of surgical and imaging skills requires regular assessment and evaluation including audit of the number of procedures performed by operators.

5.4 Clinicians adopting new surgical techniques should be appropriately trained and accredited.

6. Training Standards

6.1 Professionals need to be able to communicate, empathise and understand the issues facing patients and the impact on their quality of life.

6.2 The trainee should attend hands on training courses in diagnostic and operative hysteroscopy, insertion of LNG-IUS, ultrasound scanning and second generation endometrial ablation techniques.

6.3 The trainees should demonstrate their competence in diagnostic and operative procedures by maintaining a log book of all the procedures performed and peri-operative outcomes.

6.4 Trainees wishing to learn advanced laparoscopic surgical techniques should be rotated to units with adequate work load.

6.5 Regular training in communication skills, cultural/gender awareness, equality and diversity, safeguarding vulnerable individuals should be provided.

7. Auditable Standards

7.1 Percentage of women in different age groups with heavy menstrual bleeding having endometrial sample before having trial of treatment with the first line drugs.

7.2 Proportion of women without obvious uterine anatomical abnormality receiving each of the treatment modalities in the gynaecology unit.

7.3 An audit of the gynaecology unit's surgical activity and complications.

7.4 An audit of randomly selected case notes to ascertain that women were counselled as regards possible intra-operative and post-operative complications.

7.5 Audit of patient satisfaction for each modality and for the service provided.

7.6 Audit on the timing and delivery of interventions.

STANDARD 13

Chronic Pelvic Pain

Rationale

Chronic pelvic pain in women is well recognised as a major health problem affecting up to 24% of women worldwide (WHO). It has a significant impact on quality of life of the woman and on her family. It is a common cause of referral to the health service and affects productivity as well as having implications for healthcare systems and society.

All women with symptoms of chronic pelvic pain need access to a full range of appropriate services for assessment, counselling and management.²⁹

1. Patient Focus

1.1 There should be clear information available about the services provided, their location and working hours.

1.2 There should be clear information on the investigations and choice of treatments available.

1.3 The patients should always be provided with an explanation about the possible diagnoses, various management options, patient support groups, the expected treatment outcome and possible complications of the treatment.

2. Accessibility

2.1 The treatment must be based on the best available evidence. An integrated care pathway between primary, secondary and tertiary care should be in place.

2.2 A multi-disciplinary approach should have quality-assured communication lines, interdisciplinary networks and hold regular meetings.

3. Environment

3.1 Gynaecological units should have a referral pathway to specialised pain management clinics when required.

3.2 Gynaecology services should have a multi-disciplinary approach to the management these patients and that should include referral arrangements with other services such as

departments of neurology, psychiatry, physical therapist, physiotherapists and counsellors (alternative medicine, neuropathies specialists etc) with relevant competencies.

3.3 Gynaecological units should have an environment where the patient feels listened to and cared for even with a chronic condition.

4. Process

4.1 Women with chronic pelvic pain of more than six months duration should be referred to secondary care.

4.2 Protocol-led services should be made available in general practice, gynaecology departments and dedicated pain-clinics.

4.3 Professionals need to demonstrate empathy and understanding / impact on quality of life.

4.4 Gynaecologists should exclude all possible gynaecological causes of pelvic pain such as endometriosis, adenomyosis, pelvic adhesions etc. Necessary and appropriate care should be provided.

4.4 Persistent pain after appropriate gynaecological treatment should be managed through dedicated care management services.

4.5 All services should have best evidence guidelines in place for clinical management and follow-up and these should be regularly reviewed.

4.6 Women with deep infiltrating endometriosis (DIE) must be referred to specialised, accredited, endometriosis centres.

4.7 Complex cases may require input from other specialty outpatient interdisciplinary clinics such as neurology, psychiatry, pain-clinics, specific physiotherapy and cognitive therapy. These cases should be referred to tertiary level treatment centres when specific treatment is required.

4.8 Networks should hold regular interdisciplinary network-meetings for case discussion, guideline review and other relevant communication.

4.9 The communication between the care providers must be quality assured, preferably based on electronic media.

5. Staffing and Competence

5.1 Staff at the different levels and facilities should have core, as well as specialist knowledge of various aetiologies, diagnostic procedures and treatment modalities for chronic pelvic pain.

5.2 Staff dealing with women with chronic pelvic pain should be trained in counselling and specifically in quality of life issues.

5.3 Specialist training programmes, clinical audits and site-visitation programmes, as well as CPD programmes should be implemented according to national standards and specifications.

6. Training Standards

6.1 Trainees should acquire the basic knowledge of the physiological and neurological background of pain during their basic medical training about the various aetiologies and diseases that can produce pelvic pain syndromes.

6.2 Training should be provided to assess women with chronic pelvic pain and assess their symptoms using the visual analogue scale.

6.3 Trainees should have time allocated to attend special clinics dealing with various chronic pain conditions in gynaecology.

6.4 Trainees must have dedicated time in the operating theatre at various levels of their specialist training, achieving competence in endoscopic surgery at basic, intermediate and specialist level. Specialists dealing with women with severe endometriosis should gain experience at the accredited laparoscopic surgery centres and be up-to-date with their CPD.

6.5 Regular training in communication skills, cultural/gender awareness, equality and diversity, safeguarding vulnerable individuals and quality of life assessment using standardised and validated questionnaires should be provided.

7. Auditable Standards

7.1 Annual patient satisfaction surveys.

7.2 Qualitative outcomes in terms of improvement in quality of life (QoL) using standardised and validated questionnaires.

7.3 Referral to pain clinic according to the agreed referral care pathway.

7.4 Percentage of women referred to endometriosis centre.

7.5 Referral to other services and their outcomes.

STANDARD 14

Benign Vulval Disorders

Rationale

Symptoms and signs in the vulva may signify a wide spectrum of systemic diseases (infectious, dermatologic, metabolic, oncologic, neurologic, psychologic, etc.) rendering clinical diagnosis and treatment very difficult.

Physicians, usually involved with care for women suffering from vulval disease, are general practitioners, dermatologists, proctologists, gynaecologists and genito-urinary specialists. Increasingly, dedicated clinics offer a multidisciplinary approach to vulval disorders.³⁰

The diversity of specialists involved requires setting standards of services in order to provide an appropriate diagnosis, support and management plan.

1. Patient Focus

1.1 All women should have access to competent staff, preferably in a dedicated vulval clinic, who can provide a correct diagnosis, appropriate counselling and, if necessary, multidisciplinary treatment.

1.2 Women should be encouraged to seek advice through raising awareness of the condition and of the availability of specialised clinics and treatment options.

1.3 Patient information should be available to make women aware of and understand the significance of vulval symptoms and to motivate and educate them about adequate treatment and appropriate follow-up.

1.4 The woman should be informed that the correct management of her vulval problem may involve various specialists and may require psychological support.

2. Accessibility

2.1 All women should have easy access to a dedicated gynaecologist with specific skills in diagnostic workup and treatment in vulval disease according to the best available evidence.

2.2 An integrated referral pathway from primary care to a vulval clinic should be established.

3. Environment

- 3.1 A vulval clinic should have discrete and comfortable waiting and examination rooms.
- 3.2 Facilities for diagnostic procedures should be available, including imaging, biopsy and cytological sampling, colposcopy, direct microscopic examination of discharge and culturing.
- 3.3 An examination couch of adjustable height and with proper leg support must be available along with good lighting to visualise the vulva and the vagina.
- 3.4 Appropriate equipment must be available in the examination room.

4. Process

- 4.1 Protocols for diagnosis and management should be evidence based, made available and updated on a regular basis.
- 4.2 Following assessment and examination, the appropriate management plan should be discussed with the patient, explained and initiated.
- 4.3 Joint management with a dermatologist is standard and appropriate referral to other services such as psychology, neurology, pain management, cognitive physiotherapy and other relevant specialties.
- 4.4 Local multidisciplinary teams should meet regularly to discuss clinical policies and guidelines according to the best available evidence.

5. Staffing and Competence

- 5.1 Services for vulval disorders should have a lead clinician with the relevant competency and experience.
- 5.2. The management of vulval disorders is frequently multi-disciplinary and requires input from senior clinicians from other disciplines with an interest in vulval disorders.
- 5.3 There should be sufficient and dedicated nurses and healthcare assistants to care for women suffering from vulval discomfort.
- 5.4 All staff involved in the provision of this service should maintain the relevant Continuing Professional Development (CPD).

6. Training Standards

- 6.1 All trainees should attend a number of vulval clinics to fulfill their training requirements according to the EBCOG Log Book.
- 6.2 Advanced training will be required for those involved in specialised vulval clinics.
- 6.3 All staff providing the service should have special competency and be up to date with their relevant CPD.
- 6.4 Regular training in communication skills, breaking bad news, cultural/gender awareness,

equality and diversity and the safeguarding of children and vulnerable individuals should be provided.

7. Auditable Standards

7.1 Number of annual referrals and their pattern.

7.2 Rate of representative biopsies when and if taken to support diagnosis and subsequent choice of treatment.

7.3 Rate of appropriate coding for the diagnosis and the correct histological and/or clinical description of the abnormality according to international classification.

7.4 Rate of documented successful response to first-line treatment, including symptom control and quality of life.

7.5 Annual patient satisfaction surveys.

STANDARD 15

Menopause and Hormonal Therapy

Rationale

With increasing longevity, women are expected to spend one third of their life after the menopause. Menopause has a huge impact on the quality of life of women, their families, healthcare systems and society at large. A holistic approach to the problem should be adopted.

1. Patient Focus

1.1 Clear and objective information should be available to women on all aspects of menopause healthcare issues in particular prevention of osteoporosis, cardiovascular diseases and cancers, with a special focus on high-risk groups.

1.2 Clear and unbiased information on hormonal and non-hormonal therapies for menopausal symptoms should be readily available.

1.3 Specific counselling on the possible impact on sexual life issues, including contraception, should be provided.

1.4 A global strategy to ensure healthy lifestyle, proper physical activity and eating habits, and discouraging smoking and excessive alcohol intake should be the first-line of discussion.

1.5 Young, premature menopausal women have special needs and should have access to specialised clinics to address their sexual and reproductive health and their future reproductive potential.

1.6 Accuracy and timing of diagnosis are paramount to achieving the appropriate and effective management plan, particularly in cases of premature ovarian failure.

2. Accessibility

2.1 Women should have access to counselling, clinical assessment, basic investigations and unbiased information regarding menopausal issues.

2.2 All services dedicated to menopausal issues should be easily accessible.

3. Environment

3.1 Dedicated menopause clinic services should be available and should serve as referral centres, allowing for the integrated evaluation of complex problems.

3.2 Menopause clinics should include or have access to specialists such as cardiologists, internal physicians, rheumatologists, orthopaedics, neurologists, oncologists, geneticists etc.

4. Process

4.1 Locally agreed guidelines based on best available evidence should be in place.

4.2 Initial assessment and management of menopause in primary care settings should be provided. Integrated referral pathways to specialised clinics when appropriate, particularly for those women with co-morbidity or at high risk, should be in place.

4.3 The risk/benefit ratio should be discussed with women before prescribing hormonal therapy. This discussion should be recorded, including the indication for treatment.

4.4 Multidisciplinary meetings should be held to review complex cases with input from appropriately trained clinicians.

4.5 An appropriate follow-up plan should be formulated for patients attending these services.

4.6 Evidence based guidelines for managing post-menopausal bleeding in women should be in place. This should take into account whether the woman is on hormonal therapy or not.

4.7 Women with premature menopause should have appropriate guidance and management. The prescription of hormonal therapy (HT) should be discussed proactively with, a clearly defined long-term management strategy. Younger age groups should be appropriately referred for counselling regarding their reproductive potential if they so wish.

4.8 Women with troublesome menopausal symptoms should be offered hormone therapy unless contraindicated. Follow-up visits should be made available at appropriately regular intervals.

4.9 Women with symptoms that have contraindications to hormonal therapy should be offered holistic treatment strategies, including non-hormonal medication, complementary medicine and lifestyle advice.

4.10 Menopause clinics should include services for oncological patients and a joint protocol should be in place with oncologists. These should specifically offer support and treatment for menopausal issues ensuing after oncological treatments.

5. Staffing and Competence

5.1 The lead clinician with appropriate experience and skills should be responsible for the provision of these services.

5.2 All staff providing the service should have special competency and be up to date with their relevant CPD.

5.3 Staff should be competent in evaluating risk-benefit ratio for individual post-menopausal women particularly those with co-morbidities.

5.4 Staff dealing with menopausal women should be trained in counselling and specifically in quality of life issues.

6. Training Standards

6.1 All trainees should attend menopause clinics to fulfil their requirements according to the EBCOG Log Book.

6.2 Advanced training will be required for those involved in specialised menopause services.

6.3 Regular training in communication skills, breaking bad news, cultural/gender awareness, equality and diversity and the safeguarding of vulnerable individuals should be provided.

7. Auditable Standards

7.1 Number of new referrals to each clinic, together with the reasons for referral.

7.2 Rates of uptake of different treatments (hormonal, medical and alternative treatments) and complications reported.

7.3 Number of women with premature ovarian failure on HT and their long-term outcome data (including osteoporosis and cardiovascular disease).

7.4 Uptake and long term compliance with HT in women with POF is appropriate.

7.5 Annual patient satisfaction survey.

STANDARD 16

Benign Breast Pathology

Rationale

Benign breast conditions have a wide range of pathological and non-pathological backgrounds. Lesions may be visible, palpable or only reported during radiography or sonography. Women with benign breast disease often present to gynaecologists, and distinguishing benign breast disease from malignancy is crucial for correct management.³¹

1. Patient Focus

1.1 It is important to raise women's awareness for the need for regular breast self-examination.

1.2 It is important to educate all women to be aware of the importance of reporting any changes in their breasts and to consult their healthcare provider as required.

1.3 Women should be informed of the suspicious signs and symptoms of breast cancer.

1.4 Women should be offered screening depending on the national healthcare system.

1.5 Women with high risk should be made aware of the need for risk assessment and subsequent screening.

1.6 Women should be well informed of the risk factors of breast cancer.

2. Accessibility

2.1 Women who present with breast symptoms should be promptly seen by an experienced clinician and have access to clinical assessment and first line investigations.

2.2 Prompt referral to specialised breast clinics should be easily accessible when required.

2.3 There should be access to ultrasound scan and sampling when indicated.

3. Environment

3.1 Women should be seen in a friendly, warm environment to relieve their anxiety.

3.2 Clinical consultation and examination should ensure privacy and a chaperone offered and available when requested.

4. Process

- 4.1 Protocols and algorithms for diagnosis and further management should be based on the best available evidence.
- 4.2 A thorough history should be taken, including medication and family history.
- 4.3 A systematic breast examination should be performed.
- 4.4 Imaging techniques, including mammography and ultrasound scanning should be applied.
- 4.5 Exclusion of malignancy is a priority and prompt referral to a specialist is essential.
- 4.6 After exclusion of malignant disease, women should be counselled and reassured about the benign nature of their condition.
- 4.7 Women should be offered a follow-up appointment if indicated.

5. Staffing and Competence

- 5.1 In countries where gynaecologists are responsible for breast diseases, a lead clinician with appropriate experience and skills should be responsible for the provision of these services.
- 5.2 All staff providing the service should have special competency and be up to date with their relevant CPD.
- 5.3 Breast pathology should be managed in a multidisciplinary and integrated breast care service including gynaecological surgeons specialising in breast, radiologist, pathologist and breast care nurse.

6. Training Standards

- 6.1 All trainees should attend breast clinics to fulfil their training requirements according to the EBCOG Log Book.
- 6.2 In countries where gynaecologists are responsible for breast diseases, gynaecologists should have the appropriate training in breast diseases, preferably certified
- 6.3 The breast care nurse should have appropriate nursing qualifications and have experience in handling and supporting women with benign breast disease.
- 6.4 Regular training in communication skills, breaking bad news, cultural/gender awareness, equality and diversity and the safeguarding of vulnerable individuals should be provided.

7. Auditable Standards

- 7.1 Number and pattern of referrals of women to a breast unit.

7.2 Percentage of BI-RADS category 4 mammograms that is followed by biopsy within 7-10 days within the benign breast clinic or after referral to a breast cancer unit.

7.3 Number of days between the pathology report and documentation that patient was informed of the results.

7.4 Rate of misdiagnosis of breast cancer.

7.5 Annual patient satisfaction survey.

STANDARD 17

Colposcopy

Rationale

Organised screening has reduced the incidence of cervical cancer and the death rate from the disease by 80% in some European states. National screening policies should be encouraged throughout Europe. The introduction of HPV vaccination and HPV testing may reduce the death rate further.

Women with a suspicion of or who are at perceived high risk of developing cancer should be seen promptly in a setting conducive to professional care.

Colposcopy is not a screening tool but an investigation following reporting of cytological abnormality on cervical smear. Treatment should be directed only to those at risk of developing cancer.³²

1. Patient Focus

1.1 Women should receive an appropriately worded invitation for colposcopy with a contact name, telephone number and clinic times. Anxiety can be produced by the mere process of cervical screening when an abnormality is found which requires referral for colposcopy or treatment to allay anxiety.

1.2 Each woman should receive verbal and written information before colposcopy including a statement on whether or not immediate treatment will be offered.

1.3 Counselling should be available as an integral part of colposcopy.

1.4 The patient should be told that the results of any investigations and further plans for action will be communicated when available.

2. Accessibility

2.1 Low grade cytology (ASC-US, LSIL or equivalent)* should be seen in colposcopy clinic within 8 weeks of the cytology result being issued.

2.2 High grade cytology (HSIL+ or equivalent including ASC-H)* should be seen in colposcopy clinic within 4 weeks of the cytology result being issued.

2.3 If cancer is suspected the patient must be seen within 2 weeks.

*** Bethesda cytology grading**

ASC-US Atypical squamous cells of undetermined significance

LSIL Low grade squamous intraepithelial neoplasia

ASC-H Abnormal squamous cells of uncertain significance (high grade cannot be excluded)

HSIL+ High grade squamous intraepithelial lesion or worse.

Some colposcopy services will offer HPV testing for low grade abnormal cytology and refer only if HPV +ve for high risk types. Others may refer only if low grade cytological changes are persistent particularly for ASC-US.

3. Environment

3.1 Colposcopy units must be appropriately equipped for diagnostic and if performing treatments for therapeutic procedures. Facilities should be regularly inspected.

3.2 Clinical consultation and examination should ensure privacy and a chaperone offered and available when requested.

3.3 Colposcopy clinics should comply with health and safety regulations and should have first aid facilities on site.

3.4 There should be a SOP.

4. Process

4.1 Colposcopy clinics should adhere to a clear evidence based protocol for the management of cervical abnormalities.

4.2 All cases must have a colposcopic examination prior to treatment for abnormal cervical cytology.

4.3 There must be a standardised record of each colposcopic examination and any procedures performed during that examination. This must include:

- Whether the squamocolumnar junction (scj) has been seen or not;
- The transformation zone type as defined by the IFCPC;
- The site of any biopsies;
- Colposcopic opinion.

4.4 The number of major procedures for the treatment of CIN must be minimised.

- Preferable techniques are loop excision/ laser excision in an outpatient setting;
- Treatment for CIN should be performed with local anaesthetic.

4.5 Multidisciplinary meetings involving the cytologist, the pathologist and the clinician should be encouraged

4.6 Clinical pathways must be designed to ensure adequate follow up for patients after treatment.

4.7 Wherever HPV testing is performed, only validated HPV test formats must be used and there must be HPV reference laboratories in each country providing HPV testing.

4.8 A system of reviewing and actioning the results should be in place.

4.9 A system of communicating the results and the further plan of action to the patients should be in place.

5. Staffing and Competence

5.1 There should be a named head to monitor quality standards for their service at least on an annual basis.

5.2 All colposcopists should have had formal training and be recognised or certificated as suitable to practice colposcopy. All European training programmes should comply with European Federation for Colposcopy (EFC) training standards.

5.3 The unit should also have adequately trained support staff.

6. Training Standards

6.1 All trainees should attend colposcopy clinics to fulfil their training requirements according to the EBCOG Log Book.

6.2 All gynaecologists who are responsible for colposcopy services should have the appropriate training and be preferably certified. (communication competencies)

6.3 All colposcopists should be up to date with their CPD

6.4 Nurses who are involved in colposcopy clinics should have appropriate nursing qualifications and have experience in handling and supporting women with suspected pre-invasive disease of the cervix and its treatment.

6.5 Regular training in communication skills, breaking bad news, cultural/gender awareness, equality and diversity, and the safeguarding of vulnerable individuals should be provided.

7. Auditable Standards

The EFC document provides a full list of auditable standards. For the purpose of EBCOG standards, audited outcomes should at least include the following:

7.1 Percentage of procedures for CIN performed with local anaesthetic;

7.2 Percentage of all treatments performed with loop or laser excision;

7.3 Percentage of excisional treatments/conizations containing CIN2⁺;

7.4 Percentage of CIN2⁺ involving the endocervical or lateral margins;

7.5 Percentage of abnormal cytology and CIN2⁺ within 12 months of treatment.

7.6 Annual patient satisfaction survey.

STANDARD 18

Diagnostic and Operative Hysteroscopy

Rationale

Hysteroscopy is the gold standard for the evaluation of the uterine cavity and the treatment of abnormalities.

Diagnostic hysteroscopy should be performed on an ambulatory basis whenever possible.

Operative hysteroscopic procedures can be performed either in a conventional Operating Room (OR) setting or in an appropriate outpatient setting with efficient OR management, instrumentation and trained personnel.³³

1. Patient Focus

1.1 Women should have access to balanced and unbiased information before attending for either a diagnostic or an operative hysteroscopy.

1.2 For operative hysteroscopy, risk assessment and information on alternative treatment options should be discussed.

1.3 The “one stop approach” requires patient counselling, including the possibility of further procedures according to the findings.

2. Accessibility

2.1 Dedicated outpatient diagnostic and operative services should be readily available.

2.2 Inpatient diagnostic and operative services should be available for patients only where outpatient management is not appropriate.

2.3 Access to inpatient admission should be readily available should any complication arise.

3. Environment

3.1 Hysteroscopy units should have in place appropriate and up-to-date equipment, used in accordance with the manufacturers’ instructions and local guidelines. The unit should also provide simultaneous ultrasound scanning.

3.2 Clinical consultation and examination should ensure privacy and a chaperone offered and available when requested.

3.3 Outpatient hysteroscopy clinics should comply with health and safety regulations and should have first aid facilities on site.

3.4 There should be a SOP.

4. Process

4.1 Pregnancy should be excluded in all women undergoing hysteroscopy.

4.2 The service should be run on up-to-date local protocols, based on the best available scientific evidence.

4.3 In case of complications, there should be access to an emergency gynaecology service.

4.4 The hysteroscopy examination and treatment should be recorded in a standardised format

4.5 Instrumentation and distention medium used should be documented and any immediate or late complications should be registered.

4.6 In case of pathology suspicious for malignancy, histological evaluation must be obtained preferably by directed biopsies.

4.7 There should be clear aftercare instruction for patients to follow after the procedure.

5. Staffing and Competence

5.1 All personnel in the hysteroscopy unit should adequately been trained (* certificated as per colposcopy).

5.2 Every hysteroscopic clinic should have a record of demonstrable ability on the part of those staff carrying out hysteroscopic procedures with validation of practical and theoretical skills in OR organisation and instrument handling and care.

5.3 Every training unit should have an in vitro dry lab to train and test practical skills in a validated environment.

5.4 Hysteroscopic specialists must have an adequate workload, review their outcome data yearly and should maintain their CPD.

6. Training Standards

6.1 All trainees should attend hysteroscopy clinics to fulfil their training requirements according to the EBCOG Log Book.

6.2 Doctors in training should maintain a log book to demonstrate their competence in various aspects of hysteroscopic procedures and the outcomes .

6.3 All hysteroscopists should have had formal training or be recognised by their experience as suitable to practice by their national and local bodies.

6.4 A formal evaluation of the theoretical knowledge and practical hysteroscopic skills and instrument handling should be provided by performing in house recognised evaluation procedure or the use of a recognised and validated evaluation system.

6.5 Regular training in communication skills, breaking bad news, cultural/gender awareness, equality and diversity and the safeguarding of vulnerable individuals should be provided.

7. Auditable Standards

7.1 Number of procedures, pathologies identified and the complications within the unit.

7.2 Number of diagnostic and operative hysteroscopy per operator and the complication rate recorded annually.

7.3 Patient satisfaction survey.

7.4 Number of and peri-operative complications and outcome within the unit.

7.5 Number of diagnostic procedures and failures leading to conversion to procedure under general anaesthesia.

7.6 Audit of documentation.

STANDARD 19

Laparoscopic Surgery

Rationale

Laparoscopic surgery is reported to improve surgical outcomes and is associated with high patient satisfaction. It is essential to set standards for this highly specialised service which demands the acquisition of the necessary skill and appropriate competency. It is evident that any expansion of laparoscopic surgery without validation of the necessary skills could increase adverse outcomes.³⁴

1. Patient Focus

1.1 Women should have access to balanced and unbiased information before either a diagnostic or an operative laparoscopy.

1.2 Women undergoing laparoscopic procedures should have appropriate and clear after care instructions.

1.3 Information should be available on the level of expertise, the facilities, the range of procedures and the local quality programme.

1.4 Informed consent should be obtained and include an explanation of the risks involved and alternative interventions.

2. Accessibility

2.1 Women should have access to laparoscopic surgery when indicated and should be referred to units with appropriate expertise.

2.2 Every gynaecological unit should be encouraged to provide basic laparoscopic care (ESGE levels 1 & 2)*.

2.3 There should be a referral pathway to allow the provision of higher level-laparoscopic surgery (ESGE levels 3 & 4).

* ESGE Classification of Laparoscopic surgeons: www.esge.org/education/endoscopic-training/esge-laparoscopy-standard

Patient Safety Alert - Inform the patient about the faculty programme where laparoscopic surgery is being provided: This should include information on the levels of laparoscopic surgeries provided and the local quality programme. Information regarding OR infrastructure, the educational programmes for OR staff, the quality control system for surgeons and residents, including the standards which a future laparoscopist must meet in order to operate, either independently or under supervision should also be provided.

3. Environment

3.1 Units should have in place appropriate and up-to-date equipment which should be used in accordance with the manufacturers' guidelines.

3.2 An up to date Standard Operating Procedure (SOP) should be in place and regularly updated.

3.3 A training environment should be encouraged and facilities made available.

4. Process

4.1 Appropriate patient selection is important and a standardised protocol on inclusion and exclusion criteria for all treatment modalities should be adhered to.

4.2 Findings and the procedure should be accurately recorded preferably in a standardised format.

4.3 A see-and-treat policy should be discussed with the patient undergoing laparoscopy and preoperative consent should be obtained. See and treat policy should be based on the individual surgeon's competency level.

4.4 A multidisciplinary approach to managing complex cases should be encouraged.

4.5 Clinicians should provide reassuring communication before and after the procedure and communicate the findings and future plan of action.

5. Staffing and Competence

5.1 All surgeons should be trained according to the standards set by the ESGE.

5.2 All staff should be familiar with the equipment and should attend regular training.

5.3 There should be evidence of compliance with Continuous Professional Development (CPD).

5.4 There should be dedicated nursing staff for units providing operative laparoscopy who underwent the necessary training.

6. Training Standards

6.1 All trainees should attend laparoscopic surgery operating lists to fulfil their training requirements according to the EBCOG Log Book.

6.2 Every teaching unit should have an in vitro dry lab for validated system and procedural training.

6.3 All laparoscopists should have had formal training or be recognised by their experience as suitable to practice by their national and/or local bodies.

6.4 Regular training in communication skills, breaking bad news, cultural/gender awareness, equality and diversity and the safeguarding of vulnerable individuals should be provided.

7. Auditable Standards

7.1 Documentation of the incidence of different pathologies, the operative procedures performed and complication rates.

7.2 Documentation of activity for surgeon. According to their level of certification/expertise.

7.3 Clinical outcomes for each treatment modality.

7.4 Number of diagnostic procedures, number of diagnostic plus histological findings.

7.5 Audit of documentation to demonstrate adherence to the local/national standards

7.6 Clinicians' workload and annual activity in diagnostic and operative procedures and their complication rates.

7.7 Annual patient satisfaction survey.

STANDARD 20

Gynae-Oncology Screening, excluding Breast Cancer

Rationale

Prevention by early detection and screening could potentially improve outcome of treatment and reduce morbidity and mortality caused by cancer.

Screening is defined as the examination of asymptomatic individuals with a view to identifying those who have occult disease or who are likely subsequently to develop the disease, and would therefore benefit from further investigations or treatment.

In many countries in Europe, population screening has not been well structured or implemented. Opportunistic screening is inevitably less effective than well organised nationwide population screening programmes.³⁵⁻³⁶

1. Patient Focus

1.1 Women should be made aware of options available for screening.

1.2 Communication regarding population screening should be led by professional bodies, specifically resourced to inform large and diverse populations.

1.3 Communication regarding population screening should use modern ways of communication that will reach the target population.

1.4 The women should be informed about the possible benefits, false positive and false negative rates for screening tests and the adverse effects associated with the screening.

1.5 The information should be provided in a universally understandable fashion and language adapted to high risk and vulnerable groups.

1.6 The information should be given in such a fashion that confidentiality and efficiency are ensured.

2. Accessibility

2.1 All women should have access to established and validated methods of screening.

2.2 Preferably, screening should be offered to all women in a predefined population, usually based on age.

2.3 Screening should preferably take place at the earliest point of contact with the healthcare system preferably in primary care.

3. Environment

3.1 Women should be seen in a friendly, warm environment to relieve their anxiety and ensure privacy.

3.2 Clinical consultation and examination should ensure privacy and a chaperone offered and available when requested.

3.3 Waiting times should be kept to a minimum in clinics for screening to reduce women's anxieties and disruption.

4. Process

4.1 All women from a target population should be invited for screening.

4.2 An adequate system for call and re-call should be in place.

4.3 Screening should be performed by health care providers who have experience with the screening method and are acquainted with the consequences of its possible outcomes.

4.4 Each screening test should be performed in a standardised fashion and documented with the appropriate clinical data set to allow identification and interpretation of the results.

4.5 Results of screening should be documented and communicated to the patient in an unambiguous fashion without delay. The communication should be documented.

4.6 If an abnormal result warrants further diagnostic tests or treatment, they should be made available within 3 weeks time (usually as referral to an oncologist).

4.7 Screening methods should regularly be evaluated for validity and benefit (e.g. through NCI's Cancer Screening Overview PDQ®²).

4.8 Clinicians should provide reassuring communication before and after the procedure and communicate the findings and future plan of action.

5. Staffing and Competence

5.1 All healthcare providers involved in screening should be competent and appropriately trained according to national guidelines.

5.2 The screening service should be appropriately staffed according to the population served.

5.3 All healthcare providers involved in screening should maintain and update their competence.

5.4 Continuing Professional Development (CPD) should be appropriately documented.

6. Training Standards

6.1 Doctors in training and healthcare providers involved in screening programmes should attend theoretical and practical courses to learn about screening to fulfil the training requirement of the EBCOG Logbook.

6.2 Healthcare providers involved in the screening programme should be trained and achieve competence in providing the service including performance of the tests, communication skills, counselling, management and follow-up.

6.3 Regular training in communication skills, breaking bad news, cultural/gender awareness, equality and diversity and the safeguarding of vulnerable individuals should be provided.

7. Auditable Standards

7.1 An agreed set of auditable standards should be in place and derived from the published national and international guidelines.

STANDARD 21

Breast Cancer Screening

Rationale

Population breast screening programmes should be based within, or be closely associated with, a recognised breast unit.³⁷

Every health professional involved in the screening programme must be a core member of the associated breast unit and breast screening centres should be a part of breast units.

It is essential to define standards for breast cancer screening in order to improve the quality of healthcare available to all women in Europe.

1. Patient Focus

1.1 Breast cancer is a major health issue and the establishment of national screening programmes is recommended.

1.2 The information should be provided in a universally understandable fashion and language adapted to high risk and vulnerable groups.

1.3 The women should be informed about the possible benefits, false positive and false negative rates for screening tests and the adverse effects associated with the screening.

1.4 The information should be given in such a fashion that confidentiality and efficiency are ensured.

2. Accessibility

2.1 All women should have access to established and validated methods of screening.

2.2 Preferably, screening should be offered to all women in a predefined population, usually based on age.

2.3 Screening should preferably take place in well established screening units.

3. Environment

3.1 Women should be seen in a friendly, warm environment to relieve their anxiety and ensure privacy.

3.2 Consultation and screening should ensure privacy and a chaperone offered and available when requested.

3.3 Waiting times should be kept to a minimum in clinics for screening to reduce women's anxieties and disruption.

3.4 Screening equipment should be up to date, regularly maintained and operate according to the manufacturer's recommendations.

3.5 A SOP should be in place.

3.6 Screening units should comply with health and safety regulations.

4. Process

4.1 The Unit must have written protocols for screening, diagnosis and management of breast cancer.

4.2 Imaging equipment, preferably not older than 10 years, for complete and adequate breast diagnosis should be available:

- Mammography Unit (preferable digital)
- Stereotactic biopsy attachment and/or dedicated prone biopsy table
- Ultrasound equipped with a small part probe $\geq 10\text{MHz}$

4.3 The team consists of at least two accredited breast surgeons/gynaecologists.

4.4 Screening units should have access to an appropriate and dedicated breast pathology service as well as breast cancer specialists.

4.5 All patients should be discussed in a multidisciplinary team

4.6 Screening results should be communicated efficiently to the woman and her family doctor. It is not recommended that the results are communicated by telephone or e-mail etc..

4.7 The unit should have a data management system for recording all unit activity and an efficient recall system should be in place.

5. Staffing and Competence

5.1 The multidisciplinary team, represented at the tumour board and available for consultation, co-treatment and referral should include at least:

- Two dedicated breast radiologists
- Two dedicated breast pathologists
- Two dedicated breast surgeons (surgeon or gynaecologist) and a reconstructive surgeon (plastic surgeon) with demonstrable experience in the treatment of breast cancer.
- One medical oncologist with experience in the treatment of breast cancer and who is familiar with palliative and supportive care issues.
- One dedicated radiation oncologist.
- Two Breast Care Nursing with experience in counselling and follow-up of patients.
- One dedicated psychologist or social worker.

5.2 All clinicians involved in the provision of breast cancer screening and management thereafter should meet the standards as set out by EUSOMA - The requirements of a specialist Breast Unit. 2010.

6. Training Standards ³⁸

6.1 Doctors in training and healthcare providers involved in screening programmes should attend theoretical and practical courses to learn about screening to fulfil the training requirement of the EBCOG Logbook.

6.2 Healthcare providers involved in the screening programme should be trained and achieve competence in providing the service including performance of the tests, communication skills, counselling, management and follow-up.

6.3 Regular training in communication skills, breaking bad news, cultural/gender awareness, equality and diversity and the safeguarding of vulnerable individuals should be provided.

7. Auditable Standards

7.1 Rate of false positive and false negative screening outcomes.

7.2 Patient satisfaction survey.

7.3 Number of women for whom the time between the date of first diagnostic examination and the date of surgery or start of other treatment was within 6 weeks

7.4 Proportion of cases that was discussed in a multidisciplinary tumour board.

STANDARD 22

Gynae-Oncology Services, Including Breast Cancer

Rationale

It is well recognised that the outcome of oncological intervention depends on both the volume and the expertise of the service providers*. Specialised cancer services offer evidence-based treatment and it is reported they have reduced morbidity and better survival rates.

In certain countries in Europe, breast cancer care is provided by gynaecological oncologists, and therefore standards of care should also be defined for these services, in line with the standards described by the European Society of Breast Cancer Specialists (EUSOMA).³⁹⁻⁴⁰

1. Patient Focus

1.1 Patients should be informed about the level of specialisation of the service and the level of expertise. This information should be available publically.

1.2 The patient should be informed of a named and dedicated health care professional (case manager) who will assist her throughout the diagnostic and therapeutic process, as well as during follow-up.

1.3 The patient should be informed of all treatment options, even if they are not available in the service.

1.4 The patient should be informed of the support services available in the hospital and in the community that might assist her.

1.5 The patient's spiritual/religious and cultural needs should be met, especially in terminal care.

* Clear definitions for a cancer centre are lacking. According to the US (NCI) model adopted also in Europe, cancer centres have a scientific agenda that primarily focuses on basic, clinical or population based research, or any two of the three. In the UK the NHS defines centers on basis of their population adherence. Specialised cancer services are those services, treatments and interventions which either require service planning for populations of over one million and up to five million as specified in the relevant NICE guidance or are provided in fewer than 50 hospitals in England. In any way, dedicated services for gynaecological oncology should be distinguishable from general hospitals providing basic care for gynaecological oncological patients. ESGO has clearly defined gynaecological oncological training centres, and similar criteria should be applied to clinical gynaecological oncological services.

2. Accessibility

2.1 Women with suspected or proven cancer should have access to a gynae-oncology service within 2 weeks.

2.2 All gynaecological oncology services should have access to laboratory, imaging facilities, blood transfusion services specialised anaesthetic services and intensive care.

3. Environment

3.1 Oncology services should provide a setting allowing for the appropriate privacy and facilities to communicate and care for the patient and her family members.

3.2 The gynae-oncology unit should have facilities for confidential counselling.

3.3 The gynae-oncology unit should be equipped with advanced facilities for minimally invasive surgery.

3.4 Waiting times in outpatients should be kept to a minimum to reduce women's anxieties and disruption.

3.5 Gynae-oncology services should have high dependency units (HDU) and blood transfusion services on-site.

3.6 Gynae-oncology services should comply with health and safety regulations.

4. Process

4.1 A gynae-oncology service should provide comprehensive multidisciplinary cancer care.

4.2 The service should have established close collaboration with related disciplines, such as medical oncology, radiation oncology, psycho-oncology, pathology, radiology, urology, oncological surgery, reconstructive surgery and palliative care.

4.3 Clear and published care pathways, including detailed protocols, should be defined for patients with various oncological diseases.

4.4 All new cases should be reviewed and discussed at a multidisciplinary tumour board/team and the diagnosis and management plan should be documented.

4.5 Medical oncological treatment should be performed by specially trained gynaecological oncologists, and in case this treatment is provided by a medical oncologist this should be done in close collaboration with gynaecological oncologists.

4.6 Complex surgery should, when appropriate, be jointly performed with the relevant oncological surgical specialists and/or reconstructive surgeons.

4.7 Minimally invasive approach is the preferred mode of surgery when indicated and subject to the availability of appropriate expertise.

4.8 Patients requiring radiotherapy should be referred to the radiation oncologist.

4.9 Supportive care should be given in close collaboration with psycho-oncologists and palliative care specialists.

4.10 Treatment should be initiated within 6 weeks of referral to the specialist for cases of positive screening or suspected cancer.

4.11 Patients should be offered support by specialised services during and after the period of treatment.

4.10 An oncological database should be established to monitor activity and evaluate outcomes.

5. Staffing and Competence

5.1 The gynae-oncology service should be headed by a certified lead gynaecological oncologist or a gynaecologist with equivalent qualification and experience.

5.2 The service should be adequately staffed to serve the population of the catchment area.

5.3 Gynaecological oncologists should be certified subspecialists, trained in an accredited training centre or gynaecologists with equivalent qualification and experience.

5.4 Post-graduate continuing professional development (CPD) should be followed by all staff members according to national/professional society guidelines.

5.5 The service should be adequately staffed (at least 3 full- or part-time gynaecological oncologists and specialised nursing staff) and an adequate case load (at least 100 new invasive cases of pelvic cancer and – if applicable – at least 150 cases of breast cancer per year).

5.6 The gynae-oncology team should include nurses specialised in this area and competent in counselling as well as delivering the appropriate clinical care to patients.

6. Training Standards

6.1 Subspecialist training for gynaecological oncology is performed as defined in the EBCOG/ESGO Subspecialist Training Programme in Gynaecological Oncology and Log Book.

6.2 Doctors in training should have access to the gynaecological oncological service and be trained in peri-operative care to fulfil the requirements of their curriculum.

6.3 Doctors providing the service and those in general training should achieve competency in counselling oncological patients.

6.4 Regular updates of all staff on protocols should be organised.

6.5 Regular training in communication skills, breaking bad news, cultural/gender awareness, equality and diversity, safeguarding children and vulnerable individuals should be provided.

7. Auditable Standards

7.1 Percentage of patients seen within two weeks of referral and percentage of patients treated within six weeks of referral.

7.2 Total number of patients, number of new cases and number of radical surgery**.

7.3 Annual surgical morbidity and mortality data.

7.4 Global and disease free 5 year survival rate.

7.5 Annual patient satisfaction survey.

**** Radical surgery:**

Radical abdominal hysterectomy

Radical vaginal hysterectomy

Pelvectomy (ant, post, total)

Urinary diversion after pelvic exenteration

Cytoreductive surgery in ovarian cancer

Lombo aortic lymphadenectomy

Intensive surgical staging for ovarian cancer

Second look laparotomy in ovarian cancer

Bowel resection

Pelvic lymphadenectomy

Vulvectomy

Inguinal lymphadenectomy

Total colectomy

Breast tumorectomy

Axillary lymphadenectomy

Mastectomy

Breast reconstructive surgery

STANDARD 23

Infertility and Assisted Conception

Rationale

Infertility should be recognised as a public health issue worldwide. The provision of infertility treatment and assisted conception services is associated with challenging clinical and ethical issues.

Efficacy and cost-effectiveness are paramount and demand that services should meet the standards and that the treatment provided is based on the best available evidence.

Infertility is often stressful and the couple should be treated with empathy and get full support to alleviate the psychological burden. The infertile couple should get access to a specialised service that will provide a full diagnostic work up and therapy. Treatment should be individualised on the best available evidence and communicated effectively.⁴¹

1. Patient Focus

1.1 All men and women who are sub-fertile should have the appropriate information on the availability of diagnostic and therapeutic options, irrespective of their cultural, sexual or religious background.

1.2 Arrangements should be in place for referral of individuals/couples to specific service providing an integrated approach.

1.3 All aspects of the infertility problem must be taken into account ethical and cultural background.

1.4 Providers of fertility treatment should make available information about fertility treatment, options of treatment modality and their success and failure rates.

1.5 Older women should be considered carefully and timely managed by prompt referral for specialised services.

2. Accessibility

2.1 All individuals with infertility should have access to counselling, clinical assessment and basic investigations.

2.2 All individuals should have access to assisted reproduction units when necessary and without delay.

3. Environment

3.1 Primary and specialist care settings should all provide discrete, confidential, patient-centred and non-judgemental care.

3.2 Infertility centres should have dedicated facilities for reception, clinical and counselling activities.

3.3 Infertility centres should have on-site facilities for the storage of confidential records and access to laboratories and the storage of gametes and embryos.

3.4 The centre should have appropriate procedures to ensure compliance with the requirements for safety and environmental quality Regular evaluation for hazards to laboratory staff and infection control should be carried out.

3.5 Counselling facilities and laboratory facilities, should comply with professional guidelines and legislation.

3.6 The centre should have appropriate on-site amenities for semen collection.

3.7 Laboratories in assisted conception units should fully comply with the European Union Tissues and Cells Directives (2004).

4. Process

4.1 Protocols for pre-pregnancy counselling and pre-conception preparation and management of co-morbidity should be in place.

4.2 Integrated protocols for investigations should be in place between primary care and infertility units.

4.3 Protocols based on the best available evidence should be in place for each modality of treatment.

4.4 Treatment should be evidence based and all centres should provide documentation and meet regulatory standards.

4.5 Infertility units should make all efforts to avoid multiple pregnancies by adopting a well controlled monitoring policy when providing induction of ovulation.

4.6 The management plan, results of investigations, treatment and outcomes should be clearly documented and communicated to patients. Data collection and analysis should be carried out regularly and made available to Commissioners and Regulators when required.

4.7 All IVF centres must have a strategy to minimise multiple births. Elective single embryo transfer should be the standard practice in IVF/ICSI. All fertility centres must contribute to the reduction in multiple births by adopting the transfer of one embryo.^{4,5, 41}

4.8 Further investigations based on advanced reproductive technology should be performed in secondary care centres having properly trained staff and the appropriate facilities.

4.9 Specific treatments, such as ovulation induction, reproductive surgery and assisted conception should be carried out only in specialised centres.

4.10 Centres should comply with regulatory requirements whether in public or independent sectors

4.11 Treatment involving gamete/embryo donation, where available, should only be provided following appropriate professional counselling, including the legal, social and cultural implications and with the appropriate informed consent of the recipients.

5. Staffing and Competence

5.1 There should be a named lead clinician for infertility services and for units providing assisted conception services.

5.2 There should be a named quality manager in each specialised centre.

5.3 All staff should be certified by the appropriate professional national body.

5.4 Specialised centres should have regular meetings to discuss and manage cases in a multi-disciplinary environment.

5.5 Post-graduate continuing professional development (CPD) should be followed by all staff members according to national/professional society guidelines.

6. Training Standards

6.1 The trainees in Obstetrics and Gynaecology should attend the activities of the infertility clinic and the assisted reproduction unit to meet the requirements of the EBCOG Log Book.

6.2 Obstetricians and Gynaecologists should be able to provide appropriate consultation and referral to specialised infertility centres.

6.3 Subspecialty training should be provided according to the EBCOG/ESHRE curriculum.

6.4 All infertility centre staff should be up to date with their knowledge and skills.

6.5 Regular training in communication skills, breaking bad news, cultural/gender awareness, equality and diversity and the safeguarding of vulnerable individuals should be provided.

7. Auditable Standards

7.1 Rate of live births for each treatment modality and for IVF rate of live births per embryo transferred.

7.2 Rate of pregnancy outcomes (e.g., miscarriage, ectopic) for individual treatment modalities.

7.3 A process of identification and notification of serious untoward incidents should be in place in the centre and to demonstrate that appropriate action has been taken.

7.4 Rate of multiple embryo transfer.

7.5 Rate of multiple pregnancies and ovarian hyperstimulation (OHSS).

7.6 Annual patient satisfaction survey.

STANDARD 24

Urogynaecology

Rationale

Urinary incontinence is a social taboo which affects a large number of women globally and has a huge impact on women's quality of life. Affected women are often reluctant to seek help because of the personal nature of the problem. They need information and support in making informed choices about their care and management. The variation in level of service provision in this area should be addressed and standards formulated for these services.⁴²

1. Patient Focus

- 1.1 Information should be available to women prior to their attending urogynaecology clinics.
- 1.2 Individual information should be provided to enable them to make informed choices about their care and management options, such as conservative, surgical and medical.
- 1.3 Preoperative counselling should include operation-specific complications and outcomes. Surgeons should use both their own and national surgical data where available.
- 1.4 Women should have information on preventive measures and measures to reduce the impact of this problem on daily activities and quality of life.

2. Accessibility

- 2.1 Women should have access to care initiated in primary care and referred to a specialised unit when appropriate.
- 2.2 Where available, community based continence assessment clinics should be run by trained professionals including physiotherapists for a thorough assessment of symptoms and to offer a range of conservative treatments.

3. Environment

- 3.1 A discrete and comfortable environment should be available.
- 3.2 Specialised urogynaecology clinics should be equipped access to videourodynamics, ambulatory urodynamics and ultrasound scanning facilities.

3.3 Waiting times in outpatients should be kept to a minimum to reduce women's anxieties and disruption.

3.4 Urogynaecology services should comply with health and safety regulations.

4. Process

4.1 An integrated referral pathway from primary care to specialised urogynaecology services should be established⁴²

4.2 Management of recurrent urinary incontinence should conform to the best available evidence.

4.3 Local multidisciplinary teams should meet regularly to discuss clinic policy and guidelines.

4.4 Local referral pathway for urinary incontinence and pelvic organ prolapse should be agreed and local protocols developed for the management of pelvic floor dysfunction.

4.5 At the initial assessment, urinary incontinence should be categorised symptomatically as stress urinary incontinence (SUI), mixed (MUI) or urgency (UUI) and a management plan should be formulated based on the category.

4.6 Incontinent women should be offered advice and conservative management prior to more invasive interventions such as surgery.

4.7 Women with complex pelvic floor dysfunction should be managed by multidisciplinary teams.

4.8 Combined clinics with Urogynaecologists and Coloproctologists should be held to facilitate investigation and counselling of women with faecal incontinence following obstetric anal sphincter injury and for those with bowel dysfunction, in association with pelvic organ prolapse.

4.9 Combined clinics with urogynaecologists and urologists should be available to facilitate the care of women requiring complex reconstructive urological surgery.

4.10 There should be guidelines and protocols for the provision of aftercare to patients in primary care and the community.

5. Staffing and Competence

5.1 Urogynaecology services should be led by clinicians who regularly undertake a dedicated urogynaecology clinic.

5.2 Lead urogynaecologists should perform regular audits of treatment outcomes of their unit and individuals.

5.3 Clinicians should have an adequate annual workload in the procedure that they perform when undertaking primary surgery for SUI and urogenital prolapse.

5.4 Clinicians should be up-to-date with professional clinical development, especially in new surgical techniques and subscribe to the relevant CPD programme.

5.5 Staff should be competent in evaluating risk-benefit ratio, of the offered intervention, for individual patients particularly those with co-morbidities.

5.6 Staff dealing with patients should be trained in counselling and specifically in quality of life issues.

6. Training Standards

6.1 Trainees should attend hands on training courses on urodynamic investigations and new surgical techniques.

6.2 Trainees should maintain a log book of the cases performed, if possible with appropriate outcome measures recorded.

6.3 Clinical supervisors should ensure that trainees' clinical skills meet the competency levels described in the EBCOG curriculum.

6.4 Regular training in communication skills, breaking bad news, cultural/gender awareness, equality and diversity and the safeguarding of vulnerable individuals should be provided.

7. Auditable Standards

7.1 Percentage of incontinent women offered conservative management prior to surgical interventions.

7.2 Percentage of women continent after surgery for urodynamically confirmed stress incontinence.

7.3 Percentage of women having pre operative urodynamic investigations prior to repeat incontinence surgery.

7.4 Percentage of women suffering from complications following surgical procedures for pelvic floor dysfunction.

7.5 Annual audit of new interventions introduced in the unit, outcomes and complications rates.

7.6 Annual patient satisfaction survey.

STANDARD 25

Robotic Surgery

Rationale

Robot assistance in laparoscopy allows complex surgery to be performed. It reduces morbidity for patients as compared to open surgery and also aids the surgeon. As the role of robotic surgery in gynaecology is evolving, there is a compelling need to set standards to ensure safety and efficacy.^{43, 44}

1. Patient Focus

1.1 Patients should receive verbal and written information about their care and management by the surgeon who will perform the procedure.

1.2 The patient should be informed about the experience of the surgeon/institute with robotic surgery.

1.3 The patient should be informed about risks and complication rates.

1.4 The patient should be informed about alternative approaches, their advantages and disadvantages compared to robot assisted laparoscopy.

1.5 Valid consent should be obtained and clearly documented before the operation takes place.

2. Accessibility

2.1 Accessibility to robotic surgery should be governed by the appropriate case selection and the level of expertise of the care provider.

3. Environment

3.1 There should be a dedicated theatre for this type of surgery.

3.2 There should be a Standard Operational Procedure (SOP).

3.3 All personal in the operating theatre should be adequately trained.

4. Process

- 4.1 There should be a named lead for the service.
- 4.2 Robot assisted laparoscopy procedures should be recorded and the findings well documented.
- 4.3 Local multidisciplinary agreed protocols should be in place to deal with unexpected intra-operative and post-operative complications, and regular training in emergency procedures should be organised.
- 4.4 Protocols for after care should be in place.

5. Staffing and Competence

- 5.1 Robot assisted laparoscopic surgery should only be performed by staff appropriately trained for such procedures.
- 5.2 Following the introduction of robot assistance for laparoscopic surgery the entire team, including nurses, medical and technical staff, should meet at regular intervals to discuss protocols and safety issues.
- 5.3 Clinicians should be up-to-date with professional clinical development, especially in this new surgical technique.
- 5.5 Staff should be competent in evaluating risk-benefit ratio, of the offered intervention, for individual patients particularly those with co-morbidities.
- 5.6 Staff dealing with patients should be trained in counselling.

6. Training Standards

- 6.1 All personal in the operating theatre should be adequately trained.
- 6.2 Training should entail sufficient systematic, and validated system as well as procedural (didactic and skills) training.
- 6.3 A preceptor should provide direct supervision during the entire procedure for at least the first 3 cases. Indirect supervision by an experienced robotic surgeon should be available for at least the first 10 simple (ESGE Level 1-3) and at least the first 20 complex (ESGE Level 4) robot assisted laparoscopic cases per surgeon.
- 6.4 Regular training in communication skills, breaking bad news, cultural/gender awareness, equality and diversity and the safeguarding of vulnerable individuals should be provided.

7. Auditable Standards

7.1 Workload per operator.

7.2 Rate of complication should be documented and analysed within the unit.

7.3 Rate of conversion to open surgery.

7.4 Annual patient satisfaction survey.

Summary of Training Standards

Standard 1 - Generic Standards for the Provision of Gynaecology Services

1. All doctors in training should have a named educational supervisor.
2. All units should ensure that postgraduate trainees are observed by their supervisors performing clinical /pelvic examinations and procedures as part of their formative assessment of skills.
3. All units should have written advice for training-grade doctors covering when to seek help and what procedures they may perform without direct supervision.
4. All units should have a Postgraduate Educational Programme.
5. All units should have established audit programme where doctors in training are encouraged to present their audit projects.
6. Regular training in communication skills, breaking bad news, cultural/gender awareness, equality and diversity, safeguarding children and vulnerable individuals should be provided.

Standard 2 - Emergency Gynaecology, Acute Abdominal Pain in Women

1. All trainees should have regular training to ensure competency in dealing with acute emergencies, including basic life support.
2. Training in transvaginal ultrasound scanning is essential for all staff required to provide a scanning service in the provision of emergency gynaecology.
3. Training should be provided to ensure that all gynaecologists involved in emergency services are proficient in the laparoscopic management of patients with ectopic pregnancy.
4. Regular training in communication skills, breaking bad news, cultural/gender awareness, equality and diversity, safeguarding children and vulnerable individuals should be provided.

Standard 3 - Early Pregnancy Loss

1. All trainees in Obstetrics and Gynaecology should attend early pregnancy loss clinics to acquire competence in the management of women with early pregnancy loss to fulfil the requirements of the EBCOG Log Book.
2. Doctors in training should maintain a log book to demonstrate their competence in early pregnancy ultra sound scanning especially fetal viability, twinning and tubal pregnancy.

3. Training should be provided on the basic consultation and to initiate the appropriate investigations and management according to the departmental protocols.
4. Regular training in communication skills, breaking bad news, cultural/gender awareness, equality and diversity, safeguarding children and vulnerable individuals should be provided.

Standard 4 - Recurrent Miscarriage

1. According to the EBCOG training programme, trainees in Obstetrics and Gynaecology should attend the recurrent miscarriage unit to fulfil the requirements of the Log Book.
2. Training should be provided on the basic consultation and to initiate the appropriate investigations leading to possible referral to specialised units.
3. Regular training in communication skills, breaking bad news, cultural/gender awareness and equality and diversity should be provided.

Standard 5 - Pelvic Inflammatory Disease (PID)

1. All health care professionals working dealing with primary prevention should have appropriate and up-to-date training.
2. Doctors in training should attend theoretical courses to learn prevention, diagnosis, differential diagnosis and management of PID.
3. All gynaecologists treating this condition should be capable of undertaking laparoscopy at ESGE level 1 & 2.
4. All gynaecologists taking care of women with PID should be up to date with their CPD.
5. Regular training in communication skills, breaking bad news, cultural/gender awareness, equality and diversity, safeguarding children and vulnerable individuals should be provided.

Standard 6 - Vulvovaginitis

1. Doctors in training should attend courses that include diagnosis and management of vulvovaginitis.
2. All gynaecologists taking care of women with vulvovaginitis should be up to date with their CPD.
3. Regular training in communication skills, breaking bad news, cultural/gender awareness, equality and diversity, safeguarding children and vulnerable individuals should be provided.

Standard 7 - Ultrasound Scanning in Gynaecological Practice

1. All trainees should attend theoretical and practical basic skill courses in ultrasound scan.
2. The unit should provide the appropriate supervised, hands on training to fulfil the requirements of the EBCOG postgraduate curriculum.
3. Trainees should maintain a log book of their experience and demonstrate skills in case mix management.
4. The unit should provide regular training updates to ensure the maintenance of skills.
5. Clinicians providing gynaecological ultrasound scanning in special categories, e.g., fertility scans, early pregnancy scans etc., should have an adequate case load to ensure maintenance of skills.
6. Regular training in communication skills, breaking bad news, cultural/gender awareness, equality and diversity, safeguarding children and vulnerable individuals should be provided.

Standard 8 - Contraception and Sexual Health

1. Doctors in training in Obstetrics and Gynaecology should have access to contraceptive services to fulfil the requirements of the EBCOG curriculum .
2. Doctors providing the service should be trained and achieve competence in counselling, insertion and removal of IUDs and implants.
3. Doctors in training should maintain a log book to demonstrate their competence in various aspects of contraception counselling and care.
4. All services should have regular clinical governance meetings (training and education, risk management, review of protocols and research).
5. Regular training in communication skills, breaking bad news, cultural/gender awareness, equality and diversity, safeguarding children and vulnerable individuals should be provided.

Standard 9 - Male Contraception

1. Doctors in training should have access to contraceptive services to fulfil the requirements of their curriculum.
2. Doctors in training should maintain a log book to demonstrate their competence in various aspects of contraception prescribing.
3. All services should have regular clinical governance meetings (training and education, risk management, review of protocols and research).
4. Regular training in communication skills, breaking bad news, cultural/gender awareness, equality and diversity, safeguarding children and vulnerable individuals should be provided.

Standard 10 - Safe Termination of Pregnancy

1. Doctors in training should attend theoretical courses to learn about the legal status as regards termination of pregnancy in their countries.
2. Doctors in training should have access to the local termination of pregnancy services to fulfil the requirements of their curriculum.
3. Doctors providing the service should be trained and achieve competence in counselling in various methods of termination of pregnancy.
4. Doctors in training should maintain a log book to demonstrate their competence in various methods of termination of pregnancy and contraception offered following termination of pregnancy.
5. All staff should learn and develop skills in the management of post-termination of pregnancy complications.
6. Regular training in communication skills, cultural/gender awareness, equality and diversity and in safeguarding adolescents and vulnerable adults should be provided.

Standard 11 - Paediatric and Adolescent Gynaecology (PAG)

1. Training to be provided in PAG recognised centres
2. Trainers to be members of or work in close collaboration with national PAG Societies
3. Trainers may wish to access the RCOG website to see PAG training curriculum.
4. Regular training in age appropriate communication skills, cultural/gender awareness and the safeguarding of children and adolescents should be provided.

Standard 12- Menstrual Bleeding Disorders

1. The trainee should attend hands on training courses in diagnostic and operative hysteroscopy, insertion of LNG-IUS, ultrasound scanning and second generation endometrial ablation techniques.
2. The trainees should demonstrate their competence in diagnostic and operative procedures by maintaining a log book of all the procedures performed and peri-operative outcomes.
3. Trainees wishing to learn advanced laparoscopic surgical techniques should be rotated to units with adequate work load.
4. Regular training in communication skills, cultural/gender awareness, equality and diversity, safeguarding vulnerable individuals should be provided.

Standard 13 - Chronic Pelvic Pain

1. Trainees should acquire the basic knowledge of the physiological and neurological background of pain during their basic medical training about the various aetiologies and diseases that can produce pelvic pain syndromes.
2. Training should be provided to assess women with chronic pelvic pain and assess their symptoms using the visual analogue scale.

3. Trainees should have time allocated to attend special clinics dealing with various chronic pain conditions in gynaecology.
4. Trainees must have dedicated time in the operating theatre at various levels of their specialist training, achieving competence in endoscopic surgery at basic, intermediate and specialist level. Specialists dealing with women with severe endometriosis should gain experience at the accredited laparoscopic surgery centres and be up-to-date with their CPD.
5. Regular training in communication skills, cultural/gender awareness, equality and diversity, safeguarding vulnerable individuals and quality of life assessment using standardised and validated questionnaires should be provided.

Standard 14 - Benign Vulval Disorders

1. All trainees should attend a number of vulval clinics to fulfill their training requirements according to the EBCOG Log Book.
2. Advanced training will be required for those involved in specialised vulval clinics.
3. All staff providing the service should have special competency and be up to date with their relevant CPD.
4. Regular training in communication skills, breaking bad news, cultural/gender awareness, equality and diversity and the safeguarding of children and vulnerable individuals should be provided.

Standard 15 - Menopause and Hormonal Therapy

1. All trainees should attend menopause clinics to fulfil their requirements according to the EBCOG Log Book.
2. Advanced training will be required for those involved in specialised menopause services.
3. Regular training in communication skills, breaking bad news, cultural/gender awareness, equality and diversity and the safeguarding of vulnerable individuals should be provided

Standard 16 - Benign Breast Pathology

1. All trainees should attend breast clinics to fulfil their training requirements according to the EBCOG Log Book.
2. In countries where gynaecologists are responsible for breast diseases, gynaecologists should have the appropriate training in breast diseases, preferably certified
3. The breast care nurse should have appropriate nursing qualifications and have experience in handling and supporting women with benign breast disease.
4. Regular training in communication skills, breaking bad news, cultural/gender awareness, equality and diversity and the safeguarding of vulnerable individuals

should be provided.

Standard 17 - Colposcopy

1. All trainees should attend colposcopy clinics to fulfil their training requirements according to the EBCOG Log Book.
2. All gynaecologists who are responsible for colposcopy services should have the appropriate training and be preferably certified.
3. All colposcopists should be up to date with their CPD
4. The colposcopy nurse should have appropriate nursing qualifications and have experience in handling and supporting women with suspected pre invasive disease of the cervix and its treatment.
5. Regular training in communication skills, breaking bad news, cultural/gender awareness, equality and diversity, and the safeguarding of vulnerable individuals should be provided.

Standard 18 - Diagnostic and Operative Hysteroscopy

1. All trainees should attend hysteroscopy clinics to fulfil their training requirements according to the EBCOG Log Book.
2. Doctors in training should maintain a log book to demonstrate their competence in various aspects of hysteroscopic procedures and the outcomes.
3. All hysteroscopists should have had formal training or be recognised by their experience as suitable to practice by their national and local bodies
4. A formal evaluation of the theoretical knowledge and practical hysteroscopic skills and instrument handling should be provided by performing in house recognised evaluation procedure or the use of a recognised and validated evaluation system.
5. Regular training in communication skills, breaking bad news, cultural/gender awareness, equality and diversity and the safeguarding of vulnerable individuals should be provided.

Standard 19 - Laparoscopic Surgery

1. All trainees should attend laparoscopic surgery operating lists to fulfil their training requirements according to the EBCOG Log Book.
2. Every teaching unit should have an in vitro dry lab for validated system and procedural training.
3. All laparoscopists should have had formal training or be recognised by their experience as suitable to practice by their national and/or local bodies.
4. Regular training in communication skills, breaking bad news, cultural/gender awareness, equality and diversity and the safeguarding of vulnerable individuals should be provided.

Standard 20 - Gynae-Oncology Screening, excluding Breast Cancer

1. Doctors in training and healthcare providers involved in screening programmes should attend theoretical and practical courses to learn about screening to fulfil the training requirement of the EBCOG Logbook.
2. Healthcare providers involved in the screening programme should be trained and achieve competence in providing the service including performance of the tests, counselling, management and follow-up.
3. Regular training in communication skills, breaking bad news, cultural/gender awareness, equality and diversity and the safeguarding of vulnerable individuals should be provided.

Standard 21 - Breast Cancer Screening

1. Breast Radiologist:
The radiologist must read a minimum of 1000 mammography cases per year (5000 for those participating in a screening programme is recommended), spend at least 30% of the time in breast disease and be re-assessed every 3 years.
2. Breast Pathologist:
The specialist pathologists should see at least 150 primary breast cancer resections per year and spend at least 25% of his/her time on breast pathology, and be assessed every 3 years.
3. Breast surgeon:
Each breast surgeon should operate at least 50 new cases per year, spend at least 50% of his/her working time in breast disease and be assessed every 3 years.
4. Breast Medical Oncologist:
The medical oncologist has to spend at least 40% of working time in breast cancer and be assessed every 3 years.
5. Breast Radiation Oncologist:
The radiation oncologist must spend at least 30% of the clinical time in breast disease, with assessment every 3 years.
6. Regular training in communication skills, breaking bad news, cultural/gender awareness, equality and diversity and the safeguarding of vulnerable individuals should be provided.

Standard 22 - Gynae-Oncology Services, including Breast Cancer

1. Subspecialist training for gynaecological oncology is performed as defined in the EBCOG/ESGO Subspecialist Training Programme in Gynaecological Oncology and Log Book.
2. Doctors in training should have access to the gynaecological oncological service and be trained in peri-operative care to fulfil the requirements of their curriculum.
3. Doctors providing the service and those in general training should achieve competency in counselling oncological patients.

4. Regular updates of all staff on protocols should be organised.
5. Regular training in communication skills, breaking bad news, cultural/gender awareness, equality and diversity, safeguarding children and vulnerable individuals should be provided.

Standard 23 - Infertility and Assisted Conception

1. The trainees in Obstetrics and Gynaecology should attend the activities of the infertility clinic and the assisted reproduction unit to meet the requirements of the EBCOG Log Book.
2. Obstetricians and Gynaecologists should be able to provide appropriate consultation and referral to specialised infertility centres.
3. Subspecialty training should be provided according to the EBCOG/ESHRE curriculum.
4. All infertility centre staff should be up to date with their knowledge and skills and subscribe to the appropriate CPD programme.
5. Regular training in communication skills, breaking bad news, cultural/gender awareness, equality and diversity and the safeguarding of vulnerable individuals should be provided.

Standard 24 - Urogynaecology

1. Trainees should attend hands on training courses on urodynamic investigations and new surgical techniques.
2. Trainees should maintain a log book of the cases performed, if possible with appropriate outcome measures recorded.
3. Clinical supervisors should ensure that trainees' clinical skills meet the competency levels described in the EBCOG curriculum.
4. Regular training in communication skills, breaking bad news, cultural/gender awareness, equality and diversity and the safeguarding of vulnerable individuals should be provided.

Standard 25 - Robotic Surgery

1. Training should entail sufficient systematic, and validated system as well as procedural (didactic and skills) training.²
2. A preceptor should provide direct supervision during the entire procedure for at least the first 3 cases. Indirect supervision by an experienced robotic surgeon should be available for at least the first 10 simple (ESGE Level 1-3) and at least the first 20 complex (ESGE Level 4) robot assisted laparoscopic cases per surgeon.

3. Training should be documented by case lists and by a summary letter from proctors.
4. Regular training in communication skills, breaking bad news, cultural/gender awareness, equality and diversity and the safeguarding of vulnerable individuals should be provided.

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Appendix 1

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