Hysterectomy service

Commissioning guide
Implementing NICE guidance

December 2007
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Hysterectomy service

This commissioning guide provides support for the local implementation of NICE clinical guidelines through commissioning, and is a resource to help health professionals in England to commission an appropriate hysterectomy service, in particular for women with heavy menstrual bleeding (HMB). However, commissioners will need to consider that hysterectomy is frequently performed for reasons other than HMB, including malignancy and genital prolapse.

This commissioning guide should be read in conjunction with the following NICE guidance:

- NICE clinical guideline CG44 Heavy menstrual bleeding
- NICE clinical guideline CG30 Long-acting reversible contraception
- NICE interventional procedure guidance IP 94 Uterine artery embolisation for the treatment of fibroids.

The clinical guidelines cover clinical and cost effectiveness in detail and underpin the content of this guide.

Those involved in the commissioning of services for the care of women with HMB should also read the commissioning guides on intrauterine devices and the intrauterine system and endometrial ablation.

The guide:

- makes the case for commissioning a hysterectomy service
- specifies service requirements
- helps you determine local service levels
- helps you ensure corporate and quality assurance.

The full text of this commissioning guide is accessed from the navigation menu on the right hand side of the screen. The associated commissioning tool is available until 25 June 2010 to primary care organisations in England who are already registered to use the tool. New registrations for the existing commissioning tool will not be possible after 31 March 2010.

From 1 April 2010 the new freely available commissioning and benchmarking tool can be downloaded here. There is no need to register.

We are keen to improve the commissioning guides in order to better meet the needs of commissioners. Please send us your ideas for future topic-specific guides or other comments.

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- Topic-specific Advisory Group: hysterectomy service

December 2007
Commissioning a hysterectomy service

Hysterectomy is the surgical removal of the uterus, and has traditionally been regarded as the definitive surgical treatment for heavy menstrual bleeding (HMB). Hysterectomy is a major surgical procedure with significant physical and emotional complications and social and economic costs\(^1\). It is one of the most commonly performed operations, with menstrual disorders being one of the leading indications\(^2\). However, it is frequently performed for reasons other than HMB, including malignancy and genital prolapse.

Hysterectomy rates have been decreasing in recent years, but there remains large variation in population-based rates of hysterectomy across primary care organisations in England, from fewer than 10 per 100,000 to 100 per 100,000 female population\(^3\). The Chief Medical Officer report in 2005 identified that ‘if the average rate of hysterectomy in England was reduced to that achieved in the 20% of the country with the lowest current rates, then 5,900 operations, costing £15 million, could be avoided per annum. Although the costs of alternative treatments would need to be taken into account financial savings would still be substantial’.

HMB, also known as menorrhagia, affects around one in three women\(^4\). It is defined as excessive menstrual blood loss that interferes with the physical, emotional, social and material quality of a woman’s life. HMB is a common reason for GP consultation, referral to secondary care and subsequent surgery\(^5\).

Pharmaceutical intervention, including the use of levonorgestrel-releasing intrauterine system (LNG-IUS), is usually the first-line treatment for women with HMB. Optimal medical management of HMB improves patient choice and provides an alternative to surgery. It also reduces the cost of HMB to health services and its detrimental effects on quality of life\(^6\). Ineffective treatment of HMB is likely to lead to referral and a high chance of hysterectomy\(^7\).

Through effective commissioning of services for women with HMB based on NICE clinical guideline CG44 on heavy menstrual bleeding, it is anticipated that when women are given the choice of clinically appropriate treatment options, hysterectomy rates will be reduced further\(^7\).

**Benefits**

The potential benefits of robustly commissioning an appropriate hysterectomy service for the care of women with HMB based on an integrated care pathway include:

- **Reducing the need for hysterectomy** and the associated perioperative and postoperative complications by implementing the recommendations outlined in NICE clinical guideline CG44 on heavy menstrual bleeding
Improving patient-centred care and providing efficient clinical management of the care of women with HMB by optimising pharmaceutical management and reducing the need for referral onto specialist services. See also the commissioning guides on intrauterine devices and the intrauterine system and endometrial ablation.

Reducing referrals to specialist services and offering less invasive treatment options – both may contribute to a reduction in the number of hysterectomies performed. They also provide the opportunity to reduce inpatient stays and patient waiting times.

Improving clinical outcomes.

Reducing inequalities, and improving patient access to services that provide pharmaceutical management, including levonorgestrel-releasing intrauterine system (LNG-IUS), endometrial ablation and non-hysterectomy surgery.

Increasing patient choice and engagement in decisions about their care, and patient experience.

Better value for money, through helping commissioners to manage their commissioning budgets more effectively – this may include opportunities for clinicians to undertake local service redesign to meet local requirements in novel ways.

**Key clinical issues**

Key clinical issues in providing an appropriate hysterectomy service are:

- **Ensuring that hysterectomy is not offered as a first-line treatment** for women with HMB only.

- **Accurately diagnosing all women presenting** with HMB to support clinically appropriate care and ensuring there is access to, and sufficient capacity for, ultrasound, magnetic resonance imaging and hysteroscopy.

- **Ensuring that women have access to information** on clinically appropriate treatment options prior to their outpatient appointment. Women should have adequate time and support from healthcare professionals in the decision making process, and be made aware of the impact on fertility of any planned procedure.

- **Ensuring that appropriate referral pathways are in place** to support equity of access to LNG-IUS, endometrial ablation and other non-hysterectomy surgery. See also the commissioning guides on intrauterine devices and the intrauterine system and endometrial ablation.

- **Ensuring that the service is integrated** with other services for women with HMB to ensure continuity of care.
- **Providing a quality assured service.**

### National priorities

National priorities and initiatives relevant to commissioning a hysterectomy service include:

- **World class commissioning.**
- **The NHS in England: The operating framework for 2009/10.**
- **Delivering the 18 week patient treatment pathway** and the **heavy menstrual bleeding pathway.**

- The **Care closer to home** initiative outlined in chapter 6 of the white paper ‘Our health, our care, our say’.
- **Commissioning framework for health and well-being.**
- Considering the impact of **patient choice.**
- **A stronger local voice: a framework for creating a stronger local voice in the development of health and social care services.**

Implementation of NICE clinical and public health guidelines. These are core standards, and performance against these standards will be assessed by the Care Quality Commission in line with Standards for better health.

Although many or all of these priorities may be relevant to the services nationally, your local service redesign may address only one or two of them.

### References


Specifying a hysterectomy service

Service components

The key components of a hysterectomy service are:

- ensuring appropriate care and onward referral for women with heavy menstrual bleeding (HMB)
- effective management of women who require a hysterectomy for reasons other than HMB
- developing a high-quality service for women who require a hysterectomy. Link to ‘Ensuring corporate and quality assurance’ section within this guide

Appropriate care and onward referral for women with HMB

The diagnosis and general management of HMB is described in detail in NICE clinical guideline CG44 on heavy menstrual bleeding. It is clearly important to identify women with HMB to ensure delivery of care based on the best available evidence.

The relationship between medical management, referral and surgery is complex. There are wide variations in patterns of referral into secondary care and in the number of hysterectomy procedures carried out, despite clinically and cost effective alternatives. Some variation is likely to be due to symptom prevalence, the treatment preferences held by some women and clinical reasons. However, these are unlikely to account for all of the variation.

More effective management of HMB in primary care may reduce both the number of referrals into secondary care and surgery rates. Commissioners may wish to compare local GP referral rates and procedure rates for hysterectomy with hospital trusts to identify outliers. This will provide the opportunity to review current practice and develop an integrated care pathway with clinicians to inform local commissioning, optimise first-line medical management and identify thresholds for surgical treatments. However, commissioners will need to consider the age and ethnicity of their population, as this will have an impact on suitability for treatment options. Changing clinical practice in primary care is likely to require education and training.

Surgical treatment is usually offered to women with HMB who do not respond to pharmaceutical treatment. Because hysterectomy is associated with perioperative and postoperative complications, it is important to identify those women for whom hysterectomy is the most appropriate treatment option in order to prevent unnecessary invasive surgery and to manage service demand.

Another surgical procedure, uterine artery embolisation (UAE), is used to treat uterine fibroids, which sometimes causes HMB. The procedure is associated
with shorter hospital stays than hysterectomy, and this is likely to contribute to reducing patient waiting times. The NICE interventional procedure guidance IP 94 Uterine artery embolisation for the treatment of fibroids states that current evidence suggests that UAE is safe enough for routine use. The most commonly reported complications were the need for hysterectomy in 0.5% to 11.8% of women and the late expulsion of a fibroid in 2.2% to 7.7% of women.

The NICE clinical guideline CG44 on heavy menstrual bleeding recommends that:

- Pharmaceutical treatment should be considered where no structural or histological abnormality is present, or for fibroids less than 3 cm in diameter which are causing no distortion of the uterine cavity.

- Hysterectomy should not be used as a first-line treatment solely for HMB. Hysterectomy should be considered only when:
  - other treatment options have failed, are contraindicated or are declined by the woman
  - there is a wish for amenorrhea
  - the woman (who has been fully informed) requests it
  - the woman no longer wishes to retain her uterus and fertility.

- When surgery for fibroid-related HMB is felt necessary then UAE, myomectomy and hysterectomy must all be considered, discussed and documented.

Women with HMB should have the opportunity to make informed decisions about their care and treatment, in partnership with their healthcare professionals. Although respect for autonomy and individual choice are important for the NHS and its users, they should not have the consequence of promoting the use of interventions that are not clinically and/or cost effective.

Management of patients who require hysterectomy for reasons other than HMB

NICE has not issued guidance on the management of patients who require hysterectomy for reasons other than HMB, such as malignancy and genital prolapse.

Useful sources of information may include the NHS Evidence, Clinical knowledge summaries and NICE CG27 Referral for suspected cancer.

Developing a high-quality hysterectomy service

Information on the detailed requirements of a hysterectomy service is available from the NICE clinical guideline CG44 on heavy menstrual bleeding, which recommends that:
• a woman with HMB referred to specialist care should be given information before her outpatient appointment (see Understanding NICE guidance)
• in women with HMB alone, with uterus no bigger than a 10-week pregnancy, endometrial ablation should be considered preferable to hysterectomy
• ultrasound is the first-line diagnostic tool for identifying structural abnormalities
• taking into account the need for individual assessment, the route of hysterectomy should be considered in the following order: first line vaginal, second line abdominal
• maintenance of surgical, imaging or radiological skills requires a robust clinical governance framework.

Commissioners may wish to consider delivering a hysterectomy service for the care of women with HMB in a number of different ways, and mixed models of provision may be appropriate across a local health economy. The Shifting care closer to home: care closer to home demonstration site – report of the speciality subgroups identifies innovative ways of delivering gynaecology services, whilst improving patient access. These include a primary care led model of integrated care, direct access to some procedures and consultant gynaecologists working in primary care. The use of integrated care pathways for HMB has been shown to reduce the need for outpatient attendance while improving patient experience and maintaining quality of care[3]. The examples are offered in order to share local practice, but NICE makes no judgement on the compliance of these services with its guidance.

Local stakeholders, including service users, should be involved in determining what is needed from a hysterectomy service in order to meet local needs. The service should be patient-centred and integrated with other elements of care for women with HMB.

The service specification needs to consider:

• the required competencies of, and training for, staff responsible for providing the service
• the expected number of patients (this should take into account how quickly any changes in service provision are likely to take place)
• ease of access to all treatment options and service location within a geographical area; commissioners should engage with service users and other relevant individuals and organisations locally
• care and referral pathways to support patient choice of treatment and access
• information and audit requirements, including IT support and infrastructure
planned service improvement, including redesign, quality, equitable access, and referral-to-treatment times according to the 18 week patient pathway or equitable waiting times locally for those services currently outside 18 weeks. See Choice of scan phase 2: guidance

service monitoring criteria.

Useful sources of information may include:

- Delivering the 18 week patient pathway: 18 week commissioning pathways and the heavy menstrual bleeding pathway.
- The NHS networks: learning from practice database offers examples of innovative commissioning across the NHS and its partners.
- The Map of medicine provides an information resource that visually organises the latest evidence and best practice guidelines.
- The NICE shared learning database offers examples of how organisations have implemented NICE guidance locally, including services for the care of women with HMB, for example Bradford and Airedale PCT.
- Implementation advice for NICE clinical guideline CG44 on heavy menstrual bleeding.

References


Determining local service levels for a hysterectomy service

Benchmarks for a standard population

Available data suggest that the standard benchmark rate for hysterectomy is 0.143% per year, or 143 per 100,000 female population; 23 per 100,000 (0.023% of the female population) of these would be for the treatment of heavy menstrual bleeding (HMB).

For a standard primary care trust with a population of 250,000, assuming 50% are female the average number of women requiring a hysterectomy would be 179 per year (0.143% of the female population), of which 29 per year (0.023% of the female population) would be for the treatment of HMB.

For an average practice with a list size of 10,000, assuming 50% are female the average number of women requiring a hysterectomy would be 7 per year (0.143% of the female population), of which 1 per year (0.023% of the female population) would be for the treatment of HMB.

HMB is one of the leading indications for hysterectomy, and based on primary diagnosis accounts for 20% of all hysterectomies. However, hysterectomy is also indicated for the treatment of other conditions such as malignancy and genital prolapse. Commissioners need to be aware that HMB may be a secondary diagnosis in women who have a hysterectomy; this has been indicated in around 50% of all hysterectomies[1].

This service is likely to fall under the programme budgeting category 218X (maternity and reproductive health).

Examine the assumptions used in estimating these figures.

Use the hysterectomy service commissioning and benchmarking tool to determine the level of service that might be needed locally and to calculate the cost of commissioning the service using the indicative benchmark and/or your own local data.

Further information

Sources of further information to help you in assessing local health needs and reducing health inequalities include:

- Department of Health Delivering quality and value – focus on benchmarking.
- NICE Health equity audit – learning from practice briefing.
- The Health impact assessment (HIA) gateway provides access to HIA-related information resources, sources of evidence and networks.
- Delivering the 18 week patient pathway: 18 week commissioning pathways.
- The No delays achiever provides access to service improvement tools aimed at reducing time between referral and treatment.
- The Practice-based commissioning comparators reporting service provides access to a range of indicators and activity data at practice level, enabling a better understanding of local commissioning activity, referral patterns and outcomes.

References

Assumptions used in estimating a population benchmark

The assumptions used in estimating a female population benchmark for a hysterectomy service of **0.143% per year** are based on the following sources of information:

- **‘Hospital episode statistics’ data** to establish the current levels of activity commissioned
- **published research** on the care of women with heavy menstrual bleeding (HMB)
- **expert clinical opinion** of the topic-specific advisory group, based on experience in clinical practice and literature review.

**Activity data – ‘Hospital episode statistics’**

The ‘Hospital episode statistics (HES)’ database contains details of all admissions to NHS hospitals in England. It includes private patients treated in NHS hospitals, patients who were resident outside England and care delivered by treatment centres (including those in the independent sector) funded by the NHS.

Analysis of HES data suggests that the number of hysterectomies performed for the treatment of HMB within English trusts has been declining since 1994/95\(^1\), and the number of endometrial ablations is increasing.

Figure 1 illustrates the rolling (3-year) averages for the numbers of endometrial ablations and hysterectomies, and the total of the two procedures, performed for the treatment of HMB between 1989 and 2004 (adapted from Reid 2006 with permission).
The fall in the number of hysterectomies for the treatment of HMB is not due to the rise in endometrial ablations alone, as there has been a steady decline in the total number of procedures being performed for HMB\(^1\). This decline has plateaued in more recent years.

HES data (see figure 2) give an indication of the rates at which hysterectomies for HMB are being performed. Average rates do not necessarily correlate with the rate that would be expected if NICE clinical guideline [CG44 on heavy menstrual bleeding](https://www.nice.org.uk/guidance/cg44) was uniformly followed.
Figure 2 2005/06 Hysterectomy rates for the treatment of HMB in English primary care organisations

The mean directly standardised rate for hysterectomy for HMB for all English primary care organisations for the year 2005/06 is 30 per 100,000 female population.

As well as HMB, hysterectomy is also indicated for the treatment of other conditions such as malignancy and genital prolapse. The current rate of hysterectomy for all conditions is 150 per 100,000 female population.

HMB may also be a secondary diagnosis in those women who have hysterectomy for the treatment of, for example, fibroids or endometriosis, but these women have been excluded from the analysis of rates of hysterectomy for the treatment of HMB.

The average rate of hysterectomy for the treatment of HMB hides large variations. Procedure rates vary among primary care organisations from fewer than 10 per 100,000 to 100 per 100,000 female population. Thus, there is a 10-fold variation in rates across England.

Some of the variation in procedure rates for hysterectomies is likely to be due to symptom prevalence, the treatment preferences held by women and other clinical reasons. However, these alone are unlikely to account for all of the variation, and there may be other factors that influence it, such as variations in service capacity and differences in the management of HMB within primary care[2]. Notably, areas with high hysterectomy rates also have high rates of endometrial ablation. See the commissioning guide on endometrial ablation.
**Published research**

The relation between medical management, referral and surgery is complex\(^2\). There are wide variations in patterns of referral into secondary care for women with HMB. More effective management of HMB in primary care may reduce the number of referrals into secondary care and surgery rates\(^2\), \(^3\).

Active education in relation to good management and the promotion of effective medical management in primary care has been shown to reduce the number of referrals into secondary care by between 30% \(^3\) and 50% \(^4\).

A randomised controlled trial\(^5\) found that the provision of structured information around treatment options for women with HMB resulted in a significant decrease in the number of women who stated a preference for hysterectomy, from 48% to 38%.

A review of women undergoing hysterectomy found that 70% were not offered medical management by their GP and that 39% had a hysterectomy as primary treatment for HMB\(^6\). In addition not all women undergoing hysterectomy for HMB are offered endometrial ablation as an alternative where it is clinically appropriate to do so\(^6\), \(^7\); this figure is estimated to be between 50%\(^7\) and 56% (Owen P, Welsh J: unpublished data 2007). A midpoint of 53% is used below.

The failure rate following endometrial ablation varies between studies and depends on the length of time of follow-up. A recent Cochrane review reported that the need for re-treatment following endometrial ablation varied between 20% and 27% over 3 to 5 years, and that the rate of hysterectomy among the re-treatment groups was around 18\(^8\).

A reduction in the rate of hysterectomy for the treatment of HMB of 27% may be considered appropriate given the following:

- 53% of women undergoing hysterectomy are not offered endometrial ablation as an alternative
- 38% of women may express an explicit preference for hysterectomy when given information around alternative treatment options
- 18% of women who have endometrial ablation will go on to have a hysterectomy.

This does not take into account any reduction due to optimal management within primary care and the use of levonorgestrel-releasing intrauterine system (LNG-IUS) devices.

**Expert clinical opinion**

The topic-specific advisory group agreed that, given optimal management of HMB across the whole care pathway, a reduction in the current national
average rate of hysterectomy for the treatment of HMB of around 25% to 27% could be achieved.

The topic-specific advisory group advised that commissioners should examine local referral patterns, prescribing practice, procedure rates and differences in local populations to ensure that women with HMB receive optimal care and that appropriate rates of hysterectomies are achieved.

Conclusions

Based on the activity data and other information outlined above, it is concluded that a benchmark rate of hysterectomy of 143 per 100,000 female population, of which 23 per 100,000 female population is for the treatment of HMB, is considered appropriate. This is based on the following assumptions:

- the current rate of hysterectomy for the treatment of HMB is 30 per 100,000 female population
- the current rate of hysterectomy for conditions other than HMB is 120 per 100,000 female population
- a reduction of 25% in the rate of hysterectomy for the treatment of HMB could be achieved, based on published research on current practice
- the consensus of the topic-specific advisory group.

Therefore the total population benchmark for hysterectomy for all causes is estimated to be 0.143%.

Use the hysterectomy service commissioning and benchmarking tool to determine the level of service that might be needed locally and to calculate the cost of commissioning the service using the indicative benchmark and/or your own local data.

References


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The commissioning and benchmarking tool

**Download the hysterectomy service commissioning and benchmarking tool**

Use the hysterectomy service commissioning and benchmarking tool to determine the level of service that might be needed locally and to calculate the cost of commissioning the service, as described below.

**Identify indicative local service requirements**

The indicative benchmark based on the national average for hysterectomy for all causes is 0.143%.

The commissioning and benchmarking tool helps you to assess local service requirements using the indicative benchmark as a starting point. With knowledge of your local population and its demographic, you can amend the benchmark to better reflect your local circumstances. For example, if your population is significantly younger or older than the average population, or has an ethnic composition different from the national average, or has a significantly higher or lower number of women; or higher or lower rate of hysterectomy, you may need to provide services for relatively fewer or more people.

**Review current commissioned activity**

You may already commission a hysterectomy service for your population. You can download your own up-to-date secondary care activity data into the tool and data specifications and user notes are provided to help. You can review and amend the downloaded data for your population to calculate the service levels and cost of the service you currently commission. When commissioning outpatient appointments or activity outside of secondary care the tool provides you with tables that you can populate to help you calculate your total current commissioned activity and costs.

**Identify future change in capacity required**

Using the indicative benchmark provided, or your own local benchmark, you can use the commissioning and benchmarking tool to compare the activity that you might need to commission against your current commissioned activity. This will help you to identify the future change in capacity required. Depending on your assessment, your future provision may need to be increased or decreased.

**Model future commissioning intentions and associated costs**

You can use the commissioning and benchmarking tool to calculate the capacity and resources needed to move towards the benchmark level, and to model the required changes over a period of 4 years.
Use the tool to calculate the level and cost of activity you intend to commission and to consider the settings in which the care of women with HMB may be provided, comparing the costs of commissioning the service across the various settings. The tool is pre-populated with data on the recurrent and non-recurrent cost elements that may need to be considered in future service planning, which can be reviewed and amended to better reflect your local circumstances.

Commissioning decisions should consider both the clinical and economic viability of the service, and take into account the views of local people. Commissioning plans should also take into account the costs of monitoring the quality of the services commissioned.
Ensuring corporate and quality assurance

Commissioners should ensure that the services they commission represent value for money and offer the best possible outcomes for patients. Commissioners need to set clear specifications for monitoring and assuring quality in the service contract.

Commissioners should ensure that they consider both the clinical and economic viability of the service, and any related services, and take into account patients’ views and those of other stakeholders when making commissioning decisions.

A hysterectomy service needs to:

- be effective and efficient
- be responsive to the needs of patients and support patient choice and access to clinically appropriate treatment
- provide treatment and care based on best practice, as defined in NICE clinical guideline CG44 on heavy menstrual bleeding deliver the required capacity
- be integrated with other elements of care for women with heavy menstrual bleeding (HMB), including pharmaceutical management, endometrial ablation, uterine artery embolisation and other surgical treatments for HMB
- define agreed criteria for referral, local protocols and the care pathway for women with HMB
- be patient-centred and provide equitable access, ensuring that women are treated with dignity and respect, are fully informed about their care and are able to make decisions about their care in partnership with healthcare professionals
- audit patient treatment choices and outcomes to ensure clinically appropriate care of women with HMB
- demonstrate how it meets requirements under equalities legislation
- demonstrate value for money.

Local quality assurance

Any mechanisms for quality assurance at a local level are likely to refer to the following.

- Service and performance targets, including estimated activity levels and case mix, waiting and referral-to-treatment times (ensuring that patients do not experience unnecessary delays), complaints procedures. Commissioners may wish to consider developing key performance indicators within contractual
arrangements in line with the guidance in Care and resource utilisation; for example, by developing integrated care pathways and thresholds for treatment with clinicians, and seeking to manage levels of activity to an agreed local level for some procedures.

- **Clinical governance arrangements**, including incident reporting. Complication rates within units can be misleading, but should be explored further locally.

- **Clinical quality criteria**: appropriateness of referral, consenting procedures, clinical protocols.

- **Audit arrangements**: frequency of reporting, reporting route and format, and dissemination mechanisms; this should include auditing the proportion of eligible women with HMB who are offered a choice of different treatment options and monitoring of patient outcomes and complications. See audit criteria for NICE clinical guideline CG44 on heavy menstrual bleeding for further information.

- **Health, safety and security**: infection control, waste management, confidentiality procedures, legislative requirements.

- **Patient satisfaction**: patient surveys and perception of service provision could provide an indication of failed treatments.

- **Patient outcomes**: the number of women receiving clinically appropriate care. See audit arrangements above.

- **Staff competencies**: individual and team baseline requirements, monitoring and performance. All those involved in undertaking surgical or radiological procedures to diagnose and treat HMB should demonstrate competence (including both technical and consultation skills) either during their training or in their subsequent practice. Training programmes must be long enough to enable healthcare professionals to achieve competency in complex procedures when these are appropriate. These training programmes will usually be located in units with a particular interest and sufficient workload to allow experience of these procedures. This will require a robust clinical governance framework, including audit. See NICE clinical guideline CG44 on heavy menstrual bleeding

- **Information requirements**, including patient-specific information (NHS number, referring GP, provision of high-quality information to patients), which could include subsequent re-referral or re-admission as an indicator of failed treatments.

- **The process for reviewing the service with stakeholders**, including decisions on changes necessary to improve or to decommission the service.

- **Achieving targets associated with equalities legislation.**
Further information

General information on quality and corporate assurance can be obtained from the following sources:

- The National Patient Safety Agency (NPSA) oversees the implementation of a system to report and learn from adverse events and near misses occurring in the NHS. The publication ‘Seven steps to patient safety’ provides an overview of patient safety and gives updates on the tools that the NPSA is developing to support patient safety across the health service.

- NHS Alliance online resources. NHS Alliance is the representational organisation of primary care and primary care trusts, and provides them with an opportunity to network and exchange best practice. The alliance supports its members with an open-access helpline, in-house and joint publications and briefings, internal newsletters and a website.

- The DH commissioning framework provides guidance on the commissioning process in the context of the NHS reform agenda.
  - Delivering the 18 week patient pathway provides a range of resources to support the key NHS objective to deliver an 18 week patient pathway from GP referral to the start of treatment by the end of 2008. See the heavy menstrual bleeding pathway.

- NHS Institute for Innovation and Improvement support for commissioners, includes Commissioning for Health Improvement products to accelerate the achievement of world class commissioning; The Productive Leader programme to enable leadership teams to reduce waste and variation in personal work processes, and Better care, better value indicators to help inform planning, to inform views on the scale of potential efficiency savings in different aspects of care, and to generate ideas on how to achieve these savings.

- 10 Steps to your SES: a guide to developing a single equality scheme. This guidance has been developed to assist NHS organisations that have a duty, as public authorities, to comply with the race, disability and gender public sector duties, and in anticipation of new duties in relation to age, religion and belief, and sexual orientation.

Specific information on quality and corporate assurance for a hysterectomy service can be obtained from the following sources:

- Royal College of Obstetricians and Gynaecologists ‘Advanced training skills module: benign abdominal surgery’.
Commissioners may find documentation used for the Uterine Fibroid Registry useful to inform the development of audit criteria, competency, and governance standards.

Better metrics is a pragmatic project that provides clinically relevant measures of performance to support the development of measurable local targets and indicators for local quality improvement projects. See improving the patient experience metric number 11.

Skills for health works with employers and other stakeholders to ensure that those working in the sector are equipped with the right skills to support the development and delivery of healthcare services. See details of the clinical health skills competency framework.
Topic-specific Advisory Group: hysterectomy service

A topic-specific advisory group was established to review and advise on the content of the commissioning guide. This group met once, with additional interaction taking place via email.

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