Requirements to be a BSGE Accredited Centre

(Finalised May 2025. Active from 2026. Review date May 2028)

Severe Endometriosis should be treated in specialist centres and the BSGE will accredit centres where gynaecologists work in appropriate clinical teams, audit their outcomes and have sufficient workload to maintain their surgical skills. The requirements to be a BSGE Accredited Endometriosis Centre are:

1. Consultant Gynaecologist(s) with appropriate specialist training and expertise to provide care for severe endometriosis.

There should be a lead consultant gynaecologist, ideally working with a team of gynaecology consultants who run the service and these will be the named consultants accredited to run a BSGE Endometriosis Centre. Each consultant gynaecologist should be a member of BSGE.

Gynaecologists specialising in the surgical treatment of complex endometriosis should have achieved specialist training in advanced minimally invasive surgery. The training / expertise of each gynaecologist must be specified and can be attained by:

- ❑ Completing RCOG recognised advanced laparoscopy training modules (ATSM / SITM) or
- ❑ Equivalent post graduate university degrees (eg. MSc in Advanced Gynaecological Endoscopy) or
- ❑ An equivalent fellowship for a minimum of 2 years under an experienced gynaecologist in advanced minimally invasive surgery in an endometriosis centre or
- ❑ An experienced gynaecologist who is already working in an endometriosis centre with a proven track record in Endometriosis.
- ❑ Obtaining equivalent training under a senior gynaecologist in performing complex endometriosis surgery in a specialist centre.

Gynaecologists working within endometriosis centres should participate in professional development (CPD) within the field of endometriosis and laparoscopic surgery with attendance at an appropriate course or conference at least bi-annually.

2. Endometriosis Clinical Nurse Specialist

Having an Endometriosis CNS is a requirement and improves the quality of the service for the patients.

Endometriosis specialist nurses should be banded at Agenda for Change (AFC) Band 7 or above, or as AFC Band 6 with a clear pathway to progress to AFC 7. It is expected that each centre has a CNS with at least 15 hours per week protected time dedicated solely to the endometriosis CNS role. The amount of protected hours would increase in line with the size/activity of the BSGE Endometriosis Centre and the number of specialist consultants within the service. Eg. For centres required to submit more than 24 cases annually it is expected that increased specialist nursing time is required, ideally minimum 1 whole time equivalent

It is essential for Endometriosis CNSs to participate in professional development (CPD) within the field of endometriosis. It is expected that the CNS attends the BSGE nurses' day or BSGE Annual Scientific Meeting or an equivalent face to face update at least bi-annually.

A dedicated endometriosis nurse specialist clinic should be in place. It is the expectation that patients should have access to appointments directly with the endometriosis CNS. However, it is acknowledged that some centres run joint clinics, whereby consultants and nurses see patients together.
The above points must be demonstrated as part of the annual re-accreditation process.

3. Supporting Colorectal Surgeon

At least one named colorectal surgeon is required to support the service. It is expected that they will contribute pre-operative clinical reviews, MDT discussion input and attend complex surgery involving the bowel, operating with the centre's gynaecologists. The partnership will allow patients to receive the best advice, surgery and follow up where the pathology extends to the bowel.

It is acknowledged that management of Endometriosis is different to other conditions. Therefore the number of Colorectal surgeons named in each centre should reflect the caseload of the centre, ensuring adequate participation and expertise with Endometriosis surgery.

For joint surgeries the name of the Colorectal surgeon involved will be recorded on the database.

4. Other supporting clinicians

A support network is required which includes urologists and pain management specialists who declare that they will provide active support to the service when needed. This may involve intra-operative support or outpatient support. It is expected that the names of consultants from these specialties will be recorded on the centre's staff list. It is expected that every BSGE centre will have the following named individuals in addition to the Gynaecology endometriosis specialists and Colorectal surgeons:

- Urologist
- Radiologist
- Fertility Specialist
- Pain Specialist
- Ultrasound Lead (may be gynaecologist, radiologist, radiographer or CNS)

Some centres will also involve additional clinicians as required – eg. Plastic Surgery surgeons, Cardiothoracic surgeons, Upper GI surgeons.

Clinicians should have adequate time in job plan for the activities required to support the centre.

5. Multi-disciplinary Team Meetings (MDTs)

To be an accredited centre the service must have scheduled MDT meetings which are expected to be planned at least monthly and should take place a minimum of 6 times per year. Cases where deep bowel, bladder or ureteric disease are suspected before treatment should be discussed in the MDT, as well as any cases where MDT discussion would be helpful.
The MDT meetings should include a core membership of:

- All gynaecologists listed within the centre
- Endometriosis clinical nurse specialist
- Colorectal surgeon
- Radiologist

Other members can join meetings to discuss specific cases as required.

The MDT meetings should have recorded outcomes that are communicated with patients and GPs.

Pre-operative MDT discussion (or not) will be recorded on the database when recording operative data.

6. A dedicated specialist endometriosis outpatient clinic

This is a clinic, which is specifically devoted to endometriosis patients and accepts referral for this named condition. Ideally, it is recorded as such for any respective referrer; whether they be primary or secondary care clinicians. The clinic should have the word 'Endometriosis' in the title of the clinic with locally agreed referral criteria. The clinic should run at least monthly, but in many centres such clinics will be required much more frequently

The Endometriosis clinic may be Gynaecology only or Multidisciplinary including other surgical specialties, and should have access to Endometriosis CNS support. Some centres will have CNS led clinics. The purpose of specialist clinics is to ensure local patients and clinicians are aware of the endometriosis clinic and the advantages it will offer them.

7. Workload

It is essential that there is sufficient workload throughput to maintain surgical skills for the most complex cases. Whilst all degrees of severity of endometriosis may be treated within the service, it is a requirement for each surgeon to have at least 12 cases of deep endometriosis invading bowel, bladder or ureter according to Enzian classification (see below), treated by surgery each year. This is 12 cases per gynaecological surgeon annually, per centre that they work in (irrespective of job plan or less than full time working). So the accreditation for a centre with one named gynaecologist will be 12 cases, whereas a centre with two named gynaecologists will be 24 cases, with three gynaecologists 36 cases etc.

An index case is defined by a procedure to remove disease that is graded on the #Enzian grading as A1-A3 and /or B3 and /or C1-C3 and /or FB and /or FU and/or FI (ie deep disease affecting rectovaginal space, rectum, bladder, ureter or intestines) (see appendix 1). The cases must be recorded on the BSGE database to qualify as an index case. Whilst this can include open surgery it is expected that this will usually be undertaken laparoscopically or Robotically. The route / type of surgery will be recorded on the database (eg laparoscopic / robotic / open).

8. Data collection

An agreement from the lead gynaecologist in the Centre that all cases of surgical excision of DEEP endometriosis affecting rectovaginal space, rectum, bladder, ureter or intestines will be entered on to the database, and will be followed up for at least 12 months following surgery.

The index cases to be entered on that database should include any cases fulfilling the #Enzian grading as A1-3 and /or B3 and /or C1-3 and /or FB and /or FU and/or FI (ie deep disease affecting rectovaginal space, rectum, bladder, ureter or intestines). (see appendix 1)

All patients must give written consent to be added to the BSGE database and have completed baseline symptom and quality of life questionnaires. It is expected that every centre will achieve follow up questionnaire rates, entered on the database - 70% at 6 months and 60% at 12 months. Centres are encouraged to collect follow up data at 24 months which can also be entered on the database but this is not mandated or monitored.

9. Service sustainability and resilience

The BSGE wishes to ensure that patients suffering with endometriosis are treated as effectively and consistently as possible. All centres should be aiming to have more than one registered gynaecologist to ensure continuity of the service at times of extended leave, sickness, parental leave, retirement etc. Every centre must demonstrate that there are plans for service sustainability at each annual re-accreditation. Failure to do this may jeopardise re-accreditation.

10. Compliance with BSGE quality assessment

To ensure the quality of surgical care provided within BSGE centres centres are expected to:

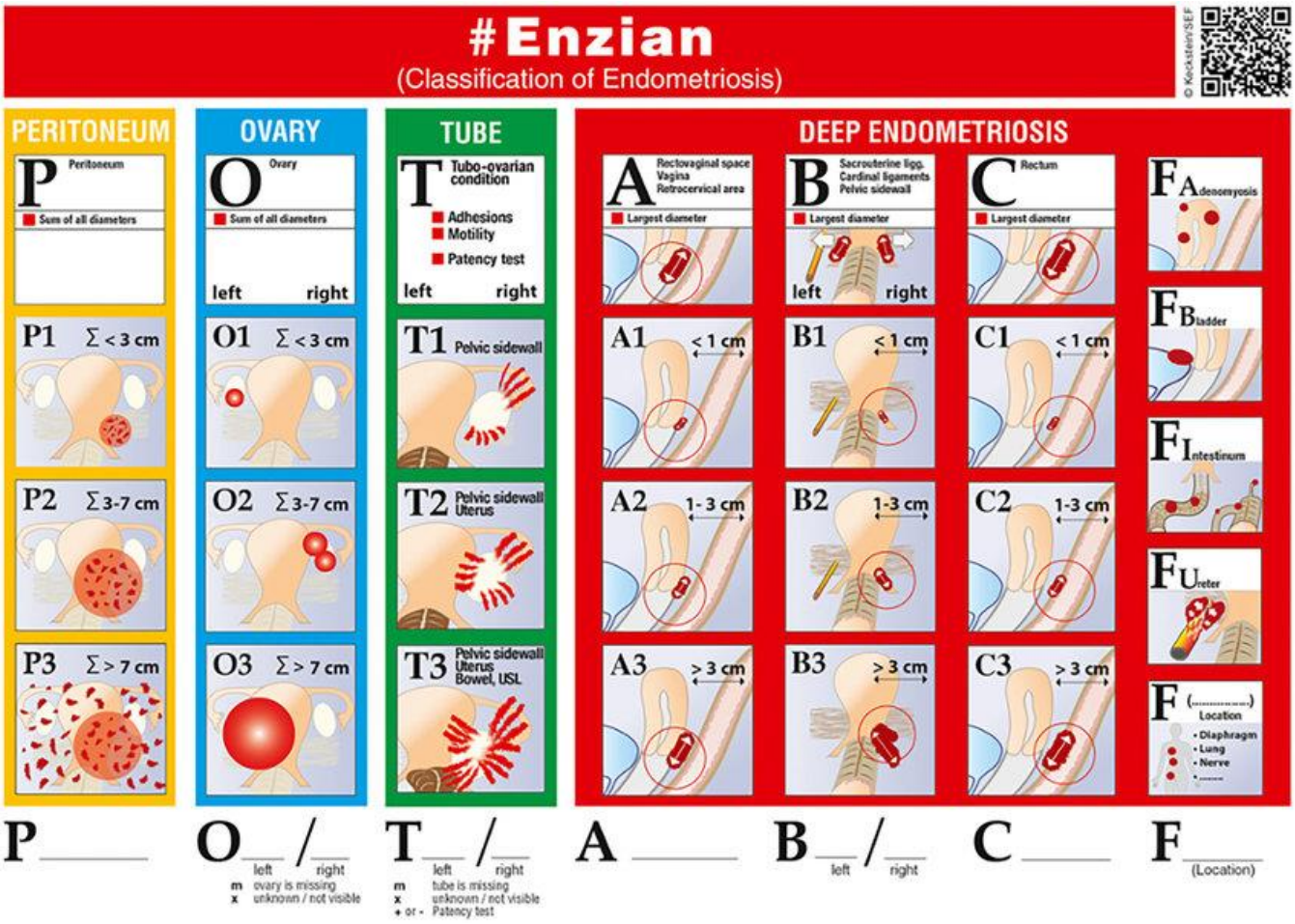
I. Provisional Centres will need to submit exemplar videos for each registered gynaecologist before 31st December of their 'Provisional' year. The videos will need to fulfil the following criteria:
   a. Maximum 3 minute normal speed completely anonymized video (with centre number at start of video).
   b. Case of deep infiltrating endometriosis affecting rectovaginal space – demonstrated by panoramic view at start of video.
   c. Demonstration of deep pararectal dissection and complete excision of disease – demonstrated by panoramic view at end of video.
   d. Case should NOT involve a hysterectomy as these are difficult to assess complete resection

   (NB – from 2025 there will no longer be an annual video submission from accredited centres unless quality concerns have been raised for other reasons)

II. Inclusion of 'before' and 'after' still surgical photos of deep disease for at least 50% cases on database (reviewed at random by the Scientific Advisory Group at time of re-accreditation)

III. Review of outcome data and complication rates (reviewed at random by the Scientific Advisory Group at time of re-accreditation)

Appendix 1:


#Enzian
(Classification of Endometriosis)
© KecksteinSEF
PERITONEUM
P Peritoneum
Sum of all diameters
P1 Σ < 3 cm
P2 Σ 3-7 cm
P3 Σ > 7 cm
OVARY
O Ovary
Sum of all diameters
left right
O1 Σ < 3 cm
O2 Σ 3-7 cm
O3 Σ > 7 cm
TUBE
T Tubo-ovarian condition
Adhesions
Motility
Patency test
left right
T1 Pelvic sidewall
T2 Pelvic sidewall Uterus
T3 Pelvic sidewall Uterus Bowel, USL
DEEP ENDOMETRIOSIS
A Rectovaginal space Vagina Retrocervical area
Largest diameter
A1 < 1 cm
A2 1- 3 cm
A3 > 3 cm
B Sacrouterine ligg. Cardinal ligaments Pelvic sidewall
Largest diameter
left right
B1 < 1 cm
B2 1-3 cm
B3 > 3 cm
C Rectum
Largest diameter
C1 < 1 cm
C2 1-3 cm
C3 > 3 cm
FAdenomyosis
FBladder
FIntestinum
FUreter
F (.....)
Location
• Diaphragm
• Lung
• Nerve
• .....
P____
O__ /__
left right
m ovary is missing
x unknown / not visible
T__ /__
left right
m tube is missing
x unknown / not visible
+ or - Patency test
A____
B__ /__
left right
C____
F____
(Location)