Setting up a primary care-based gynaecology service

Alison Bateman, general practitioner with special interest (GPwSI) in gynaecology

BACKGROUND

In 2008 Queen Square Surgery put forward proposals to run a primary care gynaecology service, led by the author. The objective was to test the feasibility of establishing a practice-based level one triage and treatment service in terms of cost effectiveness and patient satisfaction.

The pilot was designed to see patients with a specific subset of conditions to see if these patients could be dealt with quickly and effectively in a primary care setting.

Another aspect of the pilot was to streamline care pathways for conditions such as infertility and incontinence, where a referral to secondary care simply results in going away to have more tests done.

Initial audit suggested that such a service could divert 40-50% of referrals away from secondary care-based gynaecology services.

GPwSI TRAINING

Bradford University runs a number of diploma courses for GPwSIs in diabetes, cardiology, and musculoskeletal to name a few. Several GPs from the North Lancashire area have attended the courses.

I approached Mr David Burch, consultant gynaecologist at Royal Lancaster Infirmary (RLI), initially to see whether he had any experience of the course, and he was supportive of the idea.

The course runs for 18 months and includes three six-month modules covering abnormal bleeding, sexual health, incontinence and prolapse, infertility, gynaecological cancer, and pelvic pain. Each six-month module involves a two-day course of tutorials in Bradford, followed by 14 locality-based placements. These can include attendances at clinics, operative sessions or tutorials.

The support of the consultant mentor, who oversees the trainee's education programme, is a crucial part of the diploma course.

I found the course extremely rewarding and enjoyable although the amount of work involved would be challenging to someone working full time. As a GP job-share partner I felt I was able to give it the time needed, which I would estimate is roughly one day per week. At the end of each six-month module there were essays to hand in, plus a presentation to do in front of the other course participants and the Bradford consultants, which, although daunting at first, has helped me to improve my presentation skills.

LEVEL ONE SERVICE

Following discussion with North Lancashire Teaching Primary Care Trust and Mr Burch, the service went live on 8 July 2008. I had estimated five to six patients per month would be suitable for the triage service. A leaflet was designed to give to the patients, to make them aware there was a choice of going straight to RLI if they preferred. Mr Burch and I drew up protocols to facilitate direct access to hysterosalpingogram and urodynamics, provided certain criteria have been fulfilled.

A presentation was made to the GPs at the practice to explain how to refer and which conditions would be suitable. It was made clear which patients would be unsuitable, eg all two-week wait referrals, colposcopy, patients requiring cryotherapy, etc.

After a slow start the referrals started to come through and the clinic is now running well after almost two years, with occasional extra clinics being needed to fulfil the demand.

Advantages of the service include:

- easy access for GPs with a quick turnaround and feedback
- patients are seen in familiar surroundings by a practitioner they may already know
- freeing up of hospital resources to use clinic time for those whose need is greater
- patients who are referred to secondary care have a full work up done which speeds up the care pathway
- increased job satisfaction for the GPwSI, who benefits from the opportunity to enhance skills

AUDIT FIGURES FOR 2009

- 64 patients were seen in 14 clinics
- 14 patients were eventually referred on, whilst 50 were dealt with 'in house'

Problems seen (number of patients)			
Abnormal uterine bleeding (AUB) 24	*Incontinence* 7	*Prolapse* 11	*Infertility* 8
Polyp removal 3	*Vaginal discharge* 3	*Pelvic pain* 3	*Polycystic ovary syndrome* 1
Sterilisation request 1	*Endometriosis* 1	*Premenstrual syndrome* 1	*Vulval lesion* 1

Onward referral (number of patients)	
AUB	5
Infertility	3
Incontinence	2 (1 trans vaginal tape referral)
Vulval lesion	2
Pelvic pain	2
Patients to physiotherapist	5

POTENTIAL PROBLEMS AND PITFALLS

The biggest initial problem was reminding the GPs that the service existed. In a practice of 6¾ full time equivalents, a male GP may refer only three or four gynaecology patients per year, and easily forget the service is available. I undertook a monthly audit to remind people which referrals would have been suitable for level one.

Another possible problem with the service is overload when it is simply easier to refer the patient than work them up. So far this problem seems to have been avoided, and the GPs in the practice have been fairly diligent in their work up.

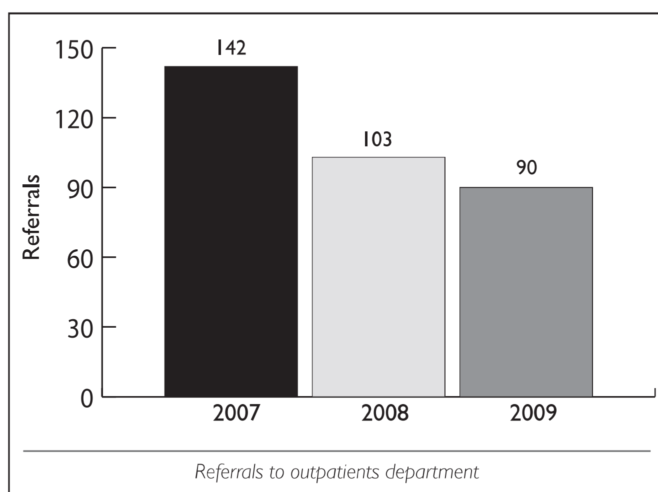
A third problem occurs when a patient waits three or four weeks to be seen in level one and then needs referral onward, thus delaying the pathway. We tried to avoid this by selecting the referrals carefully.

PATIENT SATISFACTION

The primary care trust had agreed to fund the pilot and a patient satisfaction survey was made an essential requirement. The survey carried out was extremely positive, with the vast majority of patients showing high levels of satisfaction

REFERRAL RATES TO OUTPATIENTS DEPARTMENT

The referral rates for Queen Square Surgery have dropped by approximately one third since 2007. It is important to realise that whilst a referral will be avoided altogether in some cases, in others the pathway is streamlined so that fewer outpatient appointments are needed overall. The figures to reflect this are not readily available



Referrals to outpatients department

SUMMARY

The Queen Square gynaecology pilot has proved successful in its aim to reduce referrals to secondary care and streamline patient pathways. If this service could be extended to include other practices, the impact on secondary care would be significant. This would enable cost saving, and free up consultant time to concentrate on more complex procedures, increase operating time, and reduce waiting lists.

ACKNOWLEDGEMENTS

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