

# An innovative GP training post in sexual and reproductive health care

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## What is the background to this post?

General practitioner (GP) trainees undertake a 3-year training scheme. These have traditionally included defined periods of time spent in hospital jobs, with a general practice post at the end of training.

Changes in the way GP training was funded in 2000 paved the way for the creation of 'innovative training posts', which permit trainees to combine general practice with other areas of medicine.<sup>1</sup>

The Cambridge GP training scheme offers several community-based innovative training posts with options including musculoskeletal medicine, community psychiatry, geriatrics and paediatrics. The creation of innovative training posts was in part a response to the wider political climate, with focus on care being shifted away from secondary care to primary care, including initiatives such as the Department of Health's 'Care Closer to Home' project.<sup>2</sup>

A significant proportion of GP consultations involve sexual and reproductive healthcare (SRH), with one study finding that more than 13% of consultations with female GPs involving female genital problems, and almost 7% involving contraception or pregnancy.<sup>3</sup>

The recent White Paper that proposes fundamental reform of the way health care is delivered, involving GP consortia commissioning services,<sup>4</sup> is likely to further transfer the delivery of health care from secondary to primary care. There is arguably a more pressing need for provision of good SRH in primary care than ever before. The innovative GP training post offers the potential to equip trainees with the necessary skills to function as practice leads in sSRH, or even as GPs with special interests (GPwSIs).

## How was it set up?

The three medical trainers [LG, PB and CC] discussed the idea of an innovative

training post. Following this discussion, one of them [CC] wrote a job specification and approval was sought from the Postgraduate Medical Education Training Board (PMETB). GP training programme directors and trainers on the Cambridge scheme were canvassed and there was widespread support from them. Approval from PMETB was obtained very quickly after the application was made.

Initially LG, PB and CC were the designated clinical supervisors. They are all Faculty-registered trainers with many years experience of SRH. A significant strength is the three trainers have a diverse range of experience: PB has been a GP principal for 26 years, a Faculty Instructing Doctor for 20 years, a GP Trainer for 16 years, and a GPwSI for 10 years. LG is an associate specialist in SRH and works in contraception and sexual health, as well as genitourinary medicine (GUM) clinics for Cambridgeshire Community Services; she is also the Deanery Advisor for the Eastern Region for the Faculty of Sexual and Reproductive Healthcare (FSRH). CC has a background in general practice, and currently works as a GPwSI in gynaecology, and as an associate specialist in SRH.

## What are the working arrangements?

Trainees spend 6 months in the post. Completion of the theoretical training for the Diploma of the Faculty of Sexual and Reproductive Healthcare (DFSRH) is a prerequisite, and by the end they will have been expected to gain the Diploma, as well as Letters of Competence in Subdermal Implants (LoC SDI) and Intrauterine Techniques (LoC IUT).

The first month is largely spent sitting in with nurses and doctors in the clinic. As the month progresses, trainees conduct the consultations themselves under supervision.

During the second month time is spent on consolidating skills for the Diploma,

and towards the end of this month trainees are able to apply for the DFSRH and LoC SDI.

From the third month onwards, trainees apply for the LoC IUT and run their own clinics, although there is always a designated clinical supervisor available for advice if needed.

The usual working week consists of 2 days during the week, with two sessions of contraception, and two sessions of GUM. On alternate weeks, trainees attend the community gynaecology clinic. One or two evenings may be spent in procedure clinics (dedicated sessions for intrauterine devices and subdermal implants) or further contraception sessions. Once a month they attend a Saturday morning clinic. There is some time built into the rota for private study, during which trainees may undertake audit or research.

### What do trainees think of the post?

“This post covers a vast amount of the GP training curriculum and equips you with the confidence to manage problems which ordinarily you might refer to specialist clinics.

It is interesting to work with a mix of patients who have chosen not to attend their GP for family planning and sexual health advice, and learn from the elements of this service that attract these patients, particularly the under-16s and those with complex social needs.

Being part of the GUM service takes the GP consultation a step further, enabling you to actively diagnose and manage sexual health problems while developing microscopy skills and knowledge of contact tracing.

The community gynaecology clinic is an ideal platform to hone consultation skills and further develop practical skills in procedures such as polyp removal and the retrieval of lost threads. These skills are not routinely practised in traditional obstetrics and gynaecology hospital placements, yet are invaluable for general practice. Discussing referrals from the community teaches you a great deal of gynaecology as well as how to manage the common, the complicated, and the obscure gynaecological problems that may present to you in primary care.

I left the placement with new knowledge to pass onto my colleagues, I was able to transfer the practical skills I learnt into my clinical practice, and I have found an area of special interest to continue developing throughout my career.” [RA-S]

“I found this post offered a unique opportunity to develop my skills in SRH, and then take those skills back to the practice. Working in a multidisciplinary team with SRH doctors, nurses and health care assistants was refreshing for the range of different perspectives on offer.

Here are two examples of how my own practice has changed.

I used to approach pill checks rather mechanistically, and (I suspect like many GPs) viewed them as quick and easy appointments, that could be used to make up time

if one’s surgery was running late. Now I offer a much better service to patients: I use them to discuss SRH more holistically, checking that the current method of contraception remains suitable for the woman, talking about alternative options, discussing sexual health and offering screening where appropriate.

My ability to take sexual health histories has also improved – and I am more aware of the potential relevance of this. A man presented to my surgery having had multiple skin infections, including molluscum contagiosum and impetigo. The other doctors in the practice had previously treated these as one-off episodes. After careful questioning, I discovered that he was actually at substantial risk of HIV infection. I felt comfortable discussing this with him and arranged testing.

This was a worthwhile practice-changing experience, which provided me with useful qualifications (including the Letters of Competence) and has left me enthused to continue with interest in SRH in the future.” [DE]

### What do trainers think of the post?

“A key feature of this post is that it provides the luxury of time within a consultation, over a session, and over the attachment to focus on SRH, and to do this in a setting which encourages the trainee to practise in an integrated way. A few weeks into the attachment it is clear that trainees no longer compartmentalise consultations strictly into contraception or GUM. SRH work is also very patient-centred and relies heavily on good communication skills which are key attributes for GPs.” [LG]

“As trainers of nurses we find no difference in training of doctors (compared to nurses) and it is important for doctors to know what the specialist nurses do. Training can be easily organised and completed early on, and there is then time to consolidate over the remaining time, when the trainees are a useful addition to clinic. We have been lucky to have had two trainees who have been a pleasure to teach and worked flexibly within this new training programme. Overall a positive experience.” [GD]

“In 2000 I became a GPwSi in Community Gynaecology. The vision was of a service that had equity, accessibility and cost-effectiveness, with a change of attitude from ‘mine’ and ‘your’ patients to ‘ours’, with seamless care and a blurring the primary/secondary care interface. In 2010 this service is run by a GPwSI and associate specialist, supported by a consultant gynaecologist, specialist registrar and specialist nurse. The opportunities for joined-up working with hospital colleagues, and the potential for rolling out good practice to other GPs, is ripe for development and this innovative GP training post is a step towards this goal.” [PB]

“I think that as a specialty we will benefit from the next generation of GPs having a real understanding

of the complexities of SRH. I can see them becoming ‘experts’ within their future practices, but also being able to use the knowledge and skills that they have acquired in everyday consultations. As an organisation we have benefited from their energy and enthusiasm, and having male trainees has challenged some of the gender assumptions made by our all female staff!” [CC]

#### What difficulties were encountered and how were they overcome?

The Primary Care Trust expressed some scepticism at first. The enthusiasm of the clinical supervisors and the support of the GP programme directors and trainers were instrumental in overcoming this.

There was also some initial concern among the supervisors, who were used to working with Diploma candidates in a very closely supervised way. Although the GP trainees were carefully supervised at first, they subsequently ran independent clinics. Having a designated supervisor for each session was a key component of ensuring good clinical governance and meant that trainees were never left unsupported.

The medically trained supervisors all work part time for the service. This meant that on occasion it was difficult to provide clinical supervision for every session. An attempt was made to address this by applying for formal accreditation for one of the specialist nurses [GD] as a clinical supervisor.

The premises used had limited accommodation and space is at a premium – this is particularly acute when trainees are running their own clinics. Careful and

flexible timetabling provided maximum utility from a small number of rooms.

#### Where next?

The innovative training post in SRH is about to start its second year. Although there are no formal follow-on arrangements for the trainees, it is likely that they will continue with their SRH interests in one form or another, whether as practice leads or GPwSIs.

The enthusiasm from the recent trainees means that it is highly in demand among the next cohort of GP registrars. Two 6-month posts are offered each year. Further expansion is not foreseen at present, because of limited availability of clinic space and supervisors; however, other GP training schemes could set up similar posts.

**Competing interests** None.

**Provenance and peer review** Not commissioned; internally peer reviewed.

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