

# Analysis of an innovative one-stop, hospital-based, outpatient acute gynaecology clinic: model for taking the service to community

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## INTRODUCTION

Community Sexual and Reproductive Healthcare (CSRH) consultants working closely with general practitioners (GPs) and hospital consultants can offer patients a responsive, efficient, one-stop gynaecology service in the community.

We present a retrospective analysis of outcomes of consultations in 914 patients attending a new model acute gynaecology clinic (AGC) at Birmingham Women's Hospital, Birmingham, UK over a 24-month period between July 2010 and June 2012.

## WHAT IS THE CLINIC?

The AGC is a 'one-stop' 'see and treat' service for acute gynaecology conditions for patients with severe menorrhagia, irregular vaginal bleeding, pelvic pain, and postoperative complications with symptom duration between 48 hours and 2 weeks. The philosophy is based on the premise that not all urgent gynaecology problems need immediate assessment. Where such assessments can be made by an appropriately skilled senior clinician, using suitable diagnostic tools, unnecessary hospital admission and delays in treatment can result in improved patient safety and experience.

## WHY WAS A NEW APPROACH TO MANAGING GYNAECOLOGY PATIENTS NEEDED?

A key government National Health Service (NHS) reform objective is to reduce waiting times for specialist care and improve the quality of care and patient experience.<sup>1–3</sup> Additionally, the Royal College of Obstetricians and Gynaecologists (RCOG) Standards for Gynaecology 2008 recommend that relevant gynaecology patients should have prompt access to emergency

care including diagnostic resources such as ultrasound scanning, and should be reviewed by a consultant within 24 hours of presentation.<sup>4</sup>

A local audit indicated that a consultant reviewed only 35% of patients within the first 24 hours of admission, whereas 58% of patients never saw a consultant. Furthermore, over 50% of admissions stayed in for longer than 24 (range 18–72) hours, and the main reason for delayed discharge was waiting for an ultrasound scan (65%). This indicated that unnecessary admissions were being made to the gynaecology ward through inefficiencies in clinical decision, usually by junior staff, and the lack of diagnostic facilities. This resulted in poor patient experience, including long waiting times and multiple attendances.

## HOW WAS THE AGC SET UP?

The initial work was done on a cost-neutral basis using existing staffing models and was negotiated as a Trust Commissioning for Quality and Innovation (CQUIN). Senior decision-making and ultrasound scanning was addressed by appointing a dedicated gynaecology consultant who would run clinics, perform ultrasound scanning and lead on the project.

A structured fax referral form with specified referral criteria (Box 1) and telephone triage booking system was introduced. Flyers were sent to the local accident and emergency (A&E) department, general hospitals and general practices. The lead consultant also attended GP group meetings and ran information sessions for different staff groups within the hospital to increase awareness about this clinic.

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### Box 1 Referral criteria specified on the structured fax referral form

- ▶ Duration of gynaecology symptoms such as pelvic pain, severe menorrhagia, irregular vaginal bleeding, vulval swelling, postoperative complications in discharged patients for longer than 48 hours and less than 2 weeks. Patients who have symptoms for less than 48 hours are advised to consider referral to accident and emergency department or gynaecology on call. Patients who have symptoms for more than 2 weeks are advised to consider referral to gynaecology outpatient department. The other exclusion criteria include pregnancy-related problems, post-menopausal bleeding, colposcopy-related problems and suspicion of cancer, which requires initiating a 2-week wait oncology referral.

Regular audit and evaluation led to continuous improvement, with reporting done to the Primary Care Trust via a CQUIN report.

#### HOW DOES THE CLINIC WORK?

Patients fulfilling the referral criteria are booked into the first available clinic slot within 48 hours of referral. The AGC excludes patients with pregnancy-related problems. Patients with a positive pregnancy test or pregnancy-related problems are seen and managed in the early pregnancy assessment unit. The clinic is open 5 days a week and each patient appointment is for 30 minutes to allow time for ultrasound scanning or minor procedures.

The clinic is managed by a consultant gynaecologist or a RCOG or CSRH trainee under direct supervision and a health care assistant. Appropriate investigations (e.g. swabs to screen for chlamydia, gonorrhoea, bacterial vaginosis, candida albicans and trichomonas vaginalis infections); endometrial sampling; vulval lesion biopsy and a definitive diagnosis and treatment are initiated in most cases [e.g. incision and drainage of abscess, ectropion cryocautery; polypectomy; levonorgestrel-releasing intrauterine system (Mirena®) insertion]. The ultrasound scan is used as a diagnostic tool as required to provide prompt assessment, diagnosis and management in one visit. Timely written communication is generated for the referrer.

#### WHAT HAS BEEN OUR EXPERIENCE TO DATE?

In total, 914 patients were seen in the AGC over a 24-month period between July 2010 and June 2012. The median age of patients seen was 33 (range 12–98) years. All (100%) women were telephoned with an appointment within 48 hours of referral and 89% of women were seen within 48 hours of referral.

Almost half (48%) the patients were referred by their GP, 24% from A&E, early pregnancy assessment

**Table 1** Reasons for referral of patients to the acute gynaecology clinic over a 24-month period between July 2010 and June 2012 (*n*=914)

Reason for referral*	<i>n</i> (%)
Pelvic pain	455 (48)
Vaginal bleeding†	242 (26)
Postoperative complications	101 (11)
Vulval pain/lump/cyst/infection	69 (7)
Pelvic/adnexal mass	30 (3)
Vaginal discharge	11 (1)
Intrauterine device-related problems	6 (1)
Other‡	29 (3)

\*Some patients had two or more concurrent reasons for referral.

†Vaginal bleeding not related to pregnancy, post-menopausal bleeding or colposcopy-related problems. Three patients with heavy bleeding during a miscarriage underwent manual vacuum aspiration in the acute gynaecology clinic as an emergency procedure as this was the only room available with a consultant in attendance.

‡Other includes ring pessary change, vaginal lump, etc.

unit and surgical assessment unit, and 28% by other departments such as radiology or genitourinary medicine or by other local hospitals. Pelvic pain accounted for almost half of the referrals (Table 1). This was expected as one of the aims of this clinic is to provide prompt assessment and treatment of sub-acute pelvic pain of suspected gynaecological origin [e.g. ovarian cysts; adnexal pathology including pelvic inflammatory disease (PID), tubo-ovarian abscess, hydrosalpinx, pyosalpinx; acute episodes of chronic gynaecological disorders such as endometriosis, chronic PID, degeneration of fibroid; intrauterine device-related complications] and postoperative complications such as pelvic haematoma or abscess, endometritis, and so on. Additionally, pelvic pain of non-gynaecological origin is also diagnosed in the clinic, for example, urinary tract infection, irritable bowel syndrome, constipation, musculoskeletal pain and unexplained pain where exclusion of gynaecological pathology can be verified by performing ultrasound.

More than half (55%) the patients required an ultrasound scan; 59% patients were discharged back to their GP after one visit and 4% were admitted to the gynaecology ward (Table 2).

#### WHAT WAS PATIENTS' EXPERIENCE OF ATTENDING THE ONE-STOP AGC?

Patient experience was measured using a structured anonymous questionnaire during the first 3 months of the clinic. This questionnaire addressed the clinic environment, appointment system, staff, communication and patient satisfaction. The majority (84%) of patients surveyed felt that their problems had been solved in one appointment; 8% were awaiting further tests and a further 8% felt their problem was not resolved with a single appointment.

**Table 2** Outcomes of patients attending the acute gynaecology clinic over a 24-month period between July 2010 and June 2012 ( $n=914$ )

Outcome of consultation	n (%)
Discharged back to general practitioner	540 (59)
Followed up in acute clinic	24 (3)
Followed up in gynaecology outpatient department	176 (20)
Ward admission	39 (4)
Booked for elective theatre list*	33 (4)
One-stop hysteroscopy clinic	34 (4)
Colposcopy	3 (1)
Other specialist clinics†	65 (7)

\*Elective procedure such as oophorectomy, diagnostic laparoscopy, etc.

†Other specialist clinics: vulval, post-menopausal bleeding, urogynaecology, oncology, early pregnancy assessment unit, urology, genitourinary medicine, etc.

### WHAT WAS REFERRER FEEDBACK REGARDING THE ONE-STOP AGC SERVICE?

The Clinical Lead for Birmingham Cross City Commissioning Care Group commented on the one-stop AGC service thus: “It is excellent value for money; a one-stop service and patients don’t even have to come for a second visit. From a GP and commissioner point of view it is very satisfactory. I am very pleased with it as a user of the service. It works really well, so everyone is a winner”.

### WHAT ARE THE BENEFITS OF THE AGC?

We have shown that urgent gynaecological conditions can be managed efficiently without access to expensive equipment or inpatient beds. The AGC reduces delay in diagnosis and alleviates patient anxiety. Patients spend less time waiting on the wards, have fewer follow-up appointments, and are more likely to be completely discharged. A local audit has shown a significant reduction in the A&E ward attendance rate by 66% in the first 4 months of the service operating.

### HOW CAN THE AGC WORK IN THE COMMUNITY AND WHAT ARE THE BENEFITS?

The AGC is a reproducible model of care that can easily be transferred to the community if it is deliv-

ered by trained CSRH consultants. Relocating these services from hospital outpatient to the community (i. e. providing ‘care closer to home’) will improve patient choice, access and convenience by providing alternatives to hospital outpatient department attendance. Additionally, it will improve the efficiency of hospitals by managing patients in the community who do not require the resources of an acute hospital.

### CONCLUSIONS

We have shown that an outpatient AGC is a valuable and easily implemented service with relatively low infrastructure costs. The model allows easy transfer to the community setting but requires the recruitment of CSRH consultants with appropriate gynaecological and ultrasound scanning training, provided there is a back-up link with local NHS hospitals. The establishment of such clinics will enhance gynaecological care in the community and help meet the NHS’s future goals.

**Competing interests** None.

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

### REFERENCES

- 1 Farrar M. QIPP – quality, innovation, productivity and prevention. 10 September 2009. <http://www.hsj.co.uk/opinion/columnists/mike-farrar-on-qipp-quality-innovation-productivity-and-prevention/5005811.article> [accessed 3 November 2012].
- 2 Department of Health. *High Quality Care For All*. 2008. [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/documents/digitalasset/dh\\_085828.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_085828.pdf) [accessed 3 November 2012].
- 3 Department of Health. *NHS 2010–2015: From Good to Great. Preventative, People-Centred, Productive*. 2009. [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/@ps/@sta/@perf/documents/digitalasset/dh\\_109887.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/@sta/@perf/documents/digitalasset/dh_109887.pdf) [accessed 3 November 2012].
- 4 Royal College of Obstetricians and Gynaecologists. *Standards for Gynaecology. Report of a Working Party*. June 2008. [http://www.rcog.org.uk/files/rcog-corp/uploaded\\_files/WPRGynStandards2008.pdf](http://www.rcog.org.uk/files/rcog-corp/uploaded_files/WPRGynStandards2008.pdf) [accessed 3 November 2012].

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