



Gynaecology Sub-group

Design Workshop Report

Scottish Access Collaborative Approach

The aim of the Scottish Access Collaborative is to sustainably improve waiting times for patients waiting for non-emergency procedures.

The Cabinet Secretary for Health and Sport launched the Scottish Access Collaborative in November of 2017. This will be closely aligned with the Regional Planning, Realistic Medicine, Elective Centres Programme and extant Performance Management and Clinical Priorities, Delivery Activities and Programmes. In the complex landscape of healthcare planning and delivery the Access Collaborative will focus on developing collaborations which build on existing work streams and networks to sustainably balance demand and capacity. The Collaborative is led by Professor Derek Bell, Chair of the Academy of Medical Royal Colleges, and Paul Hawkins,

Chief Executive of NHS Fife and is made up of a range of professional bodies including the Scottish Academy of Medical Royal Colleges, patient representatives and service leaders. The Collaborative has developed six fundamental principles which will shape and prioritise the way services are provided in the future. These principles are described in this report in the context of the findings.

A key strand of the Collaborative's work is the delivery of the Specialty Sub-Group programme, in which a range of experts in clinical specialties undertake a cycle of design-led workshops with the support of the Digital Health and Care Institute.

The Digital Health and Care Institute (DHI) was commissioned to design workshops aimed at producing high level mapping of each clinical area and identifying clinically led and patient centred sustainable improvements. The findings from these workshops will form the basis of a speciality-led Access Collaborative programme delivering solutions to help scheduled care services to sustainably meet the challenges of the future.

The DHI was established as a collaboration between the University of Strathclyde and the Glasgow School of Art and is part of the Scottish Funding Council's Innovation Centre Programme. It is part funded by Scottish Government. DHI support innovation between academia, the public and third sectors and businesses in the area of health and care.

For more information on the workshops please see the Collaborative's blog:

<http://bit.ly/accesscollaborative>

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ACKNOWLEDGEMENT

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Heather Currie and Sham P Konamme have provided a number of pathways currently being used in Dumfries and Galloway and Ayrshire and Arran. These are available at <http://bit.ly/Gynaecologyblog>

Executive Summary

Members of the Gynaecology Speciality Sub-Group came from 13 different specialists areas and 5 different NHS Board areas. Additional input was noted from a consultant from NHS Grampian, giving the Sub-Group both a broad geographic and functional reach. The first step for the workshops was to identify common Gynaecology patient symptoms, noting their importance. Pathways were mapped for each symptom and areas to focus on agreed. Further discussion around these focus areas led to suggestions for

sustainable improvement. These ranged from additional targeted patient information, virtual consultations for follow-up and dedicated vetting in secondary care to clinical cluster groups, and nationally accepted referral guidelines which are easy to access and follow.

Work to further scope these improvements will be under taken in the coming months allowing a prioritisation process to take place through the Scottish Access Collaborative (SAC).

Future work will involve national support to ensure the Gynaecology community, along with primary care partners are supported to make the necessary changes to ensure efficient and effective patient pathways are achieved. It is envisaged that the work areas will be taken forward either through the Gynaecology community itself or for broader issues which are not specialty specific, be achieved through the SAC Combined Action Group (CAG).

November 2018



1. Preparation 2. Map the Landscape 3. Ask the Right Questions 4. Sketch Solutions 5. Prioritise

Clinical Foreword

All Gynaecologists, Gynaecology nurses, Women's Health Physiotherapists, Practice nurses and GPs want the best, most efficient pathways for their patients requiring some Gynaecology advice, investigation and/or treatment. With ever increasing work pressures, there may not be enough time to reflect, review pathways and bravely consider doing things differently. The Scottish Access Collaborative has allowed clinical staff to take some time away from their day job to share ideas and an enthusiasm for change has been evident. There is increasing recognition that current pathways are inefficient, that variation in pathways, vetting processes and return to new ratios across Scotland is unacceptable and that there is growing evidence around the benefits of working in different ways. The Scottish Access Collaborative has generated many ideas on how Gynaecology outpatient services could be improved for our patients across Scotland and while we must be mindful of pressures across the NHS, it is hoped that this report will provide a platform to further develop and implement clinician led ideas.

Implementation Support

The aim of the Modern Outpatient Programme is to support the development of a Modern Outpatient service which, aligned with the principles of the SAC, will support effective and faster service change to ensure patients are able to access healthcare in a timely manner. This national Programme is well placed to action the outputs from the Gynaecology workshops; supporting clinical teams to test innovative ways of working and how positive improvements proven to enable the provision of high quality care for patients, can be shared and implemented at scale across Scotland.

Heather Currie

Clinical Lead for Gynaecology
Modern Outpatient Programme

Katie Cuthbertson

Director Modern Outpatient
Programme Scottish Government

Scottish Access Collaborative Principles

I.

Patients should not be asked to travel unless there is a clear clinical benefit, and that any changes should not increase the workload for primary, secondary or social care in an unplanned/ unresourced way

II.

All referrals should either be vetted by a consultant/senior decision maker or processed via a system wide agreed pathway – value vetting

III.

Referral pathways (including self-management) should be clear and published for all to see

IV.

Each hospital and referral system should have a joint and clear understanding of demand and capacity

V.

Each local system should have a clear understanding of access to diagnostics as part of pathway management

VI.

Improved and published metrics including how we record and measure virtual/ telehealth/ tech-enabled care

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Design Approach

WHY FOCUS ON THIS?

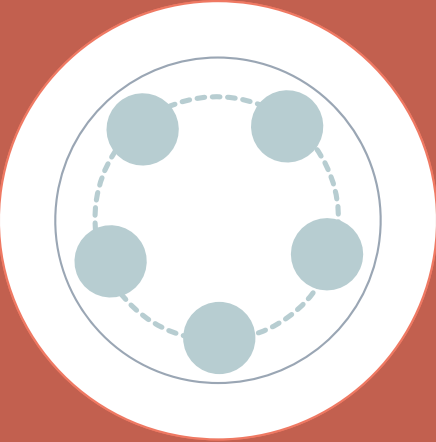
WHY FOCUS ON THIS?

WHY FOCUS ON THIS?

SYMPTOM

SYMPTOM

SYMPTOM



FOCUS MAP

PRIMARY / SECONDARY

PRIMARY / SECONDARY

PRIMARY / SECONDARY

PRIMARY / SECONDARY

PRIMARY / SECONDARY

PRIMARY / SECONDARY

PRIMARY / SECONDARY

PRIMARY / SECONDARY

choose from:

CONSULTATION

DIAGNOSTICS

DETERMINE DIAGNOSIS & TREATMENT

TREATMENT & MANAGEMENT

FOLLOW UP

WHAT ARE THE ISSUES?

FOCUS MAP

PRIMARY / SECONDARY

PRIMARY / SECONDARY

PRIMARY / SECONDARY

PRIMARY / SECONDARY

PRIMARY / SECONDARY

PRIMARY / SECONDARY

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PRIMARY / SECONDARY

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CONSULTATION

DIAGNOSTICS

DETERMINE DIAGNOSIS & TREATMENT

TREATMENT & MANAGEMENT

FOLLOW UP

WHAT ARE THE ISSUES?

- I.

III.

V.

II.

IV.

VI.

The DHI team uses the discussions and maps to distill the key challenges the group identified on each pathway. Each challenge is communicated on a focus map.

From these discussions, the DHI team distills the key ideas and insights into a set of proposed changes.

WORKSHOP 1

We look at which symptoms a clinical area works with most, and prioritise which to take forward and why. We map the current landscape and pathways for each priority symptom.

WORKSHOP 2

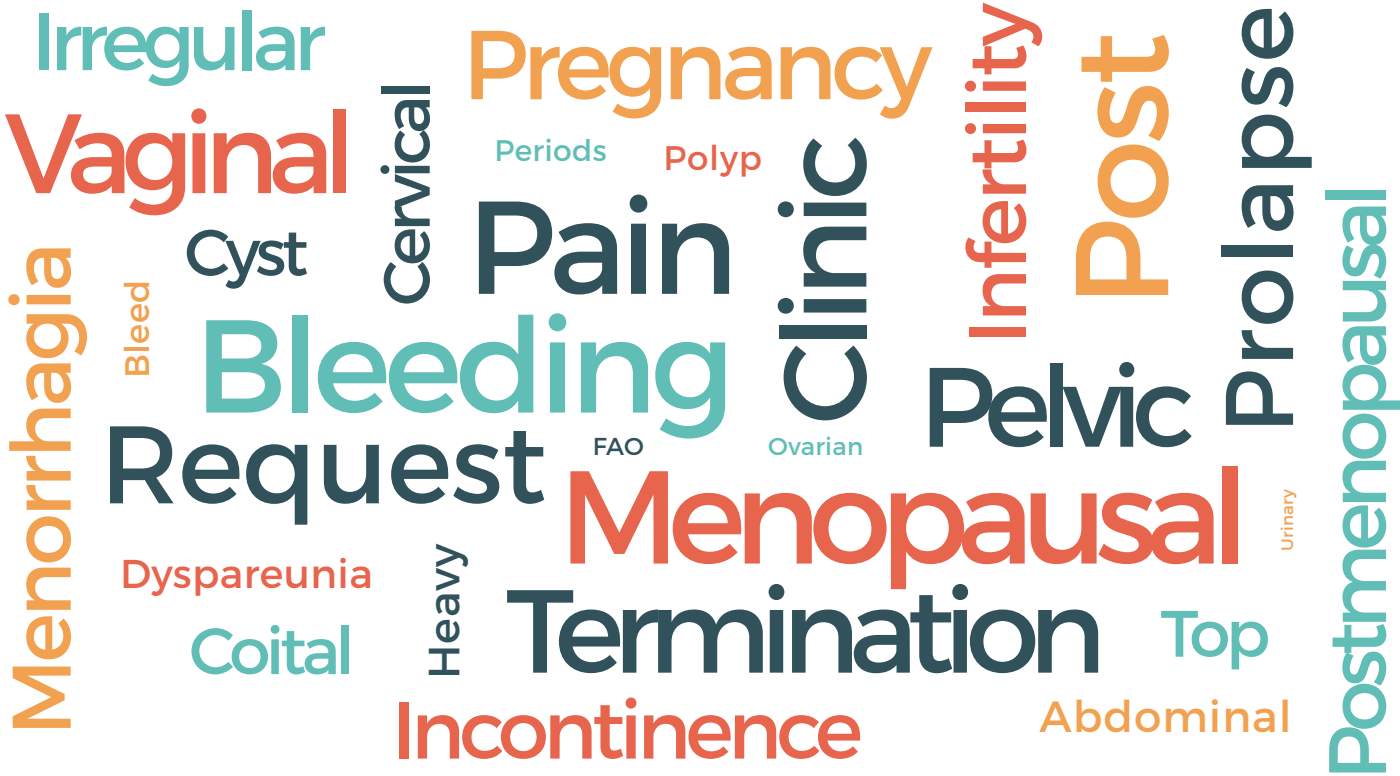
We explore the key challenges by taking into account patient feedback, and using the diverse range of expertise and experience in the group. We start identifying opportunities and map out ideas.

WORKSHOP 3

We add detail to the proposed changes. We also cross-check and prioritise the proposed changes against the Scottish Access Collaborative Principles.

Symptom Profiles

The set of design-led workshops started with the participants agreeing on a small number of gynaecological symptoms they felt were of top priority to deliver maximum impact through service improvements. These symptoms were then mapped describing the current Gynaecology services from initial consultation to eventual discharge. What follows are the four symptom profiles which were identified. Each profile is described by its approximate volume of presentation, along with other reasons why it should form an area to focus on.



This word cloud reflects the relative frequency of the most commonly used words in a group of Gynaecology referrals from Fife. The data was collected from more than five thousand referrals and was taken from the 98 character field in SCI Gateway. While the word cloud was used for reference only it does support the broad choices of symptoms made in the workshops.

Heavy Menstrual Bleeding

Heavy menstrual bleeding happens when there is a troublesome change in the normal bleeding pattern for the patient before she has gone through the menopause. The bleeding might be heavier, more or less frequent than normal.

Large Volume

Urinary Symptoms

The term urinary symptoms cover incontinence, leakage, along with increased frequency and urgency of passing urine. This affects the ability of a woman to maintain bladder control.

Large Volume

Why focus on this?

This is a common symptom which has a significant impact on the patient and can cause anxiety. There is variation in the treatment which is offered in primary care, leading to inconsistencies. Furthermore, it represents a large workload in outpatient clinics. There is a small chance of cancer.

Why focus on this?

The symptom has a high volume of presentation and it can have a significant impact on patients' quality of life. There is an opportunity for primary care management but variation in the support available within primary care is a limiting factor.

Prolapse

Prolapse is when the womb, bowel, bladder or the top of the vagina move from their normal position and impact the vagina. It occurs when the muscles and ligaments within the pelvic floor become weak and no longer can support the pelvic organs.

Medium Volume

Pelvic Pain

Pelvic pain is pain and discomfort felt in the lower torso, below the umbilicus. The symptom can either be acute or chronic for the patient. Several conditions can cause pelvic pain to occur.

Medium Volume

Why focus on this?

There are regional variations in practice. In some cases there may be an overreliance on tests. Patient expectations and anxiety can be high. Once patients reach secondary care, expectations of which treatments they will be offered may be raised which can make them less receptive to less invasive forms of treatment such as physiotherapy.

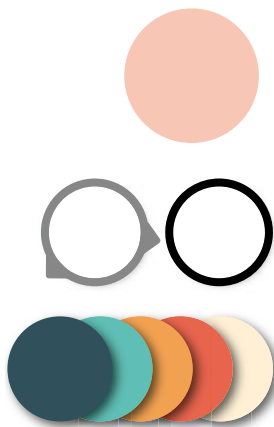
Why focus on this?

The symptom can come from a variety of origins, it is a non-specific pain which is very difficult to manage and is often referred as urgent. This symptom impacts on patients' quality of life and so there is a need to investigate to target the cause and treat. It is a resource heavy symptom meaning that it's multiple origins, difficulty in managing, and options for testing takes time and resource to come to a satisfactory outcome.

Focus areas

The second step in the workshops involved a series of collaborative mapping sessions using tools designed to explore the current landscape. The visual hands on tools helped the group to identify assumptions and insights about current Gynaecology services. Mapping these services for each of the four different symptoms discussed above, the group highlighted regional differences and explored and shared best practice. After identifying and locating key areas on this map, the group collaboratively prioritised what to focus on. This then provided an end-to-end system context for the next step of generating ideas for sustainable improvements.

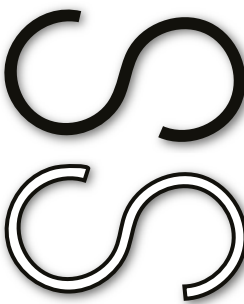
Map key



Focus Areas

Split / Referral

Steps



Primary Care

Secondary Care



Scottish Access Collaborative Principles

Following what emerged from the workshop, the DHI team translated the group’s discussions and maps into four summary maps illustrating and locating focus areas. These maps are categorised by symptom. However, many of the areas they show clearly stood out as important and challenging areas for more than one symptom, region or service. They are therefore key areas for improvement and could deliver significant impact for patients and staff.

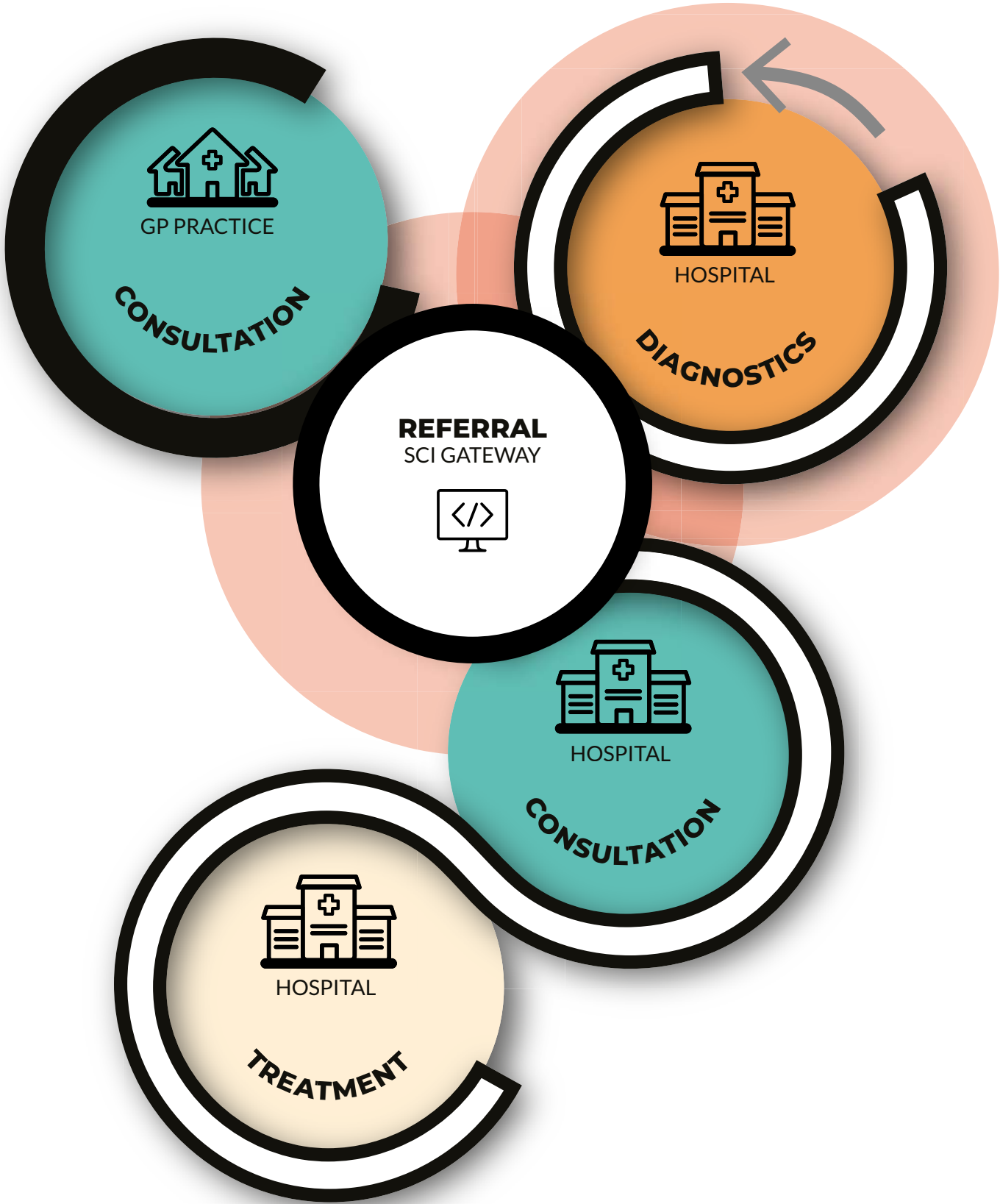


Heavy Menstrual Bleeding

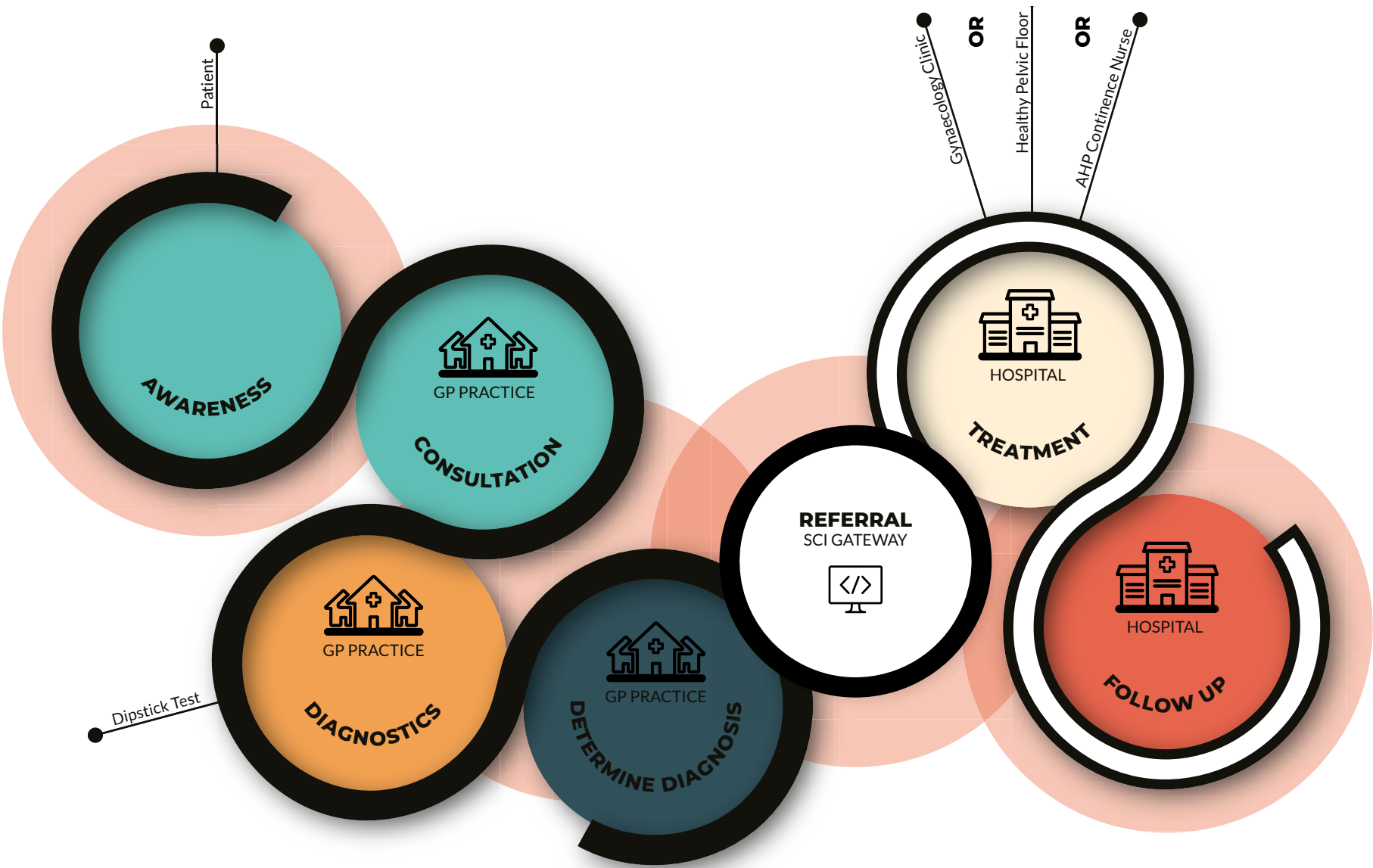
FOCUS 1
Some patients are being referred to secondary care before trying all of the conservative medical methods available in primary care. Lack of resource within primary care might be contributing to this issue.

FOCUS 2
Existing regional guidelines need to be nationally accepted, easy to follow, and easily accessible to primary care clinicians.

FOCUS 3
Diagnostics are sometimes used inappropriately by primary care. Occasionally patients are referred for diagnostics in place of a physical examination by the GP. This can lead to asymptomatic conditions being picked up, which in turn leads to further unnecessary investigations or treatment.



Urinary Symptoms



FOCUS 1

Many women do not know about the option to self-refer to a healthy bladder clinic.

FOCUS 2

Pathways need to be nationally accepted, followed, and well resourced. Non-urgent patients are being referred to secondary care when there are self-management and community options.

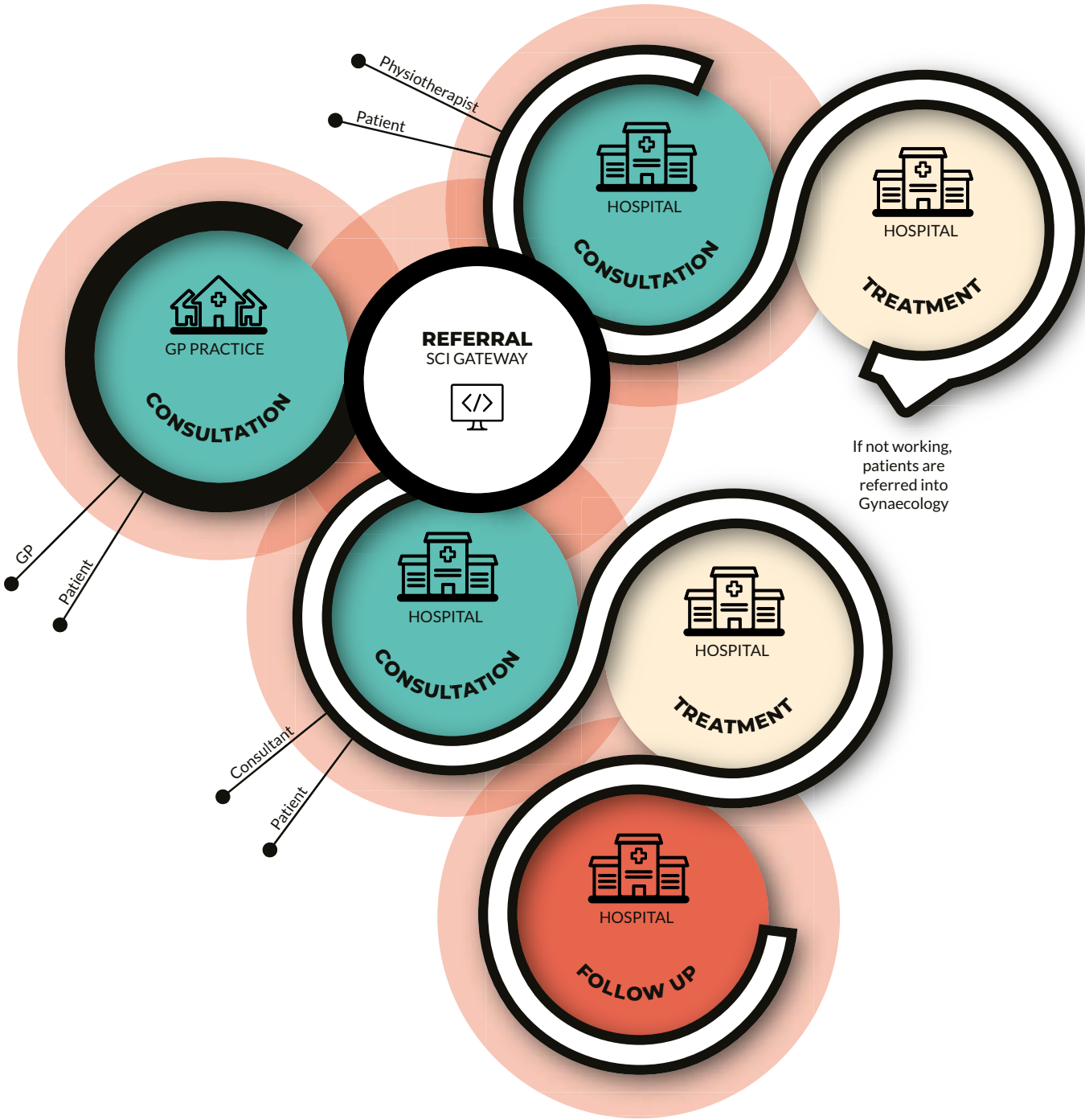
FOCUS 3

Vetting is not often recognised as such in job planning, resulting in this task not being highlighted and being completed with reduced time allocation which may result in patients being added unnecessarily to waiting lists and therefore unnecessary presentations in secondary care.

FOCUS 4

Patients may return to secondary care for unnecessary follow up appointments.

Prolapse



FOCUS 1

GPs refer to Gynaecology rather than directly to physiotherapy. As physiotherapy is the recommended first line treatment for most cases of prolapse, this adds an unnecessary step and additional waiting time.

FOCUS 2

Sometimes examination for smear tests reveal a slight prolapse and patients are referred into secondary care. This may not be necessary, as general advice is usually sufficient when there are no symptoms from the prolapse.

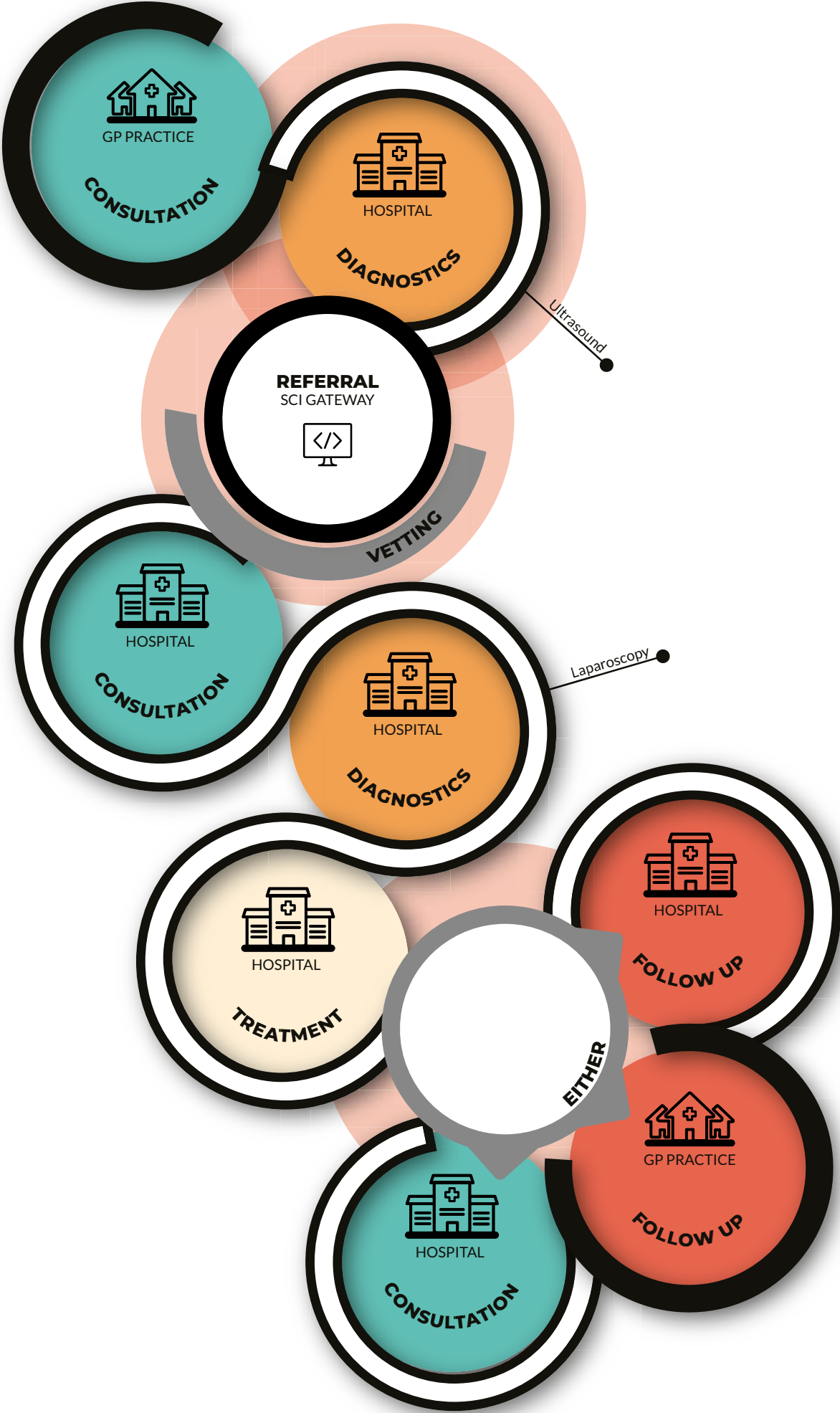
Pelvic Pain

FOCUS 1
Patients may be unnecessarily referred for an ultrasound in secondary care when there is an opportunity for primary care options. The result is adding additional hospital appointments for patients, taking time out of patients' schedules, and using up hospital resources.

FOCUS 2
Patients may be referred when hormonal treatment could be tried first in primary care.

FOCUS 3
There is little opportunity for primary care to connect and seek timely advice from secondary care, leading to unnecessary referrals.

FOCUS 4
Follow up appointments could be managed better, as some patients currently come back into secondary care unnecessarily or present as new patients.

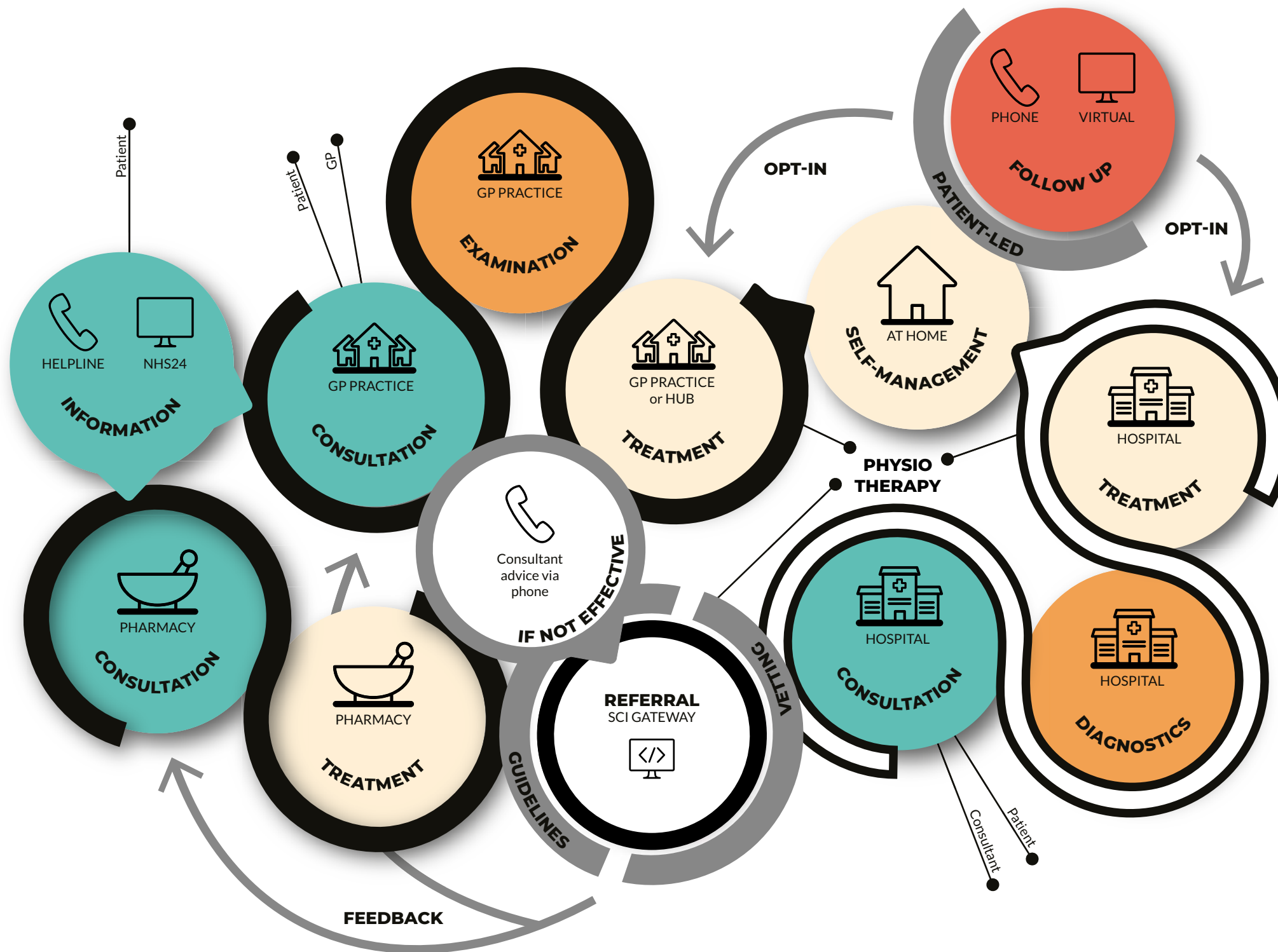


Outputs and Actions

The group started to uncover a number of improvement opportunities while mapping key areas within the current Gynaecology service. These improvements have been cross-referenced with the six principles set out by the Scottish Access Collaborative. A number of the opportunities for improvement put forward address focus areas for more than one symptom and if successful could have significant potential for sustainably improving the balance between demand and capacity. The following summary also includes a set of other ideas which emerged during the discussion but did not relate directly to the symptom maps.

It should be noted that some opportunities for improvement will have a greater impact when implemented together with another option. For example, improvements in vetting coupled with agreed referral guidelines could have a significant effect on the volume of referrals into secondary care.





- A. More high quality and readily available information for patients and GPs. Especially around options for self-referral and self-management
- B. National accepted referral guidelines which are easy to access and follow
- C. Clinical Cluster Groups; developing more opportunities for informed communication between primary and secondary care
- D. Dedicated vetting time as part of job planning
- E. Virtual Appointments for Follow Up

A.

More high quality and readily available information for patients and GPs. Especially around options for self-referral and self-management

Summary

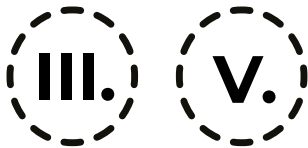
Patients being enabled to make decisions about their care, and to manage their symptoms themselves where appropriate is a key driver for Gynaecology services. Good quality and timely patient advice and information is vital for improved patient and clinical experience. There is currently variation in information given by GPs at an initial consultation about symptoms, options and a likely course of treatment. There is similar variation in the advice given to patients on discharge from secondary care about managing conditions and options regarding follow up. Informing and empowering patients was seen as a priority for future services. The better informed the patient is the easier the consultation will be. When discharged from care a better informed patient is more empowered and able to manage their own condition.

Output and Actions

The first idea is for more quality, readily available health promotion material at the point where patients first come into contact with health services. This could be in the form of advice from a GP but also other means of communicating up to date information. The second idea is for high quality treatment plans and advice for patients when they are discharged from care to support their self-management, combined with a patient initiated return option where patients can refer back to clinic themselves for a fixed amount of time after discharge, if they decide they need to. Our work found there was some precedent for this already happening with some physiotherapy services, and the early evidence shows that return rates go down when patients are given the option to return rather than by default or through the GP.

Impact

The impact from better patient information and support for self-management is fewer hospital and GP appointments. This reduces the time patients need to spend in a clinical setting, frees up appointments in primary and secondary care, and improves the patient journey experience.



B.

National accepted referral guidelines which are easy to access and follow

SAC Principles



Summary

Our work has highlighted a need for agreed national clinical pathways for Gynaecology services. Guidelines which support clear options should be in place for improved patient care, to facilitate self-management, primary care management and appropriate referral. National guidelines are agreed and implemented locally although services may vary from region to region. There are examples of best practice pathways for Gynaecology patients, especially with respect to primary care management and patient self-management.

Output and Actions

The idea is that there can be nationally agreed pathways that support best practice care options in primary care and standardise the conditions for referral to secondary care.

Ongoing work by Heather Currie for the Modern Outpatient Patient programme was raised during the workshops and can be accessed here: <http://bit.ly/Gynaecologyblog>

Impact

One of the key principles of the Access Collaborative is that patients should not travel unless there is a clear clinical benefit. Clearly defined pathways to facilitate patient self-management and primary care management will prevent unnecessary journeys to hospital for patients, reducing required travel and better managing expectations. The effects of this are fewer hospital appointments for routine cases freeing up time for more complex cases, reduced waiting times, as well as reducing demand for surgery due to better acceptance of conservative management.

C.

Clinical Cluster Groups; developing more opportunities for informed communication between primary and secondary care

SAC Principles



Summary

Sometimes, from a GP and a consultant perspective, the effective course of action for a patient can be determined by a conversation between staff in primary and secondary care. Building this level of productive communication between GPs and Consultants is seen a positive step towards an improved care experience for patients. While advice only referrals do exist currently, the group suggest this is expanded.

Output and Actions

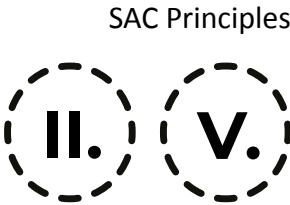
The idea entails clinics collecting and analysing their referral data for consistent themes and issues which could be fed into area GP clusters to help them develop the joint services need and support their initial consultations. There was some discussion around how this could be implemented. This could be through regular meet ups or online forums, with ongoing support through some form of synchronous communication between individuals. It was unanimously seen as a positive step for Gynaecology to take toward this service improvement. To implement this idea, groups of clinicians would record and share data about their clinics, looking for key themes and issues they can define and share with their local primary care providers. Together they can inform and collaborate on holistic care developments.

Impact

Communication between health professionals in assessing the right pathways for patients and handling cases in primary care where possible will result in fewer appointments for patients, less travel, and free up hospital appointments for more complex cases.

D.

Dedicated vetting time as part of job planning



Summary

It is hugely important to get vetting right. Quality vetting can prevent unnecessary appointments, free up clinical time, and ultimately improve patient experience. To enable this to take place, dedicated time for an experienced decision maker to scrutinize each referral and direct appropriately is required. While some Gynaecology clinics are already changing their approach to vetting referrals and dedicating senior staff time to it, there is variation across the service. In many places vetting is done whenever it can be fitted in, an approach that does not allow for recorded, recognised dedicated time for this task.

Output and Actions

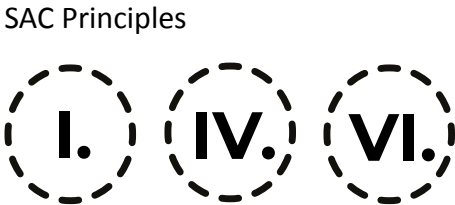
The idea is that dedicated vetting time is adopted as best practice for all Gynaecology services, and the requisite guidelines and supports be developed for a national rollout.

Impact

High quality vetting results in only those people who need to be in hospital coming into hospital, it puts patients on the right pathway at the start rather than bringing them to clinic first to make that decision which may have had no added value for the patient. The result is less appointments, fewer journeys and time out of their lives for patients, more appointments in hospital for the patients that need them, and a potential reduction in waiting times. Our work has found that patients who are referred to hospital are more likely to expect some form of surgical intervention, even if it is not necessarily required for physical health reasons. Bringing fewer patients into hospital could have the knock-on effect of reducing the number of operations for Gynaecology.

E.

Virtual Appointments for Follow Up



Summary

The Access Collaborative have asked for a holistic approach to service improvements including a reduction in the number of miles travelled by patients, which is a key principle of the Collaborative. Virtual appointments could become part of Gynaecology clinics for appropriate cases, especially in the case of follow up appointments, and appointments that only require some advice or reassurance.

Output and Actions

The idea is that under certain agreed circumstances patients are offered a phone call or some other form of virtual appointment rather than a trip to hospital. This could be a letter that is created at the point of vetting for patients who could be ‘seen’ virtually. The letter is sent to the patient’s GP and to the patient informing them of the decision. An appointment is then made for a telephone consultation and the call takes place. The idea is that this would also work well for follow up. To enable further improvements in this area, combining the return appointment with virtual consultation could further reduce the number of unnecessary trips to clinic for patients. In this scenario when a patient calls to make an appointment and the request is vetted, if appropriate this will be directed to a virtual service.

Impact

Appropriate virtual appointments could significantly reduce the number of face to face hospital appointments. Discussions during the workshop indicated that virtual appointments take less time than face to face and so more patients can be seen in an allotted time. The patients may be seen sooner and travel less.

Other Ideas

It was noted that it is important to cultivate a good relationship between primary and secondary care. This is particularly key for junior GP's. The reintroduction of meetings or teleconferences to share best case practice and knowledge was suggested. PRT sessions (Protect Learning Time), could be offered along with training for vetting. These could be virtual sessions with interactive WebEx. These could be offered within the regular working hours or in the evening.

Send out text to patients prior to call from hospital, so they are not hesitant to pick up the phone when they receive a call from an unknown number.

Newly formulated GPST posts could upskill GP trainees in the specialty so that when they are in post in General Practice they can provide certain services e.g. peripatetic women and children's health clinics.

Promotion of patient information such as Menopause Matters.

There should be the opportunity to inform patients of the time they should expect to wait before being seen in secondary care.

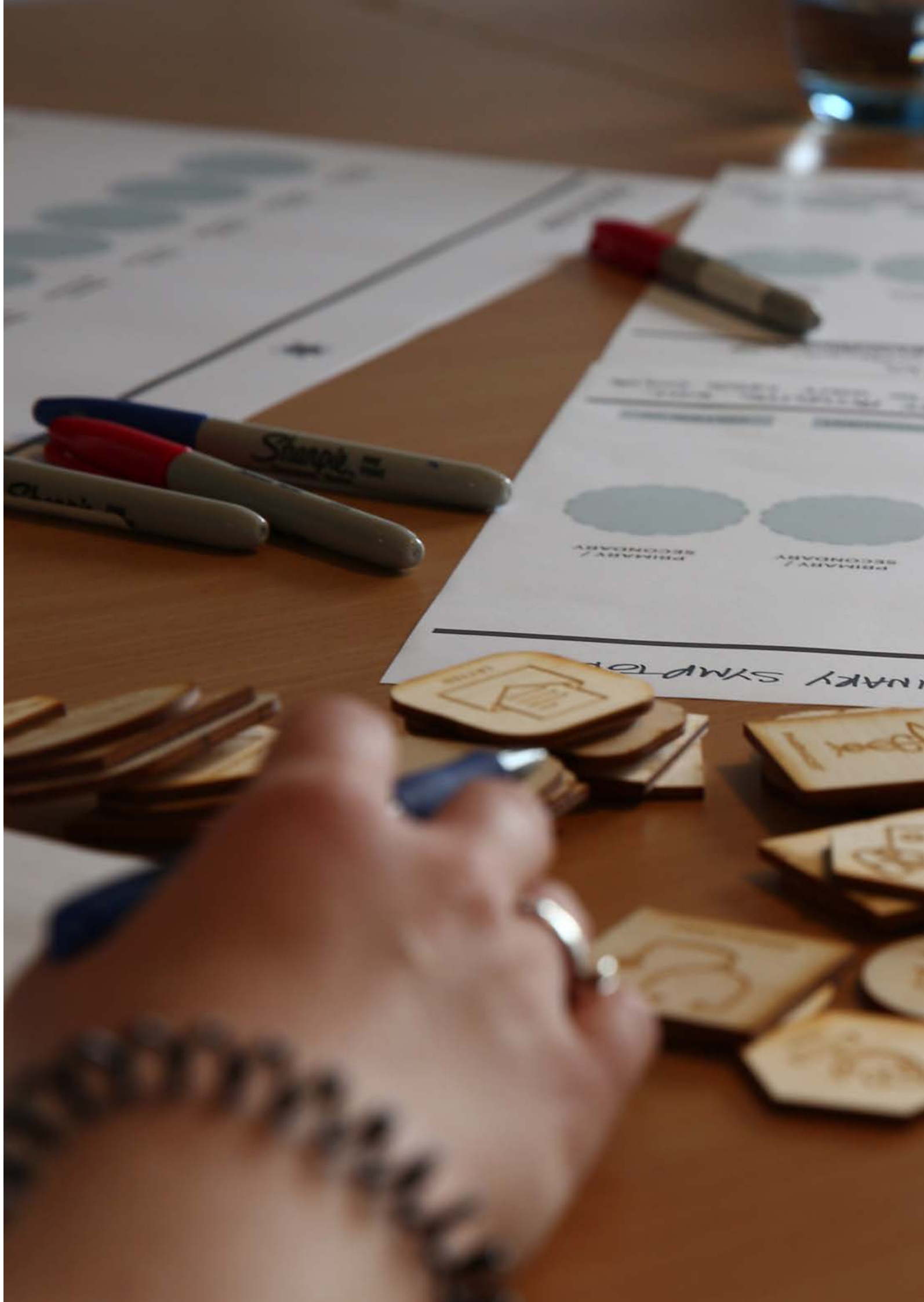
Letters which invite the patient to attend an appointment should include 'you will see a member of the clinical team' rather than 'you will see doctor x'. In that way the patient will not have expectations which are not met if a different team member comes at the consultation.

Focus on expanding and improving NHS inform, so that patients can have the opportunity for self-management and can be better informed as they move through the health care system.

Make it possible for GPs to see the cost of each test, to possibly bring down the number of unwarranted tests.

Where possible standardise letters which currently go to GP from secondary care so that they are instead sent to the patient and CC the GP. This will require the information contained in the letter to be readily understood by the patient but ensures that the patient has a summary of the discussion, investigations, procedure and management plan, and is engaged in their own care.

Constructive feedback on referrals between primary and secondary care.



Next Steps

It is clear from the Gynaecology Specialty Sub-group meetings that there was broad agreement on the areas that could make the most difference for patients requiring support and care for gynaecological symptoms.

A work plan will now be developed which outlines the national support available to enable the recommendations detailed in this report to be taken forward across Scotland. Primary and secondary care colleagues will require to work together to ensure that efficient and effective patients pathways are achieved. It is envisaged that the work areas will be taken forward either through the Gynaecology community itself or for broader issues which are not specialty specific, be attached to the SAC Combined Action Group (CAG). The CAG’s purpose is to address cross-cutting areas of challenge.

- **A.**
More high quality and readily available information for patients and GPs. Especially around options for self-referral and self-management
- **B.**
National accepted referral guidelines which are easy to access and follow
- **C.**
Clinical Cluster Groups; developing more opportunities for informed communication between primary and secondary care
- **D.**
Dedicated vetting time as part of job planning
- **E.**
Virtual Appointments for Follow Up



Scottish Government
Riaghaltas na h-Alba
gov.scot

DHI is a collaboration between:

**THE GLASGOW
SCHOOL OF ARE**

University of
Strathclyde
Glasgow

