Trust Guideline		Worcestershire Acute Hospitals NHS Trust

Minor Gynaecological Procedure Service Guideline

Department / Service:	Minor Gynaecological procedures clinic /Gynaecology
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Accountable Director:	Mr Angus Thomson, Divisional Medical Director
Approved by:	Ratified at Gynaecology Governance Meeting
Date of approval:	9th October 2020
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Target Organisation(s)	Worcestershire Acute Hospitals NHS Trust
Target Departments	Women's Health Unit/WRH Outpatients Gynaecology
Target staff categories	Gynaecology medical & nursing staff, Outpatients staff

Policy Overview:
• This policy covers the minor Gynaecological procedure services

NB. Hard copies of this policy are not permitted as they **cannot guarantee** and **risk** the content being out of date.

For assurance that the most up to date policy is being used, staff should refer to the version held on the Trust Intranet Clinical Guidelines and Policies tab on the front page

Latest Amendments to this policy:		
29th December 2023	Review extended for 6 months whilst under review	Alex Blackwell
20th August 2024	Review extended for 6 months whilst under review	Alex Blackwell

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1. Introduction

The NHS Long Term Plan makes a commitment to reduce face-to-face outpatient appointments by up to a third over the next five years, setting out the ambition to provide alternative models of outpatient care.

In December 2019, the Gynaecology Directorate was selected to take part in an NHSE/I 100-day Outpatient Transformation Programme, it was through this programme that the Gynaecology team considered a one stop minor gynaecological procedures clinic.

Introduction of a minor gynaecological procedure clinic would maximise outpatient capacity ensuring patients are referred to the most appropriate healthcare setting first time and enable patients to be seen, diagnosed, and treated during the same appointment.

Currently this cohort of patients suitable for minor Gynaecological procedure clinics are seen in Gynaecology Outpatient Department (GOPD) to receive the intended treatment/investigation or redirected from the GOPD to hysteroscopy clinic. Many of these procedures in fact do not require hysteroscopy but are seen in the hysteroscopy clinic as there is no alternate clinic space available to undertake minor procedures. This significantly impacts on an already strained hysteroscopy service and reduces the GOPD efficiency.

A one stop clinic will help to reduce patient waiting times, contribute to RRT performance and will improve patient experience.
The new service model will support the Trust Vision of “Working in partnership to provide the best healthcare for communities, leading and supporting our teams to move 4ward” and in addition the High Impact Change ‘Minimising face-face outpatients / Optimising one stop clinics.

2. Scope of this document

This policy applies to the care provided by medical and nursing staff groups who are involved in Gynaecology clinics, specifically minor Gynaecological procedures.

3. Definitions

Minor Gynaecological procedures are described as those undertaken in an outpatient setting, for which some may require local anaesthetic.

4. Responsibility and Duties

- It is the responsibility of the medical and nursing staff performing the minor gynaecological procedures and of those assisting, to ensure they are familiar with the contents of this guideline.
- It is responsibility of the medical and the nursing staff carrying out the minor gynaecological procedures to ensure: the independent competencies for the procedures outlined herein (section 5.1) have been signed off, reach out for senior advice and help where necessary and keep up to date with the knowledge related to the conditions for which the minor procedures are required.

- The clinicians assigned to this clinic should also be competent in identifying any abnormalities of the cervix and vulva and arrange the appropriate onward referral.
- They should also be competent in undertaking cervical smears (if indicated) and should possess a smear takers code.
- They should be involved with service audit and be proactive in seeking advice/engaging in remedial activity if any issues are identified.

5. Guideline Detail

5.1 Criteria for Referral

Patients who can be seen in this clinic include those requiring the following:

- Pipelle endometrial biopsy (endometrial cells found on smear/ those requiring repeat sampling for endometrial hyperplasia, failed pipelle at sampling at GOPD)
- IUS/IUD insertion
- Difficult IUS/IUD removal where this was not previously attempted under local anaesthetic by the referrer
- Vulval biopsy
- Removal of simple vulval cysts/ lump excision e.g. sebaceous cysts approximately <2 cm in size
- Cervical polyp avulsion
- Treatment of Bartholin /vulval abscess

5.2 Exclusion criteria:

2WW referrals (including PMB)
Women requiring outpatient hysteroscopy.

5.3 Considerations before Referral - the women on anticoagulants

As per the Trust guideline (WAHT-HAE-002) on "Warfarin & other oral anticoagulants guidelines and procedures", minor Gynaecological procedures do not require interruption of warfarin as long as the INR is within the target range (bedside INR testing should be undertaken by the nursing staff at the Minor Gynaecology Procedure clinic on the day of the attendance). The Direct Oral Anticoagulants (DOAC) provide a similar level of anticoagulation to warfarin with a target INR of 2.5 but produce more peaks and troughs.

Therefore;

- For morning session: withhold morning dose of DOAC. For rivaroxaban or edoxabantake missed dose 2hours after the procedure as long as haemostasis is secure, and 2 hours has elapsed from end of the procedure.
- For afternoon session: Take the morning dose of DOAC before 7AM and restart when next dose is due as long as haemostasis is secure, and 2 hours has elapsed from end of the procedure.

Women on antiplatelet agents:
Aspirin monotherapy or dual antiplatelet therapy (clopidogrel and aspirin) can be continued for minor gynaecology procedures where the associated bleeding risk is perceived to be very low.

5.4 Service provision
This service will be provided at the Women's Health Unit, Alexandra Hospital, Redditch every fortnight. The frequency of the service will be adjusted and may be extended to Worcestershire Royal Hospital (the Colposcopy clinic room) following the service evaluation three months after the launch.

5. 5 Referral process

- **Women assessed in Primary Care**
  1. Women who meet the criteria for referral can be referred directly into the service using the One Stop Minor Gynaecology Referral Form (Appendix 1). Initial pilot with the Wyre Forest Primary Care Network (PCN).
  2. Referrals forms will be completed thoroughly and sent via e RS through to the Booking office team using a RAS system.
  3. Internal referral could be generated for elgible cases identified on Advice and Guidance requests
  4. Referrals will be triaged by the on-call consultant gynaecologist to ensure the referrals are appropriate for this clinic.
  5. Any referrals not appropriate for the one stop minor gynaecology procedure clinic will be returned to the referring GP practice outlining the reasons for returning, any relevant pre-referral treatment or investigation required and advice on the appropriate clinic the woman should be referred.
  6. Upon completing the referral form, primary care will provide the patient with the appropriate patient information leaflet.
  7. The patient information leaflets for certain minor procedures are embedded in the referral to minor gynaecological conditions section on the common gynaecological conditions leading to referral guideline.

- **Women assessed within the WAHT GOPD or at the WAHT Gynaecology Assessment Unit**
  1. The women meeting the criteria for minor gynaecological procedures but unable or inappropriate to be undertaken at the initial GOPD consultation can be referred internally.
  2. The referral form for the Minor Gynaecological Procedure Clinic can be found on the Bluespier (referral forms under Obstetrics and Gynaecology)

- **Consultant triaging the Choose and Book referrals** (RAS)

1. The consultant triaging should tick the box for minor gynaecological procedure clinic in the triage form and complete the standard referral form to indicate what procedure is required.
2. The form along with the triage paperwork is sent to the booking team.
3. The booking team is responsible for booking appropriate appointments following internal referral. The team should make a note of the name of the procedure requested on the referral form and the relevant patient information should be enclosed with the appointment letter

5.6 Documentation

- Women will receive an appointment via letter that contains instructions for routine minor gynaecological procedure clinic. They will also receive a copy of the Trust patient information leaflet for the relevant procedure (pipelle biopsy, vulval biopsy, management of bartholin abscess.
- The patient information can be found within minor gynaecological procedure clinic in the Key Documents found within the Trust Intranet Clinical Guidelines and Policies.
- Documents that should have a header and barcode for scanning onto patient health record on eZnotes with patient identification details self-populated e.g. history sheet/procedure record, can be printed from patients own health record on eZnotes or as a group print from an eZnotes clinic list
- Documentation should be printed contemporaneously with the procedure where possible.

5.7 Staffing

- The minimum staffing levels are outlined below. It is the responsibility of the Unit Manager / Nursing Sister to ensure staffing requirements are met and where necessary highlight deficits to the Matron for Gynaecology.

The clinic requires:

- a clerk to book-in women as they attend for appointments onto the hospital computer system
- a health care assistant to welcome the woman and carry out baseline observations (see below)

In the procedure room there should be:

- A qualified and competent medical or nursing staff member carrying out the procedure
- A registered nurse (RN) supporting the procedure (setting up and disposing the working trolley with required equipment) and acting as ‘runner’ during a procedure
- A health care assistant (HCA) and the RN acting as ‘vocal local’ and advocate for the patient.

- **Gynaecology medical staff:** The doctors performing the procedure will be ST5 and above or equivalent (clinical fellows/middle grades) who have the independent competencies confirmed for the procedures outlined herein (section 5.1). They have immediate access to consultant for help if needed. The consultant running alongside outpatient Gynaecology

or Antenatal clinic at WHU at Alexandra Hospital is the port of contact for advice and support if needed. The on-call consultant for the gynaecology will provide the necessary support when procedure clinic is at WRH. The expectation from the middle grade allocated to the clinic are

- Check the correspondence of the patients attending the clinic in advance. If any clarifications or addtional support required, middle grade doctor to discuss with the named consultant for the clinic/ referring consultant
- If any investigations such as histology is required, the requests should be made under the referring consultant for internal referrals. For the direct referrals by the GPs, the tests should be requested under the named consultant for the clinic
- Chase the results of the tests requested, discuss the results if needed with the relevant consultant, file the results and write to patient coping to the relevant consultant

- **Nurse practitioners-** Those who have independent competencies confirmed for the procedures outlined can run minor gynaecological procedure clinic with immediate access to consultant support as above.

- **Nursing and auxiliary staff:** The clinician performing the procedures are supported by a member of nursing staff and health care assistant.

5.8 Environment and Equipment

Area for clerking
Procedure room with access to changing and toilet facilities for women
Recovery room with couch
Computer workstation
Examination light
Examination couch and stool
Equipment Trolley
Emergency Trolley
Medicine Cupboard with appropriate range of analgesia
Prescription Charts (inpatient and outpatient)
Sterile gauze swabs (the radiological detectable)
Needles for dental syringes
Dental syringes
Smear taking brush and pot
Gallipots
Sterile cleaning solution sachets
Sponge holders
Polyp forceps
Range of different sized specula, Cuscose and Sims
Range of different sized Hegar dilators
Disposable Os finder
Disposable sound dilator

Mirena IUS
Copper coil
Instillagel & Quill
Sterile swabs & Chlamydia swabs
Sterile scissors
Spencer-wells
Vulsellum Forceps
Formalin pots
Specimen bags
Sterile Coil Retriever
Key punch biopsy devices size 3-5
Suturing sets (swabs, blade, scissors, forceps, needle holder)
Vicryl rapid 2.0 and 3.0
Jelonet Paraffin Gauze Dressing
Pipelle endometrial biopsy device
Syringe endometrial biopsy device
Disposable knife with size 11 blade mounted
Word catheter
Disposable gloves
Sterile gloves
Sharps Box
Lubricating jelly
Silver Nitrate
Equipment for cryocautery
Blood taking equipment
Range of cannulas
Medications: Range of appropriate analgesia and local anaesthetic and intralipid solution
Fluids: IV Stand
1L Normal Saline
Pressure bag
IV Giving Set
3 Way Tap
50ml syringe
Disposable kidney dish

5.9 Setting up for a Clinic Session

- Before every clinic session, it is essential that the availability of all equipment is confirmed by the nursing staff allocated to the clinic for Health and Safety, patient comfort, and the smooth running of the clinic session.
- All clinical areas and equipment should be cleaned as per infection control policy.
- Setting up the working trolley depends on the intended procedure. The team assigned to the clinic should identify the equipment needed during the team brief prior to commencement of the clinic.
- The necessary equipments for the procedure should be placed on the sterile vaginal examination pack on top shelf of trolley.

- During a procedure registered nurse to assist the clinician by opening packs as requested.

5.10 Pre-procedure

- On arrival at the clinic, women should be greeted and 'arrived' on the PAS system, demographics checked.
- A procedure record sheet should be printed contemporaneously with the appointment and included in the care plan.
- They will then be clerked in by a registered nurse or health care assistant who will;
    - Re-check identity, asking the woman to state her name, date of birth and first line of address
    - Check for any allergies and put an identity band onto the women – red if there are any allergies, white if not
    - Assist the woman in completing the medical history on the nursing record
    - Take baseline observations (blood pressure, pulse, temperature and O2 saturations), their BMI and document these on the nursing record
    - Women with the potential for pregnancy, pre- and peri-menopausal, should have a pregnancy test completed
    - Should inquire whether the woman has already taken analgesia. If not offer Ibuprofen 800mg as the first line analgesia (unless the woman has history of severe asthma, gastro-oesophageal reflux or allergy/intolerance to it). If so, paracetamol should be offered unless the woman has allergy
    - Woman's choice of analgesia should be discussed with the clinician undertaking the procedure and the prescription chart should be completed before administrating the analgesia.

5.11 Obtaining consent

- Informed, valid written consent must be obtained for any investigation / treatment. This should include:
    - Benefits and risks

Alternative options for investigation / treatment

- Documented verbal consent is adequate for any vaginal / speculum examinations / genital swabs, cervical smears, endometrial biopsy removal of IUS/IUD and cervical polyp removal
- E-consent form for insertion of intra-uterine device is available

5.12 The procedure

- On meeting the woman, the clinician performing the procedure should go through the admission nursing notes, discuss the presenting complaint, obtain the relevant smears history, medical, surgical and social history to ensure that the reason for the clinic appointment is fully understood and for the safety of the procedure. Contemporaneous entries should be recorded on the appropriate history sheet.
- The results of any previous relevant investigations should be checked
- Proposed investigation / treatment / management plans should be discussed with the woman

- Where there is concern regarding a patient's suitability for the scheduled procedure e.g. possibility of pregnancy the procedure may be deferred if necessary.
- Valid informed consent will be obtained as above
- The woman will be shown to the changing area and asked to remove the lower half of her clothing and put on a theatre gown or draw sheet, maintaining her dignity
- The woman will be shown to the examination couch and into the lithotomy position. Staff will ensure she is made as comfortable as possible. A HCA or RN will attend the woman throughout the procedure providing distraction as the 'vocal local', assessing the patient's tolerance and communicating to the Team
- If the lesion to be removed is suspected of cancer (e.g vaginal or vulval cancer), assistance should be sought from the consultant prior to removal or should make urgent onward referral to 2 week wait clinic
- Encouragement to ask for the procedure to stop if it becomes too painful
- If an **endometrial biopsy is taken, the length of sampling device in the uterine cavity and cervical canal should be recorded in the notes to enable the consultant reviewing the results to ascertain whether sampling failure or tissue yield failure in the case of "inadequate" histology results**
- A Consultant clinician must always be contactable for advice and support if necessary.

5.13 Samples

- Expiry dates on sample pots containing Formalin should be checked by two members of staff before use
- The request form for the sample should be created by the clinician who took the sample on ICE computer system with as much relevant information as possible for lab staff to process and report the sample accordingly
- For internal referrals, the test requests should be made under the referring consultant. For direct referrals by the GPs, the tests should be requested under the named consultant for the clinic
- Information on the sample pot should match that on the request form
- Patient and sample identification on samples should be checked by two members of staff and any samples sent during a clinic should be listed in a record book

5.14 Post procedure

- The clinician will debrief the patient following the procedure and discuss findings; management required and schedule further appointments where necessary
- The clinician will advise the patient and agree firm arrangements with the patient as to how the results will be communicated and when this is anticipated (usually within 6 weeks)
- Women should be advised on any further tests or investigations that may be required based on the results
- The clinician / clinic staff will check that the patient has recovered from the procedure sufficiently and that it is safe for her to go to the waiting area for refreshments

- Dictation for correspondence to the General Practitioner (GP) and patient will take place either during or at the end of a clinic session with dictaphone and notes being taken to the appropriate secretary
- For women that are high risk for development of post-procedural infection, consideration should be given to prescribing a course of oral, broad spectrum antibiotics e.g. Uncontrolled diabetes / Immuno-supressed
- Both sides of the outcome sheet should be fully and accurately completed
- Women having the Word catheter, the removal of catheter should be arranged at the Gynaecology Assessment Unit (GAU). The designated nursing staff for the clinic will liaise with the GAU to arrange this prior to the woman leaving the unit. The woman should be given the appointment card found in the SOP for the management of Bartholin cyst/abscess.

5.15 Recovery

- Pre-procedure pain relief often is sufficient for post-procedure pain management
- However, if patient requires additional pain relief, this should be discussed with the clinician and woman should be offered additional simple analgesia, maintaining awareness of which analgesia, if any, has been taken pre-procedure
- All patients to be offered recuperation and refreshments
- Those who have had local anaesthetic or developed any complications such as vasovagal episode, a set of observations (pulse blood pressure, respiratory rate) should be obtained and recorded on the care plan at 30minutes (earlier if indicated clinically). If no concerns with the observations and the woman is well, the woman can be discharged
- The woman should be advised to rest for the remainder of the day and will be advised to return to work when ready.
- The woman should be advised to contact GAU/EPAU if she is unable to pass urine, develops temperature, become unwell or pain or excessive bruising /bleeding around the site of procedure (Vulval biopsy, excision of cysts, lesions of vulva)

5.16 Management of Complications

- Patients with significant post-operative pain can be admitted to a Gynae Ward for a period of observation and opiate analgesia if necessary.

Vasovagal episode

During the procedure a vasovagal episode may be caused by stimulation/manipulation of the cervix. This results in woman experiencing nausea vomiting near syncope or syncopal episode. The clinical signs include pallor clod clammy extremities bradycardia, hypotension and collapse (rarely cardiac arrest- asytole)

Action

- Immediately stop the procedure and remove instruments
- Reassure patient and calmly try to rouse them by talking to them
- Monitor pulse rate and blood pressure and record on observation chart
- Often it is self limiting or managed with simple measures as below
  i) Elevate the foot end of the examination couch higher than the head end of couch
  ii) Ensure fan is on and facing patient
- Once the vasovagal episode has fully recovered, completion of the procedure should be attempted with the woman's consent
- If the patient's pulse rate and blood pressure continues to remain low
  I. Follow ABSCD approach of resuscitation
  II. Give high flow oxygen 15l via non-re breath bag
  III. Call the Medical Emergencies Team on 2222 if necessary
  IV. IV access and fluids may be required
  V. Bring the Emergency Trolley to the procedure room – Atropine may be required, kept in the Emergency Drugs Box (Administer 500 micrograms IV/IM (maximum 2 doses)
- When the patient is stable, transfer to EGAU by ambulance
- The patient will remain under observation on the ward until well enough to go home

Cervical Trauma

Application or removal of instruments can result in bleeding from traumatised cervical tissue.
Signs: Steady trickle of bleeding from puncture site.
Action: Pressure is applied to the puncture site with cotton wool balls attached to sponge holders and held in place until the flow subsides. Silver nitrate sticks may be used for cauterisation. Infrequently may need haemostatic suture with vicryl 2.0

Suspected or confirmed Uterine perforation

- Perforation is suspected advancement of the dilator/ uterine sound/pipelle device beyond the anticipated uterine cavity length measurements on the scan (if undertaken) or estimated uterine size on clinical assessment. The patient may complain of increased pain and become faint or may notice increased bleeding vaginally
- Site of perforation could be fundal, cervical, posterior or anterior uterine walls. This can cause intraperitoneal/ retroperitoneal bleed or bleeding into the broad ligament
- Therefore, there may not be any apparent external bleeding and should be suspected if deterioration of the observations and/or clinical condition that is out of proportionate to the amount of bleeding.
- Management should include
  a) ABCDE structured approach in resuscitation including administration of high flow Oxygen, intravenous access, fluid resuscitation with intravenous fluid/blood; (cross matched of blood or O negative blood in the event of acute collapse and there is insufficient time for cross match blood to be available)

b) Early call for help (from a colleague, on call team),
c) Administration of uterotonics (Syntometrine ® one ampoule intramuscular injection or Ergometrine 500mcg intramuscular or intravenous injection or 250mcg of Cabaprost) to facilitate uterine contractions in order to compress any bleeding.

- If the woman is stable from the cardiovascular point of view, the woman should be blue lighted to EGAU if the MVA was performed at any other site. Inform the GAU staff and the on-call consultant prior to the transfer
- Keep in patient for at least 24hrs observations and administer antibiotics
- May need imaging with USS to look for blood in pelvis or CT pelvis/abdomen to look for free gas or intra/retroperitoneal blood which are indicative of uterine perforation
- If the woman required dilatation beyond 5 Hegar or perforation suspected during aspiration, diagnostic laparoscopy should be performed

Haemorrhage

- Although rare, this complication can occur following removal of cervical/ endometrial polyp and also as a result of complication of uterine perforation.
- Usually the bleeding is not catastrophic and often self limiting. If nor resolved spontaneously, bleeding can be arrested by direct pressure, application of Silver Nitrate or a haemostatic suture in the case of bleeding from the pedicle of the cervical polyp
- The bleeding from vulval biopsy site is secured by a haemostatic stich with vicryl rapid 3.0. Silver Nitrate or Monsol solution should not be used to achieve haemostasis following a vulval biopsy. .
- If it is following removal of endometrial polyp, may need intrauterine balloon tamponade using size 18 Foleys catheter (inflate with 30-50ml of saline). If any signs of shock, systematic resuscitation measures (ABCDE algorithm need to be instigated promptly.
- Once stabilised, woman should be transferred to Gynae Ward on a bed for consultant review, further observation and management

Local anaesthetic toxicity

May occur rarely in response to injection of local anaesthetic.

- Stop Procedure
- Call the Medical Emergency TEAM on 2222
- Bring Medical Emergency Trolley to procedure room
- See Appendix 3 for guidance of management of local anaesthetic toxicity

5.17 Follow up and Results

- The histology requests for the biopsies or any other investigations carried out for the women attending the minor gynaecological procedure clinic following internal referrals should be made under the referring consultant.

- For direct referrals by the GPs, the tests should be requested under the named consultant for the clinic
- Routine GOPD follow up appointments are not usually required following those procedures. If any follow up is required, woman should be informed this will be arranged only after discussing with the relevant consultant. The clinician performing the procedure should discuss this with the relevant consultant directly or via email. The woman should be informed the follow up is only arranged at the discretion of the responsible consultant. The decision needs to be communicated to the woman by a letter and the secretary for the relevant consultant should arrange the follow up if agreed.
- The Clinic Outcome Form should be completed for each patient by the clinician and returned to the secretary assigned to the clinic for coding and further actions
- Clinician performing the procedure clinic should dictate a letter to the GP copying to the woman outlining the indication for the procedure details of the procedure undertaken, specific advice to the patient and her GP and hospital follow up plan if any.
- The clinician should also include the name of the referring consultant so that secretary typing the letter can allocate the letter to the referring consultant to check and sign.
- Following clinic, the case notes and dictaphone must be returned by the clinician to the appropriate secretary in order for letters to be written to the patient and G.P and for collation of results
- Secretary(s) assigned to the clinic should ensure that there is a failsafe system in place where they can assure themselves that a result comes back for every sample they send to histology, that the woman is informed of her result
- In the rare event of rejection or loss of a sample, appropriate risk management steps should be followed including the Duty of Candour guidance

6 Implementation of Key Document

6.1 Plan for implementation

This guideline will be available on the Trust Intranet under Clinical Policies and Guidelines for anyone to refer to.

6.2 Dissemination

Gynaecology staff will be made aware via Gynaecology Governance.
Proposal be forwarded to the Clinical Advisory Group in the CCG and the Contracting teams acute/CCG will need to be informed as a change in pathway. The service provision will be discussed and agreed with the commissioners for funding arrangements. The primary care clinicians of the piloting GP practice will be informed via the practice manager.

6.3 Training and Awareness

Training on Word catheter for Bartholin abscess will be provided via Gynaecology governance meeting

It remains the responsibility of clinicians involved in the minor gynaecology procedure to maintain competency, keep up to date with local guidelines and service pathway.

7 Monitoring and Compliance

Any incidents are recorded on Datix and investigated by an appropriate senior member of team for the department involved.

8 Service evaluation

The appropriateness of the direct primary care referrals received from the Wyre Forest PCN during the six month pilot period will be audited to determine whether the primary care providers could directly book the appropriate cases to this clinic.
The clinic impact assessment and patient satisfaction will be evaluated at the first service review in six months. (Appendix 4,5)

9 Policy Review

Once approved the policy will be reviewed following any changes to recommendations / guidelines on a national or local level or every 3 years.

This clinic will initially be piloted for 6 months, with only one PCN group of GP's being able to refer into it. Therefore the number of referrals can be monitored and sufficient capacity to can be ensured .

Routine referrals are intended to be seen within 6 weeks from the referral and within 4 weeks for urgent referrals. Urgent referrals are those requiring urgent review but not suspected of cancer The aim of this clinic is to reduce multiple attendances to OP clinics, so the pathways of patients booked during the PILOT period will be reviewed to ensure success.

The Directorate are also conducting a review of patients currently on the Hysteroscopy waiting list to assess how many could be rebooked into the minor procedures clinic instead. This should assist the Directorate in reducing unnecessary patients referred to the OPH service and reduce overall waiting times.

10 References

Service Standards for Resuscitation in Sexual and Reproductive Health Services Jan 2013

Appendix 1
One Stop Minor Gynae Referral Form

ROUTINE REFERRAL: MINOR GYNAECOLOGICAL PROCEDURES CLINIC

BOLD INDICATES MANDATORY FIELDS

Patient Details		GP Details
Surname: **Forename:** **DOB:** **NHS Number:** **Address:** **Tel No. (1):** **Tel No. (2):**	**BMI:** **Double slot required (BMI>50 and severe mobility restriction** Yes ☐ No ☐ **Interpreter required** Yes ☐ No ☐ If yes, language	**Date Referred:** **Referring GP/Consultant :** **Address:** **Contact Tel No:**

Patient mobility

WHO Grade	Explanation of activity
0	Fully active, able to carry on all pre-disease performance without restriction ☐
1	Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light house work, office work ☐
2	Ambulatory and capable of all self-care but unable to carry out any work activities. Up and about more than 50% of waking hours ☐
3	Capable of only limited self-care, confined to bed or chair more than 50% of waking hours ☐
4	Completely disabled. Cannot carry on any self-care. Totally confined to bed or chair ☐

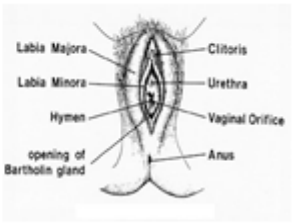
Urgency of surgery:

Urgent ☐ **Unavailable dates:**

Routine ☐

I have given the patient information leaflet on the procedure Yes ☐ No ☐

Reason for referral / Suspected Diagnosis



Surgical procedures

Vulva skin biopsy- [ ]

eg confirmation of Lichen sclerosis/planus.

For primary care referrals; please use 2 week wait referral pathway If cancer is suspected

Please precisely describe the location of the lesion; preferably using an annotated diagram

Incision/drainage of Bartholin's cyst/abscess under local anaesthesia [ ]

Removal of simple vulval cysts/skin tags (not for cosmetic reasons)/lump excision eg sebaceous cysts (<2cm) [ ]

Pipelle endometrial biopsy requiring local anaesthetic [ ]

Eg To investigate HMB in woman where outpatient pipelle failed . To investigate endometrial cells found on smear/ those

requiring repeat sampling for endometrial hyperplasia) . Not for 2 week wait pathway!	
Insertion/removal of IUCD under local anaesthetic	[ ]
Please ensure reliable contraception prior to the procedure	
Removal of polyp from the cervix	[ ]
Eg incidental finding of cervical polyps on a smear, or in a woman with PCB or IMB	
Other (Please state): eg	[ ]
PCB: postcoital bleeding IMB: intermenstrual bleeding HMB: Heavy menstrual bleeding	
Patient Alerts Latex Allergy [ ] Anti-Coagulant [ ] others [ ]	

Notes for Referrer

Considerations before Referral - the women on anticoagulants

As per the Trust guideline on- "Warfarin & other oral anticoagulants guidelines and procedures" (WAHT-HAE-002), minor Gynaecological procedures do not require interruption of warfarin as long as the INR is within the target range (Bedside INR testing should be undertaken by the nursing staff at the Minor Gynaecology Procedure clinic on the day of the attendance) . The Direct Oral Anticoagulants (DOAC) provide a similar level of anticoagulation to warfarin with a target INR of 2.5 but produce more peaks and troughs.

Therefore;

- For morning session: withhold morning dose of DOAC. For rivaroxaban or edoxabantake missed dose 2hours after the procedure as long as haemostasis is secure and 2 hours has elapsed from end of the procedure.
- For afternoon session : Take the morning dose of DOAC before 7AM and restart when next dose is due as long as haemostasis is secure, and 2 hours has elapsed from end of the procedure

Women on antiplatelet agents:

- Aspirin monotherapy or dual antiplatelet therapy (clopidogrel and aspirin) can be continued for minor gynaecology procedures where the associated bleeding risk is perceived to be very low.

Appendix 2
Appointment Letter

Dear Ms X,

We confirm the details of an outpatient appointment that has now been arranged for you to see one of the Gynaecology Doctors at the Gynaecology Minor Procedures Clinic.

Please bring this appointment letter with you to the appointment and note that you may be at the hospital for 2 hours or more for your procedure.

Your appointment is:
Clinic Location:
Hospital Site:

If you have any special requirements please contact the relevant ward/department prior to attending the hospital so that we can make reasonable adjustments.

Important information about your appointment.
Several different procedures are performed in the Gynaecology Minor Procedures Clinic; you should have received a patient information letter about the procedure you have been referred for. If you have not received this letter then please contact the department on (email address of the admin staff managing the clinic) and one can be sent to you.

The procedure will be explained fully to you at the start of your appointment to ensure you wish to go ahead. Other treatment options (where applicable and appropriate) will also be discussed with you.

A chaperone will be present during your procedure to support you and to help the clinical team member. You are also able to bring a friend or relative with you if you wish.

Please bring with you details of your medical history, any allergies to medications and a list of any medications you are currently taking (prescribed and over the counter).

It is important that you take Ibuprofen 400mg (two 200mg tablets) if you are not asthmatic and not allergic to it an hour prior to attending the clinic. Alternatively you take Paracetamol two 500mg tablets. This will help to minimise the pain and discomfort during and after the procedure that you may sometimes experience.

General information about your appointment.
Please note that if you fail to attend any agreed appointment date without notifying us, we may not be able to offer a further date and you may be discharged back to your doctor. This will help us treat other patients waiting on the list as soon as possible.

Changes to the appointment date may be feasible only if you contact us 4 weeks in advanceIf you are unable to attend the appointment due to unforeseen situation, you must contact us to inform. Failure to do so may result non offer of further appointments.

If you change your address, telephone number or GP, please let us know otherwise we will be unable to contact you to arrange your appointment.

If your condition changes whilst you are on the waiting list, please ensure you contact your GP immediately.

If you decide that you no longer require the procedure, please contact us immediately so that another patient can take your place on the waiting list.

Yours sincerely,

Appointment Co-ordinator
On behalf of Mrs C Gynaecology

Appendix 3:
Local Anaesthetic Systemic Toxicity; prevention identification and management

Toxicity relates to the free peak plasma concentration of the local anaesthetic drug and the toxic side effects occur when excessive blood levels occur. This is usually due to:

- Accidental rapid intravenous injection.
- Rapid absorption, such as from a very vascular site ie mucous membranes.
- An overdose

The systemic toxic effects due to local anaesthetic overdose primarily involve the central nervous (CNS) and cardiovascular systems (CVS). The former is more sensitive to local anaesthetics than CVS. Therefore CNS manifestations tend to occur earlier.

Early or mild toxicity:

Patients often will not volunteer information about these symptoms unless asked.

CNS

- dizziness
- tinnitus
- circumoral numbness
- abnormal taste
- confusion and drowsiness.

CVS

- tachycardia and rise in blood pressure. This will usually only occur if there is adrenaline in the local anaesthetic.
- bradycardia with hypotension will occur If no adrenaline is added

Severe toxicity:

- tonic-clonic convulsion leading to progressive loss of consciousness, coma
- respiratory depression, and respiratory arrest
- cardiac arrhythmias and hypotension. Initially hyperdynemic (tachycardia, hypertension , ventricular arrhythmias) then progressive hypotension and conduction block, bradycardia and asystole)

Reducing the risk of toxicity

- Calculate the **total dose** of drug that is allowed according to the table below
- Consider patient characteristic and alter the dose - see below
- Consider the vacularity of the site of injection

- Use the lowest effective dose
- Use the least toxic drug available. Bupvcanine more cardio toxic than lignocaine
- Local anaesthetic effect is more dependent on volume of drug injected than the total dose. Therefore if more volume is needed it is better dilute the local anaesthetic with 0.9% saline than to add more local anaesthetic and increase the dose unnecessarily.
- Add adrenaline (epinephrine) to reduce the speed of absorption.

  Adrenalin allows the increase in dose of lignocaine but not other anaesthetics. As lignocaine is a vasodilator hence increases the absorption and the toxicity. Adrenalin being vasoconstrictor it counteracts the action of lignocaine. The addition of adrenaline will make no difference to the toxicity of the local anaesthetic if it is injected intravenously

- Aspirate regularly looking for blood to indicate an accidental intravenous injection. This is not possible when dental syringe is used
- Inject the drug slowly (slower than 10ml /minute)
- Injection of a test dose of 2-3ml of local anaesthetic containing adrenaline. This will often (but not always) cause a significant tachycardia if accidental intravenous injection occurs, hence marker of intravascular injection.

Determining the optimal dose of local anaesthetic is usually based on the body weight but consideration should be given to the patient characteristics and perfusion of the site of injection (risk of rapid absorption if the site of injection is highly vascular)

Care should be exercised in obese patients and pregnant patients when calculating the optimum dose based on the body weight as it could lead to potential risk of overdose

There is increased risk of toxicity in women with severe renal impairment due to rapid absorption due hyperdynamic circulation and a reduced clearance of local anaesthetic agents

Similarly women with liver disease, clearance of local anaesthetics drugs is reduced increasing the risk of toxicity

Elderly patients are at a risk of toxicity due to reduced organ function lowering the drug clearance. Moreover, elderly patients frequently have multiple co-morbidities altering pharmacokinetics and pharmacodynamics of local anaesthetics

Adrenalin containing local anaesthetics could increase the heart rate that could impact elderly women with abnormal heart rhythms such as AF

Dose calculation rule: the number of milligrams per millilitre(**mg/ml**) =percentage concentration of solution x 10. Eg 2% lignocaine contains 2 X 10 = 20mg per ml

Drug	Maximum dose for infiltration
Lignocaine	4.5mg/kg or maximum 300 mg (70kg)
Lignocaine with adrenaline	7mg/kg
Bupivacaine	2mg/kg
Bupivacaine with adrenaline	3mg/kg
mepivacaine Hydrochloride (Scandonest® 3% plain)	7mg/kg
Prilocaine (citanest)	6mg/kg
Prilocaine **hydrochloride** and **felypressin** (3% Citanest® with Octapressin®)	8mg/kg

Treatment of Local Anaesthetic Systemic Toxicity (LAST)

If a patient shows any signs or symptoms of toxicity during injection of local anaesthetic

- **Stop the injection and assess the patient.**
- **Call for help (dial 2222)**
- **Treatment is based on the A B C D of Basic Life Support**

A. Ensure adequate **airway**, give **oxygen** 15l via nonrebreath bag
B. Ensure that the patient is **breathing** adequately. Ventilate the patient with a self inflating bag if there is inadequate spontaneous respiration
C. Start chest compressions if cardiac arrest. If circulatory failure (hypotension), gain IV access and start with intravenous fluids and may need vasopressors once the resuscitation team arrives . Treat arrhythmias occurs
D. If fitting administer IV lorazapam 4mg or rectal diazepam 10mg

Administer IV Intralipid solution - see below

Most reasonable approach to implement lipid therapy is on the basis of clinical severity and the rate of LAST. The most conservative approach of initiation of lipid therapy when anaesthetic-induced cardiac arrest that is unresponsive to standard therapy, in addition to standard cardio-pulmonary resuscitation has been criticised as infusion of lipid at the earliest sign of LAST could avoid progressing to severe toxicity

Treatment protocol for intra lipid

- Intralipid 20% 1.5 mL/kg over 1 minute
- Follow immediately with an infusion at a rate of 0.25 mL/kg/min
- Continue chest compressions (lipid must circulate)
- Repeat bolus every 3-5 minutes up to 3 mL/kg total dose until circulation is restored

- Continue infusion until haemodynamic stability is restored. Increase the rate to 0.5 mL/kg/min if BP declines
- A maximum total dose of 8 mL/kg is recommended

In practice, in resuscitating an adult weighing 70kg:

- Take a 500ml bag of Intralipid 20% and a 50ml syringe.
- Draw up 50ml and give stat i.v X 2
- Then attach the Intralipid bag to a giving set and run it .i.v over the next 15 minutes
- Repeat the initial bolus up to twice more if spontaneous circulation has not returned.

If you use Intralipid to treat a case of local anaesthetic toxicity, please report the case at www.lipidrescue.org, and ensure that a new bag of Intralipid replaces what's been used

Appendix 4 – Patient Satisfaction Survey

Patient Satisfaction Survey - Minor Gynaecological Procedures Clinic
We aim to offer all women an excellent service, and we are constantly looking for ways to improve. To help us give women a better service, we would value your feedback on your experiences before, during and after your treatment today. All survey results will be anonymous and will be used to develop and improve our services moving forward.

Before your appointment:

1. Please tell us who referred you to this clinic?

a) Your doctor

b) Hospital doctor

2. Do you understand why you have been referred to this clinic?

a) Yes

b) No

c) Not sure

3. Have you received an information leaflet with details about the procedure you are having?

a. When your doctor referred you to the clinic Yes / No / Not Applicable
b. Along with the appointment letter for the clinic sent in by post Yes / No / Not applicable

If you have received information, how satisfied are you with the information you have received on a scale of 0 - 10? (0 being not satisfied at all and 10 being very satisfied)

a. Content
b. Clarity

On the day of your appointment:

4. Did you find your privacy and dignity was catered for? Yes / No

5. Do you feel the nurses/doctors have given you all of the information you need?

a. Reasons for the procedure Yes / No
b. Information about the procedure Yes/No
c. Details on how the results or any future appointments will be communicated to you Yes/No/Not Applicable

Overall how satisfied are you on your experience of this clinic on a scale of 0 - 10? (0 being not satisfied at all and 10 being very satisfied)
Please add any further comments about your experience.

Thank you for taking the time to complete this survey.

Appendix 5 - One Stop Minor Gynaecological Procedure Clinic: Pilot Evaluation

Introduction

The One Stop Minor Gynaecological Procedure clinic was launched to:

- Enhance the patient experience
- Reduce the length of an outpatient journey
- Improve outpatient efficiency
- Negate the need for multiple outpatient attendances prior to the intended investigation/treatment being delivered.

The clinic was designed to accommodate six patients and initially intended to deliver twice a month.

Aims

The six- month service review is intended to assess the clinic performance to determine whether the key objectives of setting the clinic been met.

Objectives

To determine:

- The total no of cases referred to the Minor Gynaecological Procedure Clinic
- Percentage of cases where the intended procedure has been successfully undertaken at the Minor Gynaecological Procedure clinic
- Percentage of cases where a further referral to a different clinic or inpatient procedure had to be made due to
    a) Not been able to accomplish the intended procedure
        - Reason
        - Level of training of the clinician undertaking the procedure
    b) The performing clinician felt the referral was inappropriate
- Percentage of direct discharges following completion of intended procedure
- Proportion of women sustained immediate complications during the procedure
    a) Vasovagal syncope
    b) Uterine perforation
    c) Admission for observation - if so the reason
    d) Other
- Percentage of cases where assistance (advice or direct presence) from consultant Gynaecologist had been sought

Data collection tool

Dummy No

Name of the procedure

The level of training of the clinician undertook for the procedure

Intended procedure completed yes/no

If No- the reason

Did the patient require referral to another clinic e.g. Hysteroscopy or inpatient procedure yes/no

If yes- state why

Was the patient been discharged after the procedure yes/no

If patient was not discharged, the reason - please state

Appendix 6 – Q&A for Primary Care

The Minor Gynaecological Procedure Clinic - Q&A for Primary Care Clinicians

What is the purpose of this new service model?

The NHS Long Term Plan makes a commitment to reduce face-to-face outpatient appointments by up to a third over the next five years, setting out the ambition to provide alternative models of outpatient care.

Given the ongoing pandemic, the Gynaecology Service are trying, where possible, to minimise face-face appointments and the frequency in which patients are required to attend a hospital setting.

Introduction of a minor gynaecological procedure clinic will maximise outpatient capacity, ensure patients are referred to the most appropriate healthcare setting first time and enable patients to be seen, diagnosed, and treated during the same appointment.

Currently patients who would be suitable for the minor Gynaecological procedure clinics are seen in the Gynaecology Outpatient Department (GOPD) to receive the intended treatment/investigation or are redirected from outpatients to a hysteroscopy clinic. Many of these procedures, in fact, do not require hysteroscopy but are seen in the hysteroscopy clinic as there is no alternate clinic space available to undertake minor procedures.

A one-stop outpatient clinic will help to reduce patient waiting times; will improve patient experience and outpatient efficiency by negating the need for patients to attend multiple clinics.

How can suitable patients be referred to this clinic?

There are two sources of referral

1. Primary Care:
   - e RS referrals received from Primary Care will be triaged by a Consultant Gynaecologist and appropriate referrals will be directed to the Minor Gynaecological Procedure Clinic.
   - Direct referral may also be suggested following an Advice and Guidance request.
   - Women who meet the criteria for referral can also be referred directly into the service using the One Stop Minor Gynaecology Referral Form (Appendix 1). This will be piloted by the Wyre Forest Network of Independent Practices Primary Care Network (WFNIP PCN) and may be available to all Worcestershire PCNs in future after the initial service evaluation at 6 months.
2. Hospital Consultant

What conditions can be seen / treated?

- Pipelle endometrial biopsy (endometrial cells found on smear/ those requiring repeat sampling for endometrial hyperplasia)
- IUS/IUD insertion
- Difficult IUS/IUD removal where this was not previously attempted under local anaesthetic by the referrer
- Vulval biopsy
- Removal of simple vulval cysts/ lump excision e.g. sebaceous cysts approximately <2 cm in size
- Cervical polyp avulsion
- Treatment of Bartholin /vulval abscess
- Following a call from a GP for surgical management of abscess, On-call registrar/Gynae consultant could book the woman directly to this service if any vacant slots available within a week from referral and if the GP assessing the woman feels clinically appropriate to wait for the appointment.
-

What conditions cannot be referred to this clinic?

- 2WW referrals (including PMB)
- Women requiring outpatient hysteroscopy

Where will the clinic be based?

Initially this clinic will be based at the Women's' Health Unit at the Alexandra Hospital in Redditch. This service may be rolled out to Kidderminster Treatment Centre and Worcester Royal Hospital in the future.

How quickly patients will be seen?

The clinic is designed to accommodate 6 patients and will be held twice a month.
Routine referrals are intended to be seen within 6 weeks from the referral and within 4 weeks for urgent referrals. Urgent referrals are those requiring urgent review but not suspected of cancer e.g. endometrial cells found on a smear, painful vulval abscesses that are not responding to antibiotic therapy.

What is expected of the GP?

To refer into the Minor Gynaecological Procedure Clinic, the GP must:

1) Complete the appropriate referral form (appendix 1) thoroughly and send via eRS to the booking office team using a RAS system.
2) Provide the patient with the appropriate information leaflet.

What happens after a referral is made?

The patient will be sent an appointment letter and relevant information relating to the procedure.

How will the results/any further follow up appointments be communicated to the patient?

A copy of the clinic consultation letter will be sent to the referring GP and a copy made available to the patient. Any results and/or further appointments will be communicated to the woman by her Consultant and a copy will be sent to her GP.

What if there is a problem after the procedure - who will the patient contact?

Following the procedure, the patient will be informed to contact the Emergency Gynaecology Assessment Unit for any procedure related concerns. The patient will be advised to contact the secretary of the relevant consultant for any queries regarding results and follow up appointments.

Page/ Section of Key Document	Key control:	Checks to be carried out to confirm compliance with the Policy:	How often the check will be carried out:	Responsible for carrying out the check:	Results of check reported to: *(Responsible for also ensuring actions are developed to address any areas of non-compliance)*	Frequency of reporting:
	WHAT?	**HOW?**	**WHEN?**	**WHO?**	**WHERE?**	**WHEN?**
	These are the 'key' parts of the process that we are relying on to manage risk. We may not be able to monitor every part of the process, but we MUST monitor the key elements, otherwise we won't know whether we are keeping patients, visitors and/or staff safe.	What are we going to do to make sure the key parts of the process we have identified are being followed? (Some techniques to consider are; audits, spot-checks, analysis of incident trends, monitoring of attendance at training.)	Be realistic. Set achievable frequencies. Use terms such as '10 times a year' instead of 'monthly'.	Who is responsible for the check? Is it listed in the 'duties' section of the Policy? Is it in the job description?	Who will receive the monitoring results? Where this is a committee the committee's specific responsibility for monitoring the process must be described within its terms of reference.	Use terms such as '10 times a year' instead of 'monthly'.

11 Background

10.1 Equality requirements
The content of this policy has no adverse effect on equality and diversity.

10.2 Financial risk assessment
The content of this policy has no adverse effect on finance

10.3 Consultation
Circulated to the following for comments

Nursing staff involved with Minor Gynaecological Procedure Clinic
Consultants
Piloting GP practice
CCG

This key document has been circulated to the chair(s) of the following committee's / groups for comments;

Committee
Gynaecology Clinical Governance
Key Documents Approval Group

10.4 Approval Process
Complete as above once approved

10.5 Version Control
This section should contain a list of key amendments made to this document each time it is reviewed.

Date	Amendment	By:

Supporting Document 1 - Equality Impact Assessment Tool
To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

		Yes/No	Comments
1.	**Does the policy / guidance affect one group less or more favourably than another on the basis of:**		
	Age	No	
	Disability	No	
	Gender reassignment	No	
	Marriage and civil partnership	No	
	Pregnancy and maternity	No	
	Race	No	
	Religion or belief	No	
	Sex	No	
	Sexual orientation	No	
2.	**Is there any evidence that some groups are affected differently?**	No	
3.	**If you have identified potential discrimination, are any exceptions valid, legal and / or justifiable?**	N/A	
4.	**Is the impact of the policy / guidance likely to be negative?**	No	
5.	**If so can the impact be avoided?**	N/A	
6.	**What alternatives are there to achieving the policy / guidance without the impact?**	N/A	
7.	**Can we reduce the impact by taking different action?**	N/A	

NB:
Where an inappropriate, negative or discriminatory impact has been identified please proceed to conduct a Full Equality Impact Assessment and refer to Equality and Diversity Committee, together with any suggestions as to the action required to avoid / reduce this impact.

Advice can be obtained from the Equality and Diversity Leads in HR and Nursing Directorates (details available on the Trust intranet).

Supporting Document 3 – Financial Impact Assessment

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

	Title of document:	Yes/No
1.	Does the implementation of this document require any additional Capital resources	No
2.	Does the implementation of this document require additional revenue	Yes
3.	Does the implementation of this document require additional manpower	Yes
4.	Does the implementation of this document release any manpower costs through a change in practice	Yes
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff	No
	Other comments:	

If the response to any of the above is yes, please complete a business case and which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval