

Bristol and South Gloucestershire PCTs

Strategic Issues in Commissioning
Secondary Care Gynaecology Services
for Conditions other than Cancer

November 2004

1. Purpose

This is a brief appraisal of issues relating to commissioning of secondary care gynaecology services. Conclusions are drawn on current plans, scope for further service changes (in response to needs and national clinical guidelines) and data quality.

2. Background

A review of commissioning issues around neonates, maternity and gynaecology services was requested by the Bristol and South Gloucestershire Acute Commissioning Strategy Board. Cancer service developments were not included as they are within the remit of Avon, Somerset and Wiltshire Cancer Services Network.

This paper draws on information from:

- Interviews with lead clinicians and managers from local gynaecology services at St Michael's Hospital and Southmead Hospital.
- Comments from GP chairmen of PCT Professional Executive Committees.
- Published research.
- Local health services data.

Gynaecology is a specialism concerned with women's diseases that particularly affect reproductive organs. Other related fields of medical practice include genitourinary medicine and family planning services (increasingly known as sexual and reproductive health services). Primary and secondary care services are involved in meeting women's needs relating to all of these fields of practice, and self care is common for some conditions. The focus of this report is secondary care gynaecology services.

Gynaecological practice has changed with the introduction of less invasive interventions and increased opportunities to offer interventions in daycase and outpatient settings. Specialist practitioners (nurses and doctors) have taken on new roles in assessment and treatment of women with conditions which in the past would have been managed by a gynaecologist.

With respect to health services commissioning, this raises the following questions:

- How are needs and demands changing?
- Are there new options for meeting needs (in terms of intervention, setting and practitioner)?
- What are the best options, taking account of all dimensions of service quality: (effectiveness, efficiency, equity, access, acceptability, appropriateness) affordability and feasibility?

This paper aims to stimulate discussion on questions 1 and 2 . Work with stakeholders on question 3 could follow if this is considered a commissioning priority.

3. Population needs

Demographic changes alone are predicted to lead to a low rate of growth in secondary care gynaecology activity (appendix 1). In total, the number of admissions for BNSSG is predicted to grow by 4.8% (less than 0.5% per annum) for elective inpatients, 2.7% for non-elective inpatients and 3% of daycases over the 10 yr period of 2002-2012. Predicted growth varies between PCTs: highest growth is predicted for South Gloucestershire PCT, where elective inpatients are predicted to grow at almost 1% per annum. Minimal growth is predicted for the Bristol PCTs. Growth predicted in the 65yrs and over group may be a pressure for longer length of stay.

4. Epidemiology

Information on trends in gynaecological conditions is limited. Presenting conditions are common and open to differing definitions. Not all women with these conditions will seek health care. The following examples demonstrate that gynaecological symptoms are extremely common:

- An estimated 1 in 20 UK women aged 30–49 years consult their GPs each year with heavy menstrual bleeding. Referrals for menstrual disorders account for about 20% of all referrals to specialist gynaecology services².
- Urinary incontinence has been estimated to affect 10 – 52% of women³
- An estimated one in seven couples is affected by infertility⁴.
- Up to 80% of women are affected by menopause symptoms.
- An estimated 20% of Caucasian women over 35 yrs have fibroids, with a 3-9-fold increase in African Caribbean women⁵.

Sexually transmitted diseases are a growing problem. Chlamydia trachomatis infection is a recognised cause of pelvic inflammatory disease, infertility, as many as 40% of ectopic pregnancies, and chronic pain. As many of 70% of infected women and 50% infected men are asymptomatic, and the infection is commonest in young adults⁵.

5. Inequalities in health

Influences of social and economic factors on reproductive health, neonatal health and gynaecological cancers are the subject of a substantial body of research. Social and economic factors are relevant to non-cancer gynaecology services, although this is less clearly documented. Examples include:

- Conception rates are higher amongst under 18's living in relatively socio-economically disadvantaged areas. Numbers of terminations are higher in

² Fluid-filled thernal balloon and microwave ablation techniques for heavy menstrual bleeding. Technology Appraisal 78 NICE April 2004 <http://www.nice.org.uk/pdf/TA078fullguidance.pdf>

³ Full guidance on the use of tension free vaginal tape (GynecareTVT) for urinary incontinence. Technology Appraisal Guidance no 56. NICE February 2003. http://www.nice.org.uk/pdf/56_TVT_full_guidance.pdf

⁴ Lyons MW et al. Contraception, induced abortion and fertility services. In: Health Care Needs Assessment. 1st series 1994 <http://hcna.radcliffe-oxford.com/famplanframe.htm>

⁵ Chief Medical Officer's Expert Advisory Group. Main report of the CMO's expert advisory group on Chlamydia trachomatis. London: Department of Health, 1998 <http://www.dh.gov.uk/assetRoot/04/06/22/64/04062264.pdf>

these areas (although the proportion of all conceptions ending in TOP can be lower than more advantaged areas)⁶.

- Ethnicity. African women who have had female circumcision are noted to have high levels of health needs by general practitioners, and are at risk of complications including incontinence and sexual dysfunction. There is concern that conventional hospital based services are less acceptable to these women, and that community gynaecology would be more acceptable and accessible.

6. Commonest gynaecology consultations

A national health needs assessment published in 1997 noted the following commonest consultation categories recorded by GPs⁷:

- Candidiasis; disorders of menstruation; menopause and post-menopause; pain associated with female organs; pelvic inflammatory conditions.

Main inpatient categories were:

- Disorders of menstruation; disorders of the cervix; genital prolapse; menopause and post menopause; uterine leiomyoma (fibroids).

Commonest emergency conditions were:

- Early pregnancy loss and threatened miscarriage; ectopic pregnancy; ovarian cysts; pelvic inflammatory disease; Bartholin's abscess.

These descriptions are outdated as outpatient clinics have increasingly become the setting for procedures formerly provided as daycase or inpatient procedures.

Specialist clinics are provided eg subfertility; urogynaecology ; oncology. Lack of outpatient data coded for diagnosis and procedure increasingly limits the value of using routine data to profile gynaecology service activity.

7. Secondary care data on demand and supply

Secondary care activity data provides a limited picture of the levels of demand met in the recent past. There are important constraints:

- Procedures conducted in outpatient (as opposed to daycase or inpatient) settings are not coded. Therefore a procedure that has shifted to an outpatient setting will spuriously appear to have declined in number. In reality it may be as common or commoner (as access has improved).
- Coding changes may similarly produce a misleading picture of decline when in fact a procedure has simply been reclassified (producing growth under another code).
- As an indicator of need, secondary care data does not in any way record need met in other settings, and the volume of cases recorded reflects its capacity to supply, rather than meet all needs.

⁶ Influences on young mothers decisions about abortion and motherhood. Joseph Rowntree Foundation 2004. ISBN 09583084. www.jrf.org.uk

⁷ Wolfe C. Gynaecology. In: Health Care Needs Assessment; chapter 8, 2nd series. 1997. <http://hcna.radcliffe-oxford.com/chaptersframe.html>

Appendix 1 provides data analysis for the former Avon population over a 6 year period (1998/99-2003/04). In summary the analysis shows:

- Inpatient workload for this population is stable and overall there has been a decline in the number of daycases.
- Outpatient attendances have grown from 36,886 in 1999/00 to 39,771 in 2003/04. Between 2002/03 and 2003/04 attendances from referrers other than GPs approximately doubled (from 1872 to 3684) at all trusts in the former Avon area. 1484 of 1855 attendances in this category at UBHT in 2003/04 were attendances at the Early Pregnancy Assessment Clinic (which was first recorded in February 2003). New to follow up ratios have been stable at 2.3 – 2.4.
- Procedure analysis shows substantial declines in some common procedures: hysterectomy, dilatation and curettage, termination of pregnancy and sterilisation. Clinical advice confirms that these trends have been observed and are not data artefacts. For the first three of these procedures, reductions are consistent with the introduction of alternative interventions. Reasons for the reduction in sterilisations could include improved access to a range of contraceptive methods and advice (including vasectomy), and changes in the preferences of men and women of reproductive age. The proportion of 45 to 49 year old women using sterilisation as a method of contraception has fallen nationally from 50 per cent in 1988/89 to 44 per cent in 2002/03⁸.
- The total number of procedures recorded has not declined, despite some common procedures declining.
- Data quality issues. Lack of coding of outpatient procedures and diagnosis is a problem in assessing current service provision. Changes in coding practice may underlie some apparent changing trends in inpatient and daycase activity. Outpatient procedures and investigations eg trans-abdominal and trans-vaginal ultrasounds performed by gynaecologists may not be counted.

8. Changes in gynaecology services at UBHT and NBT

At UBHT, achieving access targets has been challenging and continues to be so for outpatient waiting times. Daycase rates are high (and against the pattern for Avon, numbers of daycases have not declined). There has also been an increase in daycase procedures now offered in the outpatient setting. Funding is constrained and bed closures have been a source of pressure on the service.

Early pregnancy clinics have been established for about a decade, and have had a major impact on out of hours gynaecology workload and admissions. GPs can advise women with early pregnancy problems eg bleeding to attend the clinic rather than referring for emergency admission. Whilst the service reduces emergency admissions, it does involve increased outpatient attendances as women attend for an initial consultation and scan, with a follow up appointment and scan one week later. The management of ectopic pregnancy has also changed to a more conservative approach, with fewer procedures performed.

Reductions in hysterectomy have been noted, but the reason for the decline could reflect a number of factors rather than the introduction of alternative interventions alone eg changing preference amongst women, different practice for the range of indications (which include cancer, prolapse and heavy menstrual bleeding). Clinical

⁸ General Household Survey. Living in Britain 2002.
<http://www.statistics.gov.uk/cci/nugget.asp?id=326>

opinion on the scale of this change in day to day practice is mixed, some observing a decline whilst others are less certain.

Requests for gynaecological opinions on women with abdominal pain (seen in Accident and Emergency Departments or admitted as general surgical emergencies) were thought to be increasing at UBHT.

Changes in the management of outpatients are being explored eg development of nurse follow up. A nurse practitioner-led rapid access clinic is being explored as a means to avoid some emergency admissions and reduce emergency lengths of stay. Additional equipment and staff would be needed to provide this. The possibility of providing 3 dedicated emergency gynaecology lists per week at St Michael's is being explored. This could improve management of patients needing surgery within 24 hrs rather than immediately. There may be scope to rationalise the current pattern of outreach outpatient services as community hospitals are developed.

UBHT notes that survival of women with complex conditions into adulthood eg congenital heart disease, childhood is increasing demand for more specialist obstetric and gynaecology services, and will increase needs for high dependency and intensive care.

Recent gynaecology staffing problems were noted: participation in AGW benchmarking is underway and thought likely to improve understanding and management of these. UBHT highlighted previous benchmarking showing the Obstetrics and Gynaecology service to be low cost, with the lowest number of WTE consultants (compared to other teaching hospitals).

Length of stay is being reduced through provision of new procedures. Thermal endometrial ablation is probably reducing the number of hysterectomies at NBT, and enables greater choice for women (see graph 3 in appendix 1). UBHT has stopped doing microwave endometrial ablation on the grounds that NICE funding has not been provided. This reduces choice for women and is potentially wasteful of resources in cases where hysterectomy is the alternative.

All gynaecological services for NBT are provided in a new unit at Southmead incorporating outpatient, daycase and theatre facilities, except for one outpatient clinic still provided at Frenchay. More 'one-stop' provision has been achieved as gynaecologists undertake scanning rather than radiographers.

9. Commissioning plans

- **Services for termination of pregnancy**

TOP is the commonest gynaecological procedure recorded for the PCT populations. Long waiting times and relatively late terminations in Bristol and South Gloucestershire are reflected in very low rankings for local PCTs in national performance ratings. Both trusts are working with PCTs to tackle delays in access to termination of pregnancy (TOP). Delays in assessment and lack of access to a full range of TOP procedures were identified as the main problems in a service evaluation⁹. Work is underway to implement

⁹ Report of the BNSSG TOP Working Group. Services for Termination of Pregnancy. July 2004

new commissioning arrangements¹⁰. UBHT is changing the assessment service, increasing the number of available appointments and reducing the number of unstaffed clinical sessions. The appointment of a lead Consultant in Sexual and Reproductive Health to provide clinical leadership across the TOP care pathway is underway at NBT.

- **Infertility services**

NICE published guidance on the management of fertility problems in 2004¹¹. In response to recommendations on eligibility and availability of in vitro fertilisation, the Secretary of State for Health has asked for initial implementation to allow all eligible couples to receive one full cycle of IVF. This will require local service development.

Implementation of the NICE guideline in BNSSG has been led by North Somerset PCT. Work is underway to reach agreement on how the number of cycles of infertility treatment can change by April 05. NHS funded IVF is provided at NBT only. The service needs confirmation of PCT intentions regarding implementation of this guideline. The current service level agreement is for provision of 3 cycles for 10 couples.

To prevent infertility, action is needed to reduce the growing problem of sexually transmitted diseases. The Government has published a white paper on public health which includes commitments to chlamydia screening covering all of England, and waiting times for genitourinary clinic appointments being 48 hrs or less, by March 2007¹². These commitments are part of a wider strategy to improve services, access and communication with the public on improving health.

- **Gynaecology services at South Bristol Community Hospital**

UBHT has put forward a list of procedures that could transfer to the South Bristol Community Hospital as part of the Bristol Health Services Plan. Planning for this service development needs to take account of training needs for clinical staff eg junior doctors.

- **Opportunities for further change**

Maximise capacity to assess and manage conditions that do not necessarily require referral to specialist services. There is a wider range of options for managing heavy menstrual bleeding (HMB) in primary and secondary care than ever before. This condition is estimated to account for 12 - 20% of gynaecology referrals each year^{13,1}.

¹⁰ B Coleman. Termination of pregnancy options paper. Bristol North PCT September 2004.

¹¹ Fertility: assessment and treatment for people with fertility problems. National Institute for Clinical Excellence. London 2004. <http://www.nice.org.uk/page.aspx?o=104435>

¹² Choosing health: making healthy choices easier. Department of Health. London 2004.

http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4094550&chk=aN5Cor

¹³ The effectiveness of the mirena coil (Levonorgestrel-releasing intrauterine system) in menorrhagia. A West Midlands Development and Evaluation Service Report. December 1999. <http://www.publichealth.bham.ac.uk/wmhtac/pdf/menorrhagia.pdf>

'Many women who are referred to secondary care for HMB will eventually undergo hysterectomy. More than 47,000 hysterectomies were carried out in the NHS in England in 2000–01. It is estimated that HMB was the presenting complaint in about half of these cases. Furthermore, about half of all women who have a hysterectomy for HMB are believed to have a normal uterus removed'¹.

Ensuring full implementation of RCOG guidelines¹⁴ in primary as well as secondary care would maximise choice of therapies offered to women and could reduce referrals to secondary care⁸. Medical treatments and Levonorgestrel Progestogen-only Intra-uterine devices (also known as Mirena IUS) can be effective in reducing menstrual blood loss. The latter can be fitted by trained GPs, specialist family planning services and secondary care. Maximising use of these treatments may enable further reductions in the number of hysterectomies⁸. The guidelines note that 'hysterectomy is an established, effective treatment for menorrhagia' but 'the widespread use of hysterectomy as a treatment for menorrhagia should be balanced against its potential mortality and morbidity.' Mortality is estimated as 1 in 2000 hysterectomies. A randomised controlled trial is starting to assess 10 year outcomes and cost effectiveness of Levonorgestrel Intra-uterine devices compared with other treatments, funded by the NHS R&D Health Technology Assessment Programme.

The National Enhanced Services scheme offers one mechanism for increasing choice and access to primary care management of menorrhagia. The NES for Intra-uterine Contraceptive Device (IUCD) Fittings aims to ensure that the full range of contraceptive options is provided by practices to patients. The outline of the service includes: the fitting, monitoring, checking and removal of IUCDs as appropriate; production of an up-to-date register of patients fitted with an IUCD; chlamydia screening before insertion of the IUCD; regular patient assessment; provision of information at the time of counselling; and the use of LNG-IUS for the management of menorrhagia in primary care¹⁵. For any particular NES, local PCTs decide whether implementation fits with local needs and priorities.

Primary care prescribing data on the number of Levonorgestrel Intra-uterine devices (LIUDs) prescribed in Bristol and South Gloucestershire shows an upward trend between August 2001 and July 2004 (see graph 4 in appendix 1). NBT data shows a decline in the number of hysterectomies during the same period. A causal relationship cannot be assumed between these two trends, but it is clear that patterns of service provision have changed. Nevertheless it was suggested during this review that there may be further scope to promote alternatives to surgical management of heavy menstrual bleeding. The ratio of LIUDs to other forms of IUD prescribed by practices in S Glos was 2:1, and approximately 1:1 in Bristol. In some practices LIUDs now outnumber other forms of IUDs prescribed, whilst a minority have no IUD prescribing recorded for Sept 03 - Aug 04¹⁶. NBT

¹⁴ The initial management of menorrhagia. RCOG 1998.

<http://www.rcog.org.uk/guidelines.asp?PageID=108&GuidelineID=28>

The management of menorrhagia in secondary care. RCOG 1999

<http://www.rcog.org.uk/guidelines.asp?PageID=108&GuidelineID=29>

¹⁵ RCGP information on enhanced services at

<http://www.rcgp.org.uk/information/publications/information/PDFInfo/06-AUG04HTML/V.SERVICECAT.asp>

¹⁶ PACT prescribing data. Avon IM&T.

observes good quality of primary care in Bristol, with many women having been offered a comprehensive choice of treatments prior to referral – and hence some doubt about the scope for further change.

More diagnostic and therapeutic procedures undertaken in daycase or outpatient settings

and

More diagnostic and therapeutic procedures undertaken by practitioners other than a consultant gynaecologist

It is clear that services are being actively developed in these respects, but there is scope for further changes. Reference has already been made to UBHT proposals for procedures suitable for provision at South Bristol Community Hospital, and to plans for changes in commissioning of termination of pregnancy that will lead to earlier intervention at non-acute hospital settings. Nurses are already taking a greater role in the colposcopy service (although the service is still consultant led and largely consultant-delivered).

Whilst referrals with a high probability of needing complex surgery should continue to only be referred to consultants, many common presenting complaints could be assessed (and in some cases managed) by other appropriately trained practitioners with access to appropriate facilities eg ultrasound scanning.

Suggestions included:

- a GP provided service for HMB might have benefits in encouraging less reliance on surgical management (discussed above);
- Abnormal bleeding and post menopausal one stop clinics;
- Incontinence: role for nurse specialists as incontinence advisors;
- Infertility: initial work-up by GPs is already encouraged but might be further developed by a GPSI.
- Termination of pregnancy: assessment and provision of early TOPs.
- There may be potential for nurse practitioners to provide outpatient hysteroscopies.

There is no evidence base for informing commissioning decisions on which practitioners are best placed to provide these services. Some clinicians are concerned about community provision of all but the simplest procedures by non-consultants. In each case it is important to assess the costs, risks and benefits: some clinicians feel risks are higher for some procedures when performed in the community. Community gynaecologists would be an ideal source of professional support for community based practitioners developing gynaecology services.

Given the need to develop more local and accessible gynaecology services for women with high levels of health need and to provide area wide leadership for TOP services, there was support for a better developed community gynaecology service. This was expected to have a significant impact on the way that local health needs are met in community settings, and in improving access to all gynaecology services for women with relatively high needs. The single Consultant in Sexual Reproductive Health post currently being

established was welcomed but considered insufficient to meet all of the above service demands.

Monitoring the changing pattern of secondary care activity. Information systems for recording outpatient procedures and diagnosis are inadequate as a means of understanding current service profiles and monitoring changes in service provision.

10. Risks related to further service changes

This analysis suggests that specialist gynaecology workloads may remain stable or contract as certain procedures decline in number and/or there is a shift in the setting and practitioner involved. Laparoscopic procedures are expected to become more common (with increased operative time but faster recovery and shorter inpatient stay). Some very specialist work may increase eg meeting needs of teenage and adult women who have had congenital heart disease or been treated for cancer during childhood, and tertiary work relating to rare conditions like intersex. There are risks:

- Potential reduction in specialist gynaecology training opportunities (and opportunities for established gynaecologists to maintain skills) – although it was also noted that increasing numbers of community gynaecologists are being trained, with good potential to support a move towards community based services.
- Training and clinical governance requirements must be met for those practitioners taking on new roles.
- Obstetrics and Gynaecology are currently interdependent. Changing the balance of work from each specialty in consultant job descriptions may have an impact on career choices and consequently in ensuring appropriate staffing for both specialties.

These risks must be managed through joint strategic planning by primary and secondary care services.

11. Conclusions

This brief appraisal of strategic commissioning issues for gynaecology services has identified:

Demography based predictions indicate modest growth in specialist gynaecology activity during 2002 - 2012, although other factors may lead to higher rates of growth. Prevention of sexually transmitted diseases that cause infertility and other gynaecological complications is a high priority. Numbers of women with complex conditions may increase as survival from childhood cancers and chronic diseases has improved.

Continuing work to meet national targets and policies, and to meet local needs. Termination of pregnancy is the commonest gynaecological procedure of all, and is a high priority for further change given the very low national ranking of local services for access to early terminations. Infertility services present problems in terms of the gap between provision and need. The needs of ethnic minority groups were highlighted eg complications arising from female circumcision.

Services are already changing in terms of the types of procedures offered, and the settings in which they are offered now. Opportunities for further changes include:

- Ensuring full implementation of RCOG guidelines on heavy menstrual bleeding, so that women are offered a full range of treatments, and further potential for reducing referral to specialist services and numbers of hysterectomies can be realised.
- Developing other services in community settings, and specialist service provision by other practitioners, where option appraisal predicts net benefits in terms of costs, quality and risks. Suggestions include clinics for abnormal bleeding, incontinence, menopause, initial investigation of infertility, termination of pregnancy and hysteroscopy.

A more community focussed gynaecology service could benefit women with the greatest health needs. Professional leadership need to be considered eg through development of community gynaecology, and the impact on professional training and updating for gynaecologists in all settings.

Routine data indicating changing trends in specialist services, notably reductions in some common procedures, increases in some categories of outpatient attendance, relatively constant inpatient workloads (with scope for further reduction in length of stay as more laparoscopic procedures are used) and a decline in daycases. Lack of coded outpatient data limits the value of this analysis, giving a spurious picture of the number of gynaecology interventions provided.

Dr Christine Hine
Consultant in Public Health
Bristol and South Gloucestershire PCTs

November 2004

Appendix 1

Gynaecology services: data analysis

Table1 Projected Growth In Gynaecology Activity based on demographic changes only, 2002 – 2012

UA		Ages 0 - 15	Ages 16 - 24	Ages 25 - 44	Ages 45 - 64	Ages 65 - 74	Ages 75+	All Ages
South Gloucestershire PCT	Non-elective	-6.1%	20.2%	-4.2%	15.6%	26.7%	30.6%	4.1%
	Elective IP	-6.1%	20.2%	-4.2%	15.6%	26.7%	30.6%	9.6%
	Day Cases	-6.1%	20.2%	-4.2%	15.6%	26.7%	30.6%	4.9%
Bath and North East Somerset PCT	Non-elective	-3.9%	17.4%	-2.0%	8.4%	14.7%	3.3%	3.5%
	Elective IP	-3.9%	17.4%	-2.0%	8.4%	14.7%	3.3%	5.4%
	Day Cases	-3.9%	17.4%	-2.0%	8.4%	14.7%	3.3%	4.3%
Bristol PCTs	Non-elective	-12.7%	4.9%	3.4%	-1.5%	-2.6%	-10.6%	3.1%
	Elective IP	-12.7%	4.9%	3.4%	-1.5%	-2.6%	-10.6%	0.8%
	Day Cases	-12.7%	4.9%	3.4%	-1.5%	-2.6%	-10.6%	2.4%
North Somerset PCT	Non-elective		8.4%	-9.7%	12.2%	34.3%	13.8%	-1.6%
	Elective IP	-2.2%	8.4%	-9.7%	12.2%	34.3%	13.8%	7.1%
	Day Cases	-2.2%	8.4%	-9.7%	12.2%	34.3%	13.8%	1.2%
Avon PCTs	Non-elective	-8.2%	9.6%	-0.6%	6.9%	14.7%	4.1%	2.7%
	Elective IP	-7.3%	9.4%	-1.3%	7.4%	15.4%	7.7%	4.8%
	Day Cases	-8.3%	10.4%	-1.5%	7.3%	16.1%	4.4%	3.0%

Table 2 Female population aged 15yrs and above. 2003 GP registered population.

No of women	15 - 19	20 - 24	25 - 29	30 - 34	35 - 39	40 - 44	45 - 49	50 - 54	55 - 59	60 - 64	65 - 69	70 - 74	75 - 79	80 - 84	85+	Total
S Glos	7333	6871	7870	10076	11272	9783	8349	8052	8505	6467	5667	5096	4020	3299	2784	105444
B Nth	7916	9851	9006	9283	9135	7888	6725	6251	5865	4525	3944	4133	4089	3729	3317	95657
B SW	5898	10598	8772	8110	7141	6081	5244	4752	4673	3702	3498	3331	2990	2484	2185	79459
Total	21147	27320	25648	27469	27548	23752	20318	19055	19043	14694	13109	12560	11099	9512	8286	280560

Source: Exeter System, Avon IM&T. Available from http://nww.avon.nhs.uk/phnet/data2/population/registered/exeter_03.xls

Analysis of routine secondary care activity data

The following comments relate to data on Avon Health Authority residents using services at NBT, UBHT, RUH and Weston during the six year period 1998/99 – 2003/04.

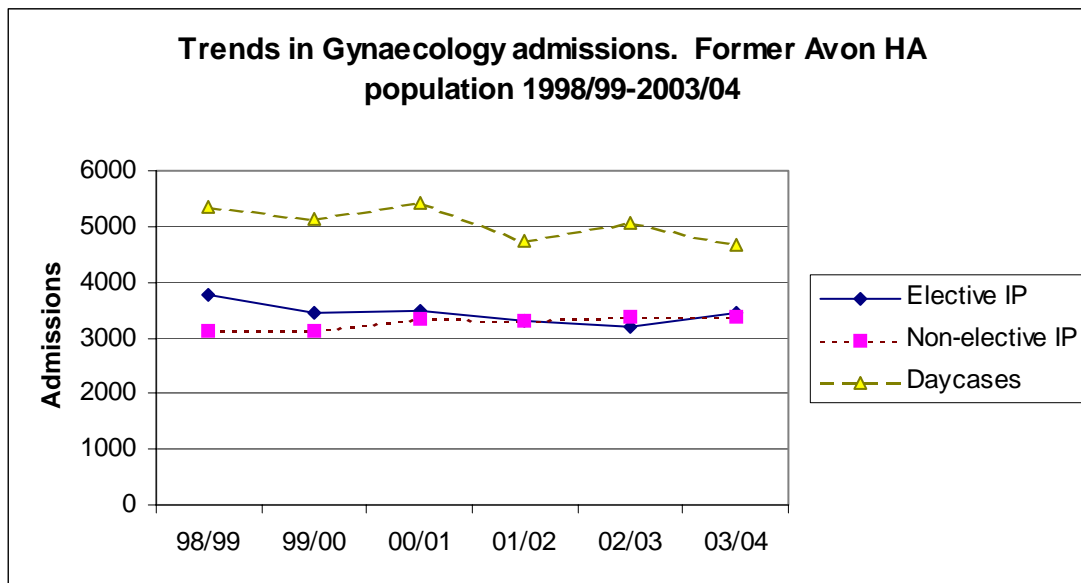
Total inpatient activity is stable, whilst daycases have fallen. Inpatient LOS has not fallen (Graph 1).

Total elective inpatient activity shows little change in the number of FCEs, admissions, beddays or average length of stay (LOS).

Non-elective inpatients show a small rise in FCEs and beddays, and no change in average LOS (1.7 days). UBHT has a substantially higher non-elective volume of activity than NBT (1951 compared with 1060 FCEs respectively in 2003/04). There are more missed abortions recorded at UBHT.

Daycases in total have fallen. Numbers have fallen at NBT and RUH. No change is seen for Weston, whilst numbers at UBHT have fluctuated. As noted, a shift of some procedures to outpatients is likely to have contributed to this pattern. One specific contributory factor in the apparent fall in the number of terminations of pregnancy (TOPs) recorded is the increased use of early medical terminations, which are not recorded as daycase procedures. Referrals out of area of TOP patients who would previously have been treated locally may also contribute.

Graph 1



Source: admitted patient data sets. Patient using NBT, UBHT, Weston and RUH only.

Outpatient activity

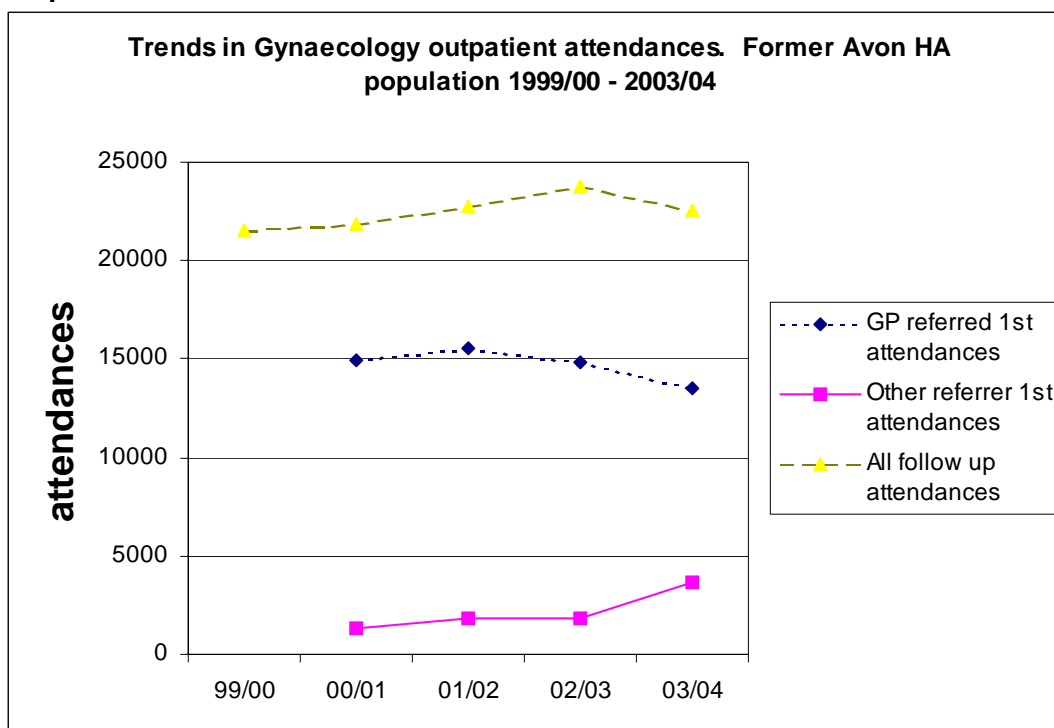
GP referred first attendances have fallen.

'**Other referrer**' first attendances approximately doubled between 2002/03 and 2003/04 (from 1872 to 3684) at all trusts in the former Avon area. 1484 of 1855 attendances in this category at UBHT in 2003/04 were attendances at the Early Pregnancy Assessment Clinic (EPACs) first recorded in February 2003. As EPACs have been running at UBHT for about a decade, it is not clear why this activity has not appeared in the data set before now. For all trusts the rise in 'other referrer' attendances is partly offset by the fall in GP attendances, hence there may have been an underlying change in data coding.

In total, all first attendances increased from 15354 in 1999/2000 to 17161 in 2003/04.

Follow-up attendances have grown from 21532 to 22610 over this period. The ratio of new to follow up attendances has been stable at 2.3 –2.4.

Graph 2



Source: admitted patient datasets. Patients using NBT,UBHT, Weston and RUH only.

Commonest diagnoses and procedures

This analysis is based on first FCEs (for diagnoses) and all FCEs (for procedures) recorded for admissions under the care of gynaecologists.

Non-elective

The commonest diagnosis was abdominal pain (583 of 3384 non-elective FCEs in 2003/04). 'Complications following surgical/medical care' was 7th commonest diagnosis (151 FCEs for Avon – about 5% of non-elective FCEs).

Table 3 Emergency first FCEs in specialty of Gynaecology. Total numbers and most common diagnosis. Avon Residents presenting at NBT, UBHT, RUH and Weston, 1998/9 to 2003/4

Diagnosis	1998/9	1999/0	2000/0	2001/0	2002/0	2003/0
Abdominal pain	550	557	582	601	577	583
Spontaneous abortion	412	395	379	363	374	386
Abnormal products of conception	302	341	300	329	295	290
Excessive vomiting in pregnancy	155	140	188	232	232	231
Ectopic pregnancy	169	189	136	190	205	152
Haemorrhage in early pregnancy	125	160	132	168	197	217
Complications following surgical/medical aftercare	132	114	117	129	131	151
Medical abortion	120	97	96	79	127	101
Cysts of ovary/corpus luteum	117	98	107	103	102	81
Abnormal uterine & vag bleeding	95	90	102	92	69	84
Diseases of Bartholin's gland	64	84	91	79	78	80
Other	878	860	1128	942	983	1028
	3119	3125	3358	3307	3370	3384

Source: Avon IM&T Consortium. Hospital inpatient data sets.

Two emergency diagnoses have increased at NBT and UBHT over these 6 years: haemorrhage in early pregnancy (doubled from 96 to 188) and complications following surgical/medical aftercare (94 to 143 FCEs). Note that the problem of under-recording of gynaecological procedures in outpatients prevents reliable estimation of the rate of first FCEs for complications in terms of the total number of procedures being performed.

All settings (non-elective, elective and daycase)

Substantial falls are seen in the recording of several common procedures during 1998/99 – 2003/04:

Sterilisation – from 1048 to 341. Alternative procedures are offered eg Mirena IUS.

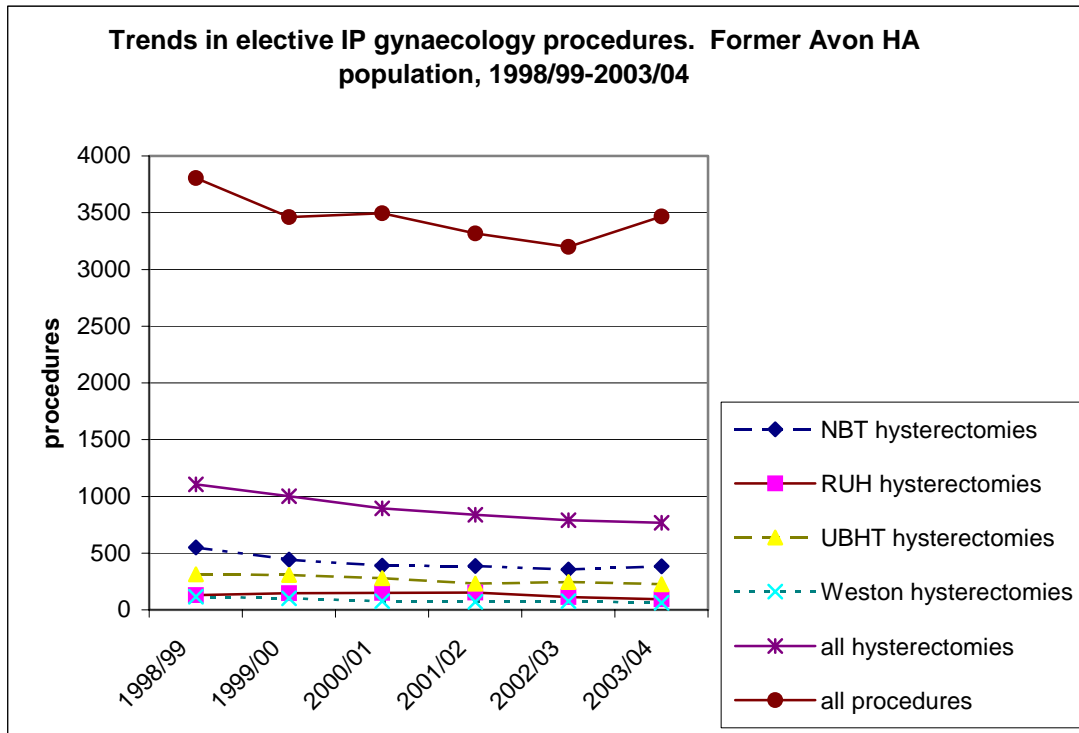
Hysterectomy – from 1107 to 766 (graph 3)

D&C – from 379 to 184. Clinical advice is that this procedure is now obsolete, and that these procedures have been miscoded.

Graph 3 shows a decline in the number of elective inpatient hysterectomies.

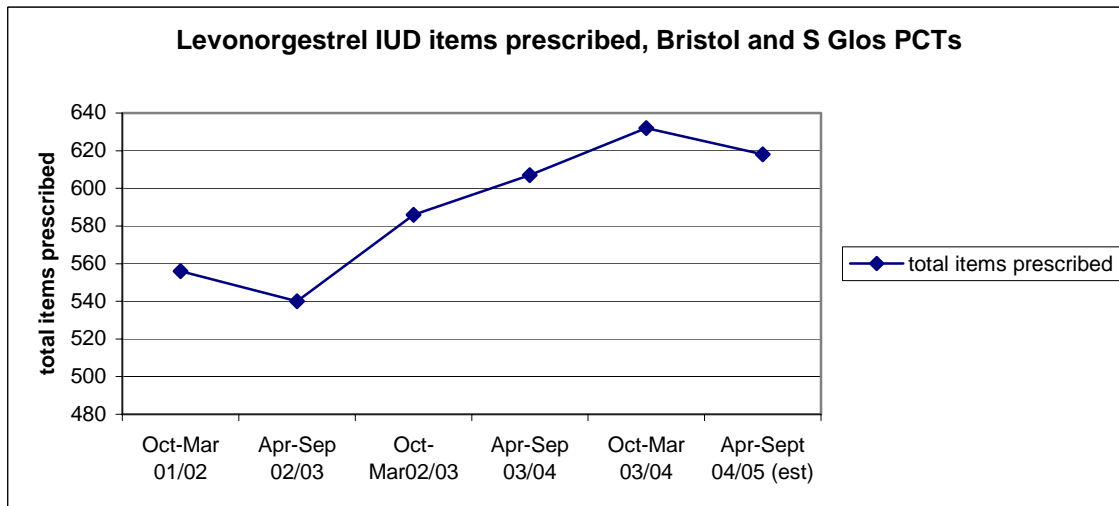
Primary care prescribing data shows an increase in use of Levonorgestrel Intra-uterine devices during 2001 – 2004 (graph 4). These are a relatively new treatment for heavy menstrual bleeding, expected to reduce demand for hysterectomies, but the optimum population uptake is not known.

Graph 3



Source: admitted patient data sets. Patient using NBT, UBHT, Weston and RUH only.

Graph 4



Source: PACT data. Estimate for Apr – Sept 04/05 assumes prescribing rate of 100 items per month for Sept 04.

Amongst NHS family planning clinic attenders nationally, IUDs (of any kind) have been used by 5-6% for the past decade¹⁷. The contraceptive pill, sterilisation and the condom are the three most commonly used methods of contraception used in the UK. The contraceptive pill

¹⁷ NHS Contraceptive Services England 2003/04. Department of Health Statistical Bulletin 2004/17 <http://www.publications.doh.gov.uk/public/sb0417.pdf>

was used by 26 per cent of women aged 16 to 49 in 2002/03. Sterilisation (of either the woman or her partner) was used by 21 per cent, and the male condom by 19 per cent.

Growth is recorded in:

Colporrhaphy – from 293 to 402 FCEs.

Vaginal excision of lesion of uterus – from 26 to 123 FCEs, recorded almost entirely at NBT

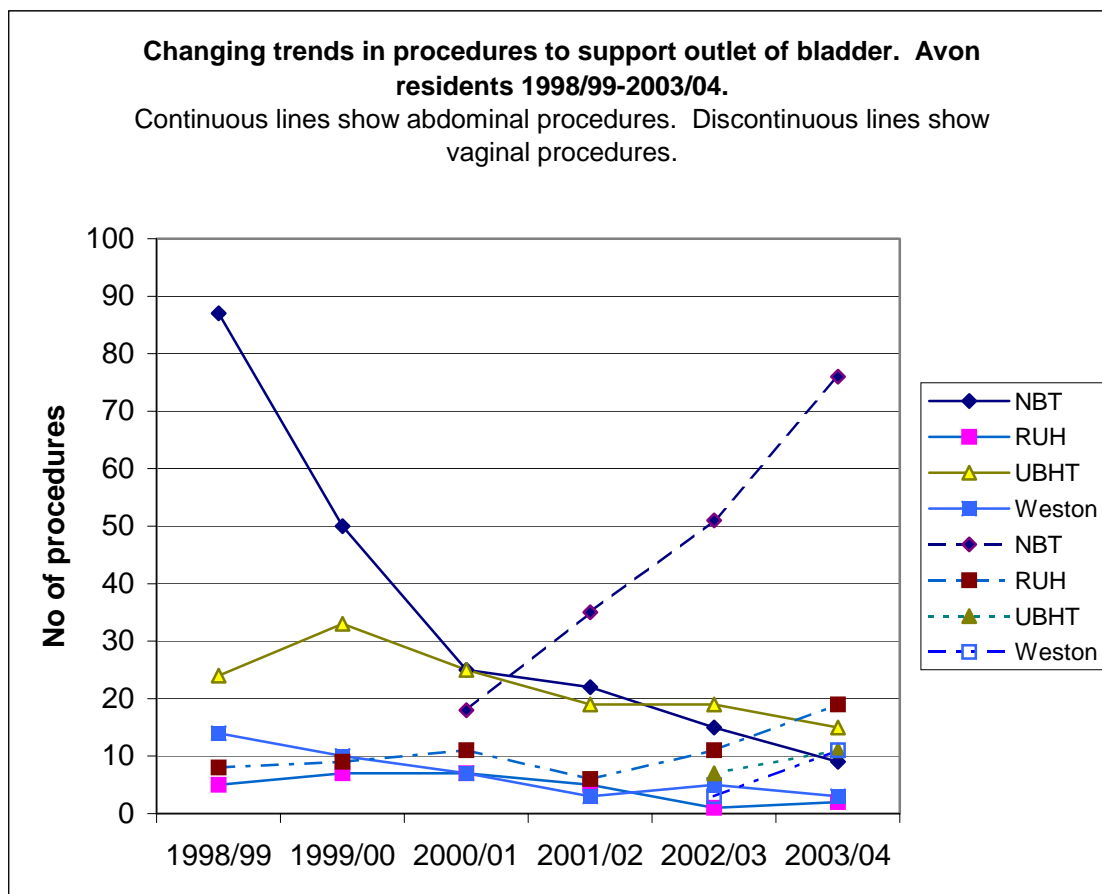
Salpingectomy/oophorectomy – from 244 to 360 FCEs.

Changes in coding and/or clinical practice are seen:

Destruction of lesion of cervix is recorded less, and excision of lesion of cervix is recorded more frequently.

'Abdominal procedures to support outlet of female bladder' is recorded less, whilst vaginal procedures are recorded more frequently. Clinicians advise that this reflects change in clinical practice as use of tension-free vaginal tape (TVT) has been introduced (graph 5). Use of TVT is supported by NICE guidance as an acceptable option for treating stress incontinence.

Graph 5



Source

e Avon IM&T Consortium. Hospital inpatient data sets.

CE Hine, Public Health, Bristol & S Glos PCTs

J Coulson, Avon IM&T Consortium

Nov 2004

