

Bure Clinic
James Paget Hospital

13 June 2005

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1.0 Executive Summary

The Bure Clinic at James Paget Hospital participated in a national review of genito urinary medicine (GUM) services in June 2005. A multi-agency review of the GUM element of the service was carried out and this report is written to inform the context in which this service operates, and to highlight potential areas for further development.

The overarching impression of this clinic was of an experienced and committed team who provide a high quality patient focused service. A single-handed consultant has led the service. This quota is inadequate for the diverse needs of this health economy. There are now plans to recruit an additional consultant and it is envisaged that this additional resource will enable significant development within the service and to the wider community.

The team has introduced some modernisation initiatives to make the most of the existing resources and has been particularly successful addressing the new and follow up ratio for patients, but there are constraints within the clinic that must be addressed to ensure this service is able to meet future demands. Patients have to wait between three and six weeks to access this clinic which is an unacceptably long waiting time for a GUM service. There is scope to further modernise aspects of service delivery including the development of some multidisciplinary team (MDT) roles. It is clear that demand for GUM services is likely to continue to increase, and future service developments will need to be made within the context of a local sexual health strategy. There is potential to build a strong network of services in Great Yarmouth and Waveney with the GUM service at the hub of this network, but restrictions created by the physical environment together with the need for additional consultant resource and the need for a stronger multidisciplinary approach to care will be essential components for success.

This report outlines the process for the review of GUM services at James Paget Hospital. It aims to identify the potential priorities for service modernisation and capacity development for this GUM clinic, offer feedback on the review's findings and makes key recommendations. The recommendations may also be useful for Norfolk, Suffolk & Cambridgeshire Strategic Health Authority (SHA) in relation to its performance management of Great Yarmouth PCT & Waveney PCT.

2.0 Introduction

The demand for sexual health services exceeds supply nationally. Genito Urinary Medicine (GUM) clinics are currently working at above capacity and uptake of services continues to rise. GUM service delivery should be informed by *The national strategy for sexual health and HIV* (Department of Health (DH), 2001) and its implementation action plan and take note of the conclusions and recommendations of the House of Commons Health Select Committee report on sexual health (2003). Service planning and delivery should be supported by use of the guidance set out in the toolkit for primary care trusts (PCTs) and local authorities, *Effective commissioning of sexual health and HIV services* (DH, 2003) and resourced by PCTs to meet local needs. The recently published Public Health White Paper, *Choosing Health* (DH, 2004) outlines new targets for GUM services including a 48-hour access target. To support these initiatives at local level, and given the levels of concern around capacity and resources for GUM, the need to undertake a national service review was identified as a priority by the DH and representatives of the British Association for Sexual Health and HIV (BASHH).

The national review has been commissioned by the DH as part of its implementation action plan for *The national strategy for sexual health and HIV*. The Medical Foundation for AIDS

& Sexual Health (MedFASH), a charity supported by the British Medical Association, manages the review as a project. A central project team is facilitating a programme of review visits to all GUM clinics in England.

3.0 Terms of reference

The terms of reference for the review were:

- to undertake a multidisciplinary assessment of Bure clinic, highlighting factors both facilitating and obstructing its ability to offer a prompt and high quality service,
- to offer recommendations for service improvement and modernisation arising from the assessment, to the GUM clinic, the PCT and the SHA,
- to use findings and recommendations from this review in putting together national findings and recommendations for the DH.

4.0 Method of Service Review

A physical visit to the clinic was arranged to review the premises and to interview members of staff. Prior to the visit a preliminary questionnaire was completed by the service and analysed by the project team. The visiting team also reviewed some background material including: organisation charts, employee lists, budget statements, meeting minutes and draft business plans.

The visit schedule showing the format of the day and individual interviews is attached. (appendix 1)

5.0 Personnel

| | | |
|----------------|--|---|
| Visiting team: | Dr Immy Ahmed Cathy Harman Colin Kelsey | <i>(Consultant GUM Physician) (Senior GUM Nurse, Project Manager) (Public Health Manager, Norfolk Suffolk & Cambridgeshire SHA)</i> |
| | Dr Alistair Lipp | <i>(Director of Public Health, Great Yarmouth PCT & Waveney PCT)</i> |
| Observer: | Dr Abhijit Bagade | <i>(Norfolk Suffolk & Cambridgeshire SHA)</i> |
| Clinic staff: | Dr T.C. Harry Chris Souter Paul Nickolls Roachine Squires | <i>(Lead Consultant, Bure Clinic) (Sister, Bure Clinic) (Senior Health Adviser) (EN, Bure Clinic)</i> |
| JPH Trust : | Wendy Slaney Gary Nicholson | <i>(Medical Director) (Pathology Manager)</i> |
| PCT | Sajceroni Muncsigi | <i>(Spr (Public Health) Great Yarmouth PCT)</i> |

6.0 Scope and timescales

The intention was to focus on aspects of the service concerned with the management of sexually transmitted infections (STIs). The review did not focus on HIV or contraception services, but did review aspects of HIV care where this is delivered within the GUM setting.

As part of a clinic review the project aimed to identify the formal and informal links between GUM clinic services and other sexual health services provided in the locality, but it did not intend to make any formal assessments of the latter.

This report offers clear recommendations on how to improve the GUM service, which may be utilised as part of the local business or service development plans

The central project team will pull together its findings from this service and all other services that participate in the national programme of clinic reviews to inform a national report to the DH.

7.0 Acknowledgements

We appreciated the patience and understanding that was afforded to the project team by all those involved in this review. We would like to thank all the people who participated, particularly those who took the trouble to reflect, write, find information, come in when not on duty or otherwise put themselves out for us.

8.0 Background to Service

The Bure GUM clinic is located at The James Paget Healthcare NHS Trust which serves a population of around 220,000 people in the Great Yarmouth, Lowestoft and Waveney areas. Great Yarmouth and Waveney PCTs are the main commissioners for this service

The local population is very mixed. Although it includes some affluent areas there are also significant areas, which have very high levels of deprivation and poor health. Teenage pregnancy rates are well above the national average, and local STI surveillance data indicate a significant rise in STIs and HIV. The local economy often uses migrant workers. It is not uncommon for short term contracts to be offered to African workers, and there is now a significant population of temporary residents from Malawi and Angola.

There is a local prison but currently there is no specialist STI or sexual health services commissioned for this population.

9.0 Findings

In July 2004, the Department of Health released *National Standards, Local Action*.¹ The key findings from this service review will be reported as assessed against the domains of this framework.

9.1 First domain: Safety

Domain outcome: Patient safety is enhanced by the use of health care processes, working practices and systemic activities that prevent or reduce the risk of harm to patients.

¹ National Standards, Local Action: Health and Social Care Standards and Planning Framework 2005/6-2007/8 (DH July 2004)

Within the constraints of this review, the visiting team did not identify any health care processes or working practices that would lead us to feel concerned about patient safety.

9.2 Second domain: Clinical and Cost Effectiveness

Domain outcome: Patients achieve health care benefits that meet their individual needs through health care decisions and services based on what assessed research evidence has shown provides effective clinical outcomes.

Commissioning

Currently the commissioning arrangements for the GUM service are managed separately according to county boundaries. We heard that the different financial pressures in the PCTs make joint commissioning very challenging. Unfortunately this has meant that some service developments are PCT specific and opportunities for joint working are limited. However a multi-agency group for sexual health has been established with senior representatives from the PCTs, JPH and a specialist commissioner for Norfolk. The responsibilities and accountability of this group are still evolving, but there may be opportunities to use this forum to develop collaborative commissioning across the stakeholder organisations for sexual health.

The general contract to GUM is part of a block payment to the Trust, based on historical arrangements that have not been updated for many years. There is a lack of information about value for money, patient waiting times, information for benchmarking and no definable breakdown of service costs.

The DH has made available additional revenue to support sexual health reform as outlined in 'Choosing Health' Public Health White Paper. The table below (table 1) shows the indicative recurrent revenue allocations for the local PCTs in 2006-7. A separate allocation is provided for the national chlamydia screening programme. Additional recurrent allocations will be made in 2007-8. We would recommend that PCT(s) investment plans must include measures to achieve sexual health targets including, a 48-hour access target, a decrease in the rates of new diagnosis of gonorrhoea and an increase in the percentage of sexually active population aged 15-24 accepting screening for chlamydia.

Table 1:

| 2006-07 PCT recurrent revenue allocations (,000) | | | | | |
|--|---------------------|------------------------|-----------|-------|------------|
| PCT Name | sexual health total | indicative amounts for | | | |
| | | gum | contracep | Abort | perf mangt |
| Great Yarmouth PCT | 65 | 34 | 23 | 3 | 3 |
| Waveney PCT | 117 | 62 | 42 | 6 | 6 |

Recommendations

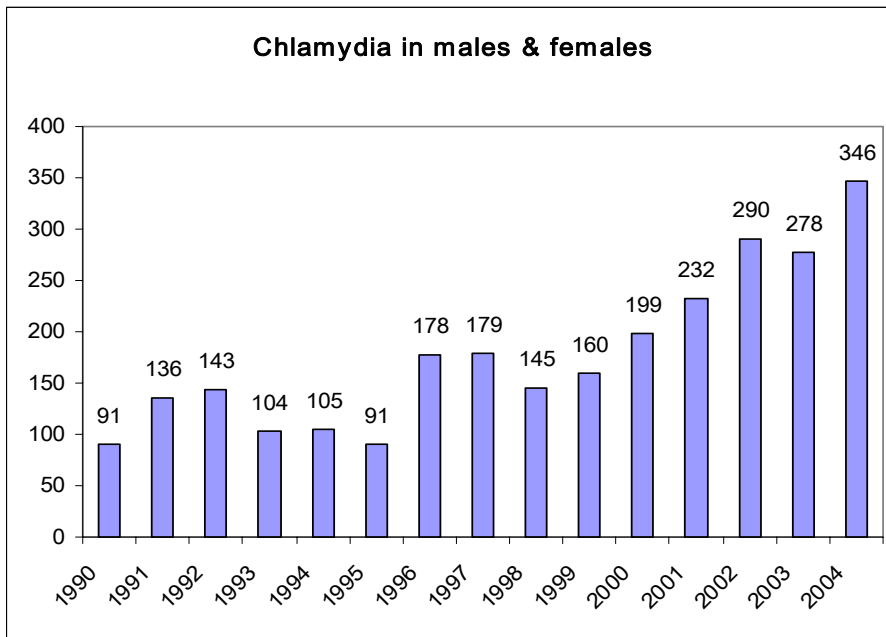
- We would strongly suggest that a review of existing contracts for this GUM service be undertaken. In the future national tariffs for GUM services under the 'payment by result' scheme should clarify potential income for the STI element of the service. In the interim period, we recommend that current and projected attendance patterns be mapped against Healthcare Resource Groups (HRGs) to inform service business plans. It should be noted under "payment by results", PCTs cannot determine, nor can Trusts bid for a specific level of funding. Allocations will be based on out-turn activity.

- PCT spending plans should demonstrate how the additional DH revenue would be utilised to support the ‘White Paper’ sexual health targets. These plans should be shared with relevant stakeholders including the GUM clinical team.

Activity Trends

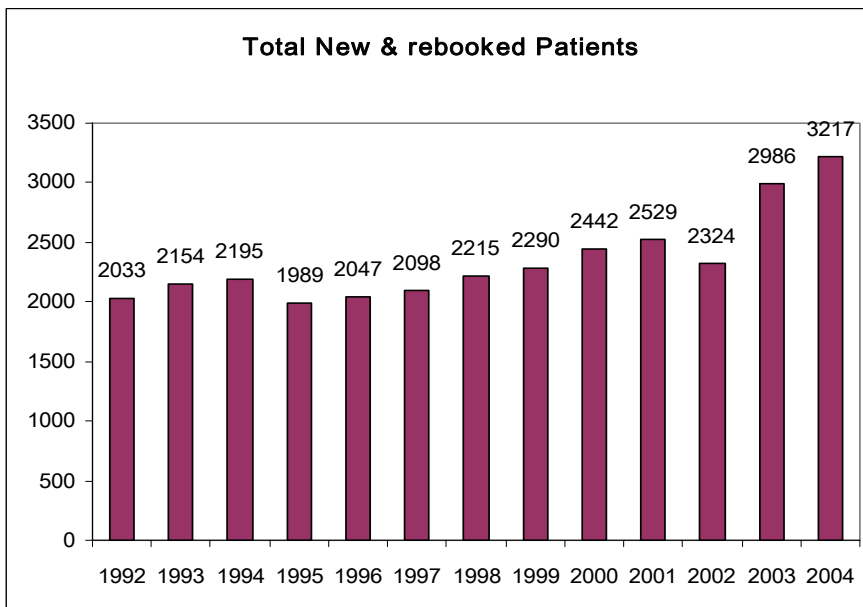
In the last 10 years there has been a significant increase in the diagnosis of STIs in the local population. The Bure clinic diagnosed over 341 cases of Chlamydia in 2004 (table 2) but we also heard that approximately 300 additional cases were identified outside the clinic. The anticipated roll out of the national chlamydia screening programme may mean that these figures will continue to rise as patients who were not previously identified are diagnosed.

Table 2



The rising incidence of STIs is reflected in increased activity in the GUM clinic as demonstrated in Table 3. Demand for this service is likely to continue to rise, creating pressure on the service to increase capacity in order to achieve waiting list targets.

Table 3



Clinical effectiveness

Reviewers were concerned that patients were still being tested for chlamydia using an enzyme-linked immunosorbent assay (ELISA) method of testing. The specificity of this test is significantly inferior compared to the recommended nucleic acid amplification tests (NAAT) method.²³⁴ Use of sub-optimal tests risks people being falsely reassured of the absence of infection (or falsely diagnosed as infected). Clinically this is a serious concern since failure to detect chlamydia infection can result in potentially serious health consequences for those undiagnosed, removes the opportunity to notify partners who may also be infected and increases the risk of onward transmission of infection. We heard that there are plans to introduce NAAT testing in the near future and this should be available in the clinic from October 2005.

NAAT technology can be adapted to test for both chlamydia and gonorrhoea with a single urine specimen. This service should consider introducing the dual test as it could deliver significant benefits in the GUM clinic. The diagnostic process can be streamlined and it is feasible for non-medical staff to carry out STI screens for asymptomatic patients. This technology can also simplify and facilitate testing for STIs outside the GUM setting.

Recommendation

- NAAT technology should be available in the GUM clinic from October 2005 for all chlamydia samples. Implementation plans should be monitored to ensure there is no further delay. The introduction of dual gonorrhoea and chlamydia testing should be considered as a longer term service development. The Trust should ensure that this capacity is reflected in the ongoing modernisation of pathology services within Norfolk.

General

The *national strategy for sexual health and HIV* has set a target for reducing undiagnosed HIV infection by suggesting that all GUM clinic attendees should be offered an HIV test on their first screening for sexually transmitted infections (and subsequently according to risk). This clinic has implemented a robust HIV 'opt out' testing policy. As a result the uptake of HIV testing in this clinic is excellent, as more than 90% of all new patients consent to having the test.

There is scope to modernise the roles of the wider MDT, particularly the nursing team in this service. Further analysis and recommendations regarding this aspect of the service will be made under section 9.3 of this report.

Within the constraints of the review process it was not possible to fully review the clinical practice in this service, but we understand the clinic utilises the evidence-based protocols published by the national organisations BASHH and the British HIV Association (BHIVA).

² Department of Health (2003) *Use of Sub-optimal testing platforms for the detection of genital chlamydia trachomatis infection in England*. London: Department of Health.

³ Watson EJ, Templeton A, Russell I, Paavonen J, Mardh PA, Stary A, Pederson BS. (2002) The accuracy and efficacy of screening tests for Chlamydia trachomatis: a systematic review. *Journal of Medical Microbiology* **51(12)**:1021-31.

⁴ Verkooyen RP, Noordhoek GT, Klapper PE, Reid J, Schirm J, Cleator GM, Ieven M, Hoddevik G. (2003) Reliability of nucleic acid amplification methods for detection of Chlamydia trachomatis in urine: results of the first international collaborative quality control study among 96 laboratories. *Journal of Clinical Microbiology* **41(7)**: 3013-6.

9.3 Third domain: Governance

Domain outcome: Managerial and clinical leadership and accountability, as well as the organisation's culture, systems and working practices, ensure that probity, quality assurance, quality improvement and patient safety are central components of all the activities of the health care organisation.

Information Technology

The service has recently commissioned a new IT system (LILIE), which has been designed to meet the needs of a GUM clinic. At the time of the visit the staff were experiencing considerable difficulties, as the new system was not embedded and the functionality was very different from the previous system. However this system has been found to be effective in other GUM services, therefore with additional support and training it is anticipated that the initial problems will subside. This system should be able to provide data to support future SLAs and also information anticipated in the forthcoming DH sexual health common data set.

Recommendation

- We recommend that the GUM take up the offer of Great Yarmouth PCT to work with their data and information analysts to see how GUM data can best be utilised in shaping service configuration and development within the local communities.

Communication

This is a relatively small team with many staff on part-time contracts. Naturally most communication happens face to face on an informal basis. It was clear that there are very positive working relationships between the teams, however operational processes have been constantly changing in this service and there were concerns that communication strategies within the department were not always effective. The multidisciplinary meetings are scheduled every three months and we heard that often the agenda is medically driven. As a single handed consultant, the clinical lead has had to make many strategic decisions but we did not see evidence that other senior members of the team have a strong voice in the decision making processes in this service. A second substantive consultant post should provide much needed support for the current clinical leader, but this will be an important opportunity to also develop a multidisciplinary culture which should engage all teams in decisions about the running of the department.

Recommendation

- We recommend that MDT should review all current formal and informal processes of communication with a view to improve information flow to all members of staff. Given the number of changes that are happening in the service we suggest that the MDT meetings be held on a more frequent basis. We would suggest that rotating the chair for the team meetings might be a way to help all staff to engage with and have ownership of the agenda for this meeting. This also provides an opportunity for different members of the team to develop skills in managing and leading meetings.

Clinical Governance

There was evidence of a good generic clinical governance framework and the clinic adheres to the policies and procedures of the Trust. There was evidence of good clinical audit and IPR processes for the MDT are in place. In general there appeared to be good access to training and education for staff in all teams. One of the main clinical governance concerns in this team is the reliance on a single consultant for supervision and senior clinical cover. The wider MDT team is dependent on this sole post to provide senior clinical support, when this consultant is on leave or absent from the service for other reasons the wider team will be restricted in their clinical activities.

Recommendation

- Recruitment plans for the additional consultant need to be expedited as soon as possible.

HIV

There are currently approximately forty-nine patients receiving regular HIV care from this clinic. Although the numbers are relatively low we heard that their complex needs represent 18% of the overall workload in this clinic. Patients are predominantly heterosexual, middle aged Caucasian men but there is a growing cohort of patients of African decent (24%).

It is intended that the job plan for the new consultant will include an additional HIV clinic. The reasons for the high workload associated with this HIV cohort of patients should be analysed further. A caseload of fifty regular patients will on average generate the need to see six cases per week. The case for an additional HIV clinic needs to be explored in greater detail and should be considered in context of other priority needs of this service.

There are no formal links between the James Paget Hospital Trust and any other HIV centre, but the consultant participates in an informal regional HIV clinical network. This allows clinicians to discuss clinical cases and can provide opportunities for shared care where appropriate.

Range of Services

The clinic provides a comprehensive range of services as follows;

- comprehensive screening and treatment for sexually transmissible infections,
- partner notification and provider referral,
- HIV antibody tests with pre and post test counselling,
- clinical, virological and immunological monitoring of HIV antibody positive/AIDS patients,
- support for HIV positive patients, family and friends,
- emergency hormonal contraception,
- genital dermatitis clinic run jointly with Consultant Dermatologist,
- hepatitis B immunisation programme for 'at risk patients',
- provision of inpatient care to HIV/AIDS patients.

Currently the service is unable to provide general contraceptive services, psychosexual or erectile dysfunction services. There are close links with the psychology service and patients can be referred directly if required.

Medical Staffing

This review team strongly supports the proposal for a second consultant in this service. The Royal College of Physicians (RCP) recommends at least two consultants with appropriate support staff for a hospital serving a population of 250,000⁵. This clinic serves Great Yarmouth and Waveney PCTs, which have a population of approximately 225,000. Single handed consultants are not recommended because the post holder may be vulnerable to clinical isolation; also the wider MDT team is dependent on this sole post to provide senior clinical support. There are a number of other vacant sessions for non-consultant grade medical staff. This would be an ideal environment for GP's with a special interest to work as clinical assistants, but unfortunately current pay structures can inhibit this practice. The service currently has a locum consultant covering the gaps in medical staffing, but it is essential that substantive appointments be made as soon as possible in this team.

⁵ Consultant Physicians working with patients

Recommendation

- We recommend that the job description and TORs for the new consultant be reviewed. This is a good opportunity to use this development to develop capacity in Primary Care and therefore we recommend that the responsibilities of this post should be to oversee the implementation of local enhanced services, develop training for primary care clinicians to enable them to execute this service. The local enhanced services should be linked with the GUM services as part of a clinical network to ensure consistency of the quality of care and clinical governance framework.

Nursing

This clinic has is a small nursing establishment of 3.4 WTE registered nurses. All posts are part time. It was notable that there are no health care assistants in this team. Lack of junior nursing staff can cause delays to patient flow through the clinic and experienced nursing staff will be used to carry out some generic nursing functions. Whilst this may be desirable for nursing staff who are developing GUM nursing competencies, this team is very experienced and they could extend their roles to manage patients autonomously contributing to the capacity in the service to see new patients.

The sister of this service is keen to take on new responsibilities. She has visited other services and learnt from different models of nursing care in other GUM services. We heard that patient group directions (PGDs) were compiled, but unfortunately the Trust clinical governance committee did not accept these. Nursing PGDs are now widely used in GUM clinics and a number of different evidence based protocols, which have been ratified in other Trusts are available via GUM professional organisations, including BASSH.

Recommendation

We strongly recommend the implementation of nurse led clinics to see new patients in this service. This could have considerable impact, increasing the capacity to see new GUM patients and assisting the service to deliver against the 48-hour access target. However to achieve this and to ensure robust clinical governance for this service the following steps will need to be taken;

- a review of the existing workloads and an assessment of additional nursing resource that may be required to backfill work carried out by the registered nurses,
- a training plan to ensure practitioners meet the required competencies,
- introduction of a wide range of PGDs to support nursing practice,
- regular clinical supervision for registered nursing staff,
- regular protected time with a senior nursing professional for lead nurse.

Health Advisers

1.7 WTE health advisers support the clinic. Health advisers focus on partner notification, sexual health promotion, patient education and counselling which are essential components to managing STIs in a GUM clinic. We heard that the health advisers see approximately 90% of all patients who attend the clinic to provide results and to administer medication if required. In this team the health advisers also have responsibility for the majority of the triage and telephone consultations. Much of this work is routine and does not necessarily need to be carried out by specialist health advisers, but currently there is insufficient capacity in the nursing team to carry out this part of the service. As a result the health adviser team have limited time to manage the more specialist aspects of their role which could include targeted HIV and health promotion activities both in the clinic and in the wider community.

Clinical reviewers were concerned to hear that there are no formal arrangements to provide clinical supervision to this team. The nature of this work and the counselling elements of this

role can be psychologically complex and the provision of formal supervision is considered good practice for health advisers in GUM.

Currently all health advisers are line managed through the senior nurse. As both teams expand and take on new roles the structure for this team may need to be reviewed. Consideration should be given to developing a senior health adviser post to act as a spokesperson and professional lead for this team.

Recommendation

- As many health advisers are also trained nurses, there will be overlap of functions and responsibilities between the two teams. We would recommend that the review of workload and resource assessment for the nursing team should also include the health adviser team.

Admin & Clerical

The review team felt that there are considerable demands placed on the admin team, which is made up of three members of staff in part-time posts. This is a very flexible team who are all able to cover all aspects of each others roles. In addition to office management, secretarial and reception responsibilities, this team maintains and runs the IT system and supports the data management and coding requirements of the service. Staff also manage the clinic website which patients can use to request appointments. All GUM notes are managed and stored within the clinic. A GUM service will generate a vast amount of results and clinical reports which have to be sorted and filed appropriately.

Recommendation

- The diversity of responsibilities for admin teams in GUM services are not always recognised and we recommend additional support under the agenda for change process to ensure their remit is appropriately recognised.

9.4 Fourth domain: Patient Focus

Domain outcome: Health care is provided in partnership with patients, their carers and relatives, respecting their diverse needs, preferences and choices, and in partnership with other organisations (especially social care organisations) whose services impact on patient well-being.

Patient Involvement

The clinic has done some work to capture patient feedback. We heard that a patient satisfaction survey was recently completed but the team did not have an opportunity to look at the results of this. It is often difficult to engage patients with STIs in service developments, but the review team felt there may be potential to improve PPI aspects in this service. It was notable that the links between the clinic and the health promotion units at both PCTs did not appear strong. We heard there is considerable outreach activity undertaken particularly by the Great Yarmouth health promotion unit. It was felt that the GUM team and the Health promotion teams would benefit from closer collaboration with each other.

Recommendation

- The clinic should develop a strategy to increase patient involvement and feedback in the service. This could include developing links with the Trust patient forum, and seeking feedback from voluntary groups that may represent service users. There should also be stronger links between the clinic and the health promotion services who are in contact with service users in outreach programmes.

9.5 Fifth domain: Accessible and Responsive Care

Domain outcome: Patients receive services as promptly as possible, have choice in access to services and treatments and do not experience unnecessary delay at any stage of service delivery or of the care pathway.

Access

This service operates a standard appointment system. The waiting time for an appointment at the time of the review visit was approximately 3-4 weeks but we heard that at busy times, waiting time can go up to 6-7 weeks which is an unacceptably long wait for a GUM clinic. In an attempt to see urgent cases sooner, a triage process has been established. If the patient discloses symptoms suggestive of an STI a nurse or health adviser will assess the patient by phone and arrange to see the patient sooner if required. The excessive waiting times are a grave concern in this service. However robust, all triage systems are fallible and this is not an acceptable substitute for a full assessment and treatment plan.

For a period of one month the service operated a restricted access system to allow same day booking. We heard that there were high levels of dissatisfaction from patients and GPs and the system was withdrawn. The service ran an audit to scope success of the system but this has yet to be analysed. In general terms restricted booking systems can offer some advantages as it allows short notice changes to the clinic appointment slots which is particularly helpful for a team such as this where there is little or no flexibility to back-fill unplanned absences. However there are also very significant disadvantages as this system may disadvantage vulnerable groups who may not call back if appointments are not immediately available and in general terms patients who are unsuccessful in obtaining an appointment can feel extremely dissatisfied with this as a service. Actual waiting times can be hidden and the service may not be able to measure the real demand for service. In this area there is no other accessible GUM service.

The clinic has introduced a number of initiatives to manage additional demand. The service has participated in a national research based project in GUM (6 sigma). This project has carefully analysed, the ratio of new and follow up patients and adjusted clinical protocols to decrease follow up activity in the clinic. This unit has brought the new and follow up activity down to a 7:3 ratio, and the next step will be to make a corresponding increase to clinical slots for new patients. However it should be recognised that the amount of time required to manage a follow-up patient is less than that required for a new patient.

It was noted that the clinic was not open all day throughout the week and that there was scope for operating additional clinics, if staff and resources could be identified to run them. There is also potential to develop out of hours clinics. We heard that a patient survey in the family planning service indicated that this would be popular, but it may be advisable to do a patient 'access survey' for this, before undertaking this development.

Clinic sessions run along very traditional lines. Sessions run between 9.30am and 12.30pm in the morning and 2.00pm and 5.00pm in the afternoon. STI clinics are mixed and will book between eight and ten patients per session. We heard that the current timetable of STI clinics and the number patient slots per session has not been reviewed for some time, and there may be scope to increase the capacity for new patient slots if the clinic profiles and timings are re-organised.

Although waiting times are monitored there has been little other activity to measure demand. We heard that the PCT may be able to offer support from the modernisation team to do some focused work including an analysis of the patient journey and an exercise to map the demand and capacity in this service. A better understanding of these issues will be crucial for future service development.

Recommendations

- With external support from the PCT modernisation team the current operational practices should be analysed with a view to rationalise and improve efficiency in the current systems.
- It is clear that a great deal of activity is already happening to assist this service to reduce waiting times. In order to ensure that this progress is maintained at the required pace we recommend that this service develop a strategic plan including a timetable of milestones of achievement and a realistic outline on how to meet the 48 hr GUM access target as outlined in the Public Health White Paper.⁶

9.6 Sixth domain: Care Environment and Amenities

Domain outcome: Care is provided in environments that promote patient and staff well-being and respect for patients' needs and preferences in that they are designed for the effective and safe delivery of treatment, care or a specific function, provide as much privacy as possible, are well-maintained, and are cleaned to optimise health outcomes for patients.

Transport links to the hospital appeared to be good and car-parking facilities are available for patients. There was clear sign posting to the 'Bure' clinic but we did not see any indication on public signs that the Bure clinic is a GUM or sexual health department. Unless patients are advised to look for the clinic by name they will need to enquire at the main reception for directions which can be extremely difficult and embarrassing, especially for young people.

Recommendation

- External sign posting to the clinic should make it clear that the Bure clinic is a GUM service.

Environment

The general impression of the environment in the clinic was positive. The area was well decorated and there is a reasonable lay out, however there are a number of constraints within the physical space that cause operational problems in the service.

The waiting area is very small. There is a separate waiting area for male and female patients with limited seating particularly on the male side, which has only nine seats. We heard that if more than one clinic is running at a given time there is not enough seating. Health promotion leaflets were available for patients to read and take away on the male side but none for the female area.

The booking in area at reception is open, which is reassuring for patients. However extra care is needed to ensure patient confidentiality is maintained, as it is possible for patients to read computer screens at the desk.

There are two combined examination and consulting rooms on the male and female side. We were very concerned to hear that one of these rooms may need to be converted to provide office space for the new consultant. The reduction in clinical space may have considerable impact on the service's ability to develop nurse led services. There is also a shortage of space for health advisers who are required to use one of the offices for counselling and giving treatment to patients.

It was also notable that there is no staff rest room. A storeroom is used to as a mini kitchen. A staff room in the actual clinic where all teams meet and relax often has a positive impact on team dynamics in multidisciplinary teams. Lack of space for general communication was a notable omission in this environment.

⁶ Department of Health (November 2004) Public Health White Paper, *Choosing Health: making healthier choices easier*

The overall impression of the care environment is that these premises are of a good general standard but the physical layout was not designed to meet the needs of a modern MDT. The increase in patient numbers both for the HIV and the GUM services were not anticipated when this facility was designed and built. There is potential to use the existing space in different ways, making the rooms more multi-functional but ideally this space would benefit from structural re-design. If this is not feasible there may be potential to use the existing space at different times and the service may need to consider extended or different service hours as a way to increase capacity.

Recommendation

- A formal review of the current space should be undertaken by the Trust. The barriers to modernisation and to further development of the multidisciplinary team, and the potential to increase capacity by changing service hours should be assessed as part of the review.

9.7 Seventh domain: Public health

Domain outcome: Programmes and services are designed and delivered in collaboration with all relevant organisations and communities to promote, protect, and improve the health of the population served and reduce health inequalities between different population groups and areas.

Sexual health strategy

Great Yarmouth and Waveney PCTs and James Paget Hospital Trust have established a sexual health forum which reports to the commissioning groups of both PCTs. The forum is currently chaired by the CEO of Great Yarmouth PCT and is tasked with responsibility to develop the local sexual health strategy in this health economy. Membership includes representation from public health, GUM, obstetrics and gynaecology, GPs, health promotion, teenage pregnancy, specialist commissioning, and PCT sexual health leads. Notably there is no representation from the patient or voluntary care organisations. Financial pressures in the Waveney economy may hamper service developments, which can be more readily achieved in Great Yarmouth. This can impinge on the group's ability to work in partnership. As an example there is a comprehensive health promotion team in Great Yarmouth that has been able to provide a wide range of services including outreach in gay clubs and work with schools. In Waveney there is a single handed post holder and this person does not have the capacity to provide the same level of service. In spite of some apparent inequalities it will be important that a collaborative approach is used to address sexual health initiatives where possible.

To ensure adequate access to GUM in the long term, the PCTs need to ensure patients have access to STI services in a variety of settings outside the GUM clinic. The nature and scope of sexual health services have been mapped across the economy and as a result of this both PCTs have commissioned some level 2 services across GP practices and community based 'one stop' shops. This includes the conversion of a former pharmacy and a GP surgery in a part of Great Yarmouth into a young person's sexual health service including family planning services. Waveney PCT has converted their former HQ into a similar service. Both developments have been targeted at wards with high deprivation factors and high teenage pregnancy rates. Phase II of the national chlamydia screening programme is underway in Norfolk, Waveney is due to join scheme. It appeared that the individual PCTs had some difficulty agreeing the relevant PGDs and protocols under the scheme but this has now been signed off.

Unfortunately as a single handed consultant service the GUM has not been able to provide support to Primary care or to offer STIF courses which provide training in STI treatment and care to local practices. We heard that copies of all positive cultures for gonorrhoea taken by GPs are sent to the clinic, but currently there is no follow-up on this information. Outreach services from GUM has been urgently desired by both PCTs but in the past this service has

not had sufficient capacity to engage significantly in this work. The recruitment of an additional consultant is an opportunity to become more involved in training and out-reach initiatives. It would be helpful if the role of the GUM clinic in the implementation plans of the sexual health strategies is now defined and clarification provided around training and outreach requirements.

Recommendations

- Membership of the sexual health forum should be expanded to include patient or voluntary sector participation.
- We would recommend that the GUM service is closely involved in the theoretical and practical training for primary care to support community based services to provide level 1 and if appropriate level 2 STI services. Robust patient pathways between services need to be outlined and joint protocols to ensure equity of treatment and care between services should be developed. The potential resources and costs required to implement the strategy should be assessed and taken into account when developing implementation plans.

10.0 Summary

The review team were very impressed by the skill, experience and evident commitment of individuals in both the clinical and management teams. It was clear that all team members are motivated to provide a high quality service to patients, but the demand for service has outstripped capacity in this small team.

Reducing the current waiting times for patients is an essential objective. Plans to develop STI services outside the GUM clinic will be highly beneficial, but the access targets can not be achieved without investment and development in the hub of the STI services which is the GUM clinic. Crucial elements to promote success in this service will be the reconfiguration of the medical establishment, development of the wider MDT, increased patient participation in service developments and an improved environment which must meet the needs of patients and staff.

The following key service recommendations should be considered in the context of existing business plans and the emerging PCT sexual health strategy.

11.0 Recommendations

11.1 Safety

No recommendations

11.2 Clinical and Cost Effectiveness

- a) We would strongly suggest that a review of existing contracts for this GUM service be undertaken. In the future national tariffs for GUM services under the 'payment by result' scheme should clarify potential income for the STI element of the service. In the interim period, we recommend that current and projected attendance patterns be mapped against Healthcare Resource Groups (HRGs) to inform service business plans. It should be noted under "payment by results", PCTs cannot determine, nor can Trusts bid for a specific level of funding. Allocations will be based on out-turn activity.
- b) PCT spending plans should demonstrate how the additional DH revenue would be utilised to support the 'White Paper' sexual health targets. These plans should be shared with relevant stakeholders including the GUM clinical team.
- c) NAAT technology should be available in the GUM clinic from October 2005 for all chlamydia samples. Implementation plans should be monitored to ensure there is no

further delay. The introduction of dual gonorrhoea and chlamydia testing should be considered as a longer term service development.

11.3 Governance

- a) We recommend that MDT should review all current formal and informal processes of communication with a view to improve information flow to all members of staff. Given the number of changes that are happening in the service we suggest that the MDT meetings be held on a more frequent basis. We would suggest that rotating the chair for the team meetings might be a way to help all staff to engage with and have ownership of the agenda for this meeting. This also provides an opportunity for different members of the team to develop skills in managing and leading meetings.
- b) We recommend that the GUM take up the offer of Great Yarmouth PCT to work with their data and information analysts to see how GUM data can best be utilised in shaping service configuration and development within the local communities.
- c) Recruitment plans for the additional consultant need to be expedited as soon as possible.
- d) As many health advisers are also trained nurses, there will be overlap of functions and responsibilities between the two teams. We would recommend that the review of workload and resource assessment for the nursing team should also include the health adviser team.
- e) The diversity of responsibilities for admin teams in GUM services are not always recognised and we recommend additional support under the agenda for change process to ensure their remit is appropriately recognised.

11.4 Patient Focus

- a) The clinic should develop a strategy to increase patient involvement and feedback in the service. This could include developing links with the Trust patient forum, and seeking feedback from voluntary groups that may represent service users. There should also be stronger links between the clinic and the health promotion services who are in contact with service users in outreach programmes.

11.5 Accessible and Responsive Care

- a) With external support from the PCT modernisation team the current operational practices should be analysed with a view to rationalise and improve efficiency in the current systems.
- b) It is clear that a great deal of activity is already happening to assist this service to reduce waiting times. In order to ensure that this progress is maintained at the required pace we recommend that this service develop a strategic plan including a timetable of milestones of achievement and a realistic outline on how to meet the 48 hr GUM access target as outlined in the Public Health White Paper.⁷

11.6 Care Environment and Amenities

- a) External sign posting to the clinic should make it clear that the Bure clinic is a GUM service.
- b) A formal review of the current space should be undertaken by the Trust. The barriers to modernisation and to further development of the multidisciplinary team, and the potential to increase capacity by changing service hours should be assessed as part of the review.

⁷ Department of Health (November 2004) Public Health White Paper, *Choosing Health: making healthier choices easier*

11.7 Public health

- a) Membership of the sexual health forum should be expanded to include patient or voluntary sector participation.
- b) Phase II of the national chlamydia screening programme is underway in Norfolk. Waveney is due to join scheme. The individual PCTs need to agree the relevant protocols PGDs and protocols under the scheme.
- c) We would recommend that a joint approach is used to agree any changes to the national guidance and that this is ratified jointly through clinical governance structures.
- d) We would recommend that the GUM service is closely involved in the theoretical and practical training for primary care to support community based services to provide level 1 and if appropriate level 2 STI services. Robust patient pathways between services need to be outlined and joint protocols to ensure equity of treatment and care between services should be developed. The potential resources and costs required to implement the strategy should be assessed and taken into account when developing implementation plans.

12.1 Visit Schedule

| | | | | |
|---------|--|--|--|---|
| 9.45am | REVIEW TEAM MEETING 9.45am – 10.00am | | | |
| 10.00am | INTRODUCTIONS – ALL 10.00am – 10.15am | | | |
| 10.15am | Introductory briefing– ALL 10.15am – 11.00am | | | |
| 10.30am | 1. Visiting Team Leader Background to project, aims and objectives of this review visit (10 mins) 2. PCT representative The local sexual health strategy, needs of local population (10 mins) 3. Clinical Lead of Service Overview of current service, vision for the future, how to get there (10 mins) | | | |
| 10.45am | | | | |
| 11.00am | | | | |
| 11.15am | TOUR – ALL 11.00am – 12.00pm | | | |
| 11.30am | Tour of premises, highlighting factors which help or hinder service modernisation. | | | |
| 11.45am | | | | |
| 12.00pm | CONSULTANT 1:1 with senior medical representative | NURSE / HA 1:1 with senior nurse | SHA REP Virtual patient journey following patient pathway talking to multidisciplinary team / patient questionnaires | PCT REP (Sit in with either senior nurse or consultant) |
| 12.15pm | | | | |
| 12.30pm | | | | |
| 12.45pm | | NURSE / HA 1:1 with senior HA | | |
| 1.00pm | | | SHA REP 1:1 with PCT representatives | PCT REP 1:1 with SHA representatives |
| 1.15pm | CONSULTANT 1:1 with non consultant supporting medical staff | | | |
| 1.30pm | | NURSE / HA 1:1 with A & C lead | | |
| 1.45pm | | | | |
| 2.00pm | LUNCH - ALL | | | |
| 2.15pm | | | | |
| 2.30pm | ROUND TABLE DISCUSSIONS (Q's & A's) – ALL Chairperson: Review Team Lead | | | |
| 2.45pm | To include visiting team, clinical lead for service +/- senior medical representative, senior nurse, senior A&C manager, senior manager | | | |
| 3.00pm | | | | |
| 3.15pm | | | | |
| 3.30pm | Topic 1: Patient access to service and building future capacity | | | |
| 3.45pm | Topic 2: Business planning, service development plans | | | |
| 4.00pm | | | | |
| 4.15pm | VISITING TEAM DISCUSSIONS | | | |
| 4.30pm | | | | |
| 4.45pm | INITIAL FEEDBACK FROM VISITING TEAM TO SERVICE AND TO AGREE NEXT STEPS | | | |
| 5.00pm | | | | |

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