# Turning around the Darlington GUM clinic

**Dr. Kailash Mohanty**
**Consultant Physician, Department of Genito-urinary Medicine & Sexual Health**
**Darlington Memorial Hospital**
**Kailash.Mohanty@cddft.nhs.uk**

## Summary

In a joint HPA and MedFash review (approved by the Department of Health) in 2006, the GUM clinic at Darlington Memorial Hospital was rated as one of the worst in the country in respect of its 48 hour access. The service provisions were redesigned and modernised according to the DH document *Ten High Impact Changes for GUM* published in 2006. The changes came into effect on 4th June 2007 and within a week 48 hour access was achieved in 100%. The 48 hour access was backed up by robust Clinical Governance to maintain a high quality of service.

## Background

In 2001 over a million patients attended the Genitourinary Medicine (GUM) clinics in England.[1] In 2002, Implementation Action Plans were published by the Department of Health (DH) but the plans were not implemented - to control the rising incidence of sexually transmitted infections (STIs). Originally it was intended for primary care to provide the Level 1 and Level 2 GUM/Sexual Health service, leaving secondary care to deal with more complicated GUM cases (Level 3). In 2004 it was noted that HIV, Chlamydia and total STI cases had doubled within the previous four years.

The ever-increasing incidence of STIs and HIV is one of the major social ills in the UK. In 2005 the GUM Clinic workload was 2,732,329 in England with 790,443 new diagnoses. The incidence of Chlamydia infection was more than 100,000. In the North-East there were 3,722 cases of Chlamydia reported from GUM clinics in 2007. In addition, the National Chlamydia Screening Programme (NCSP) in the North East reported 5972 cases in only three months (October-December 2007). According to North East Local Sexual Health Profile, March 2008, Darlington PCT had the highest proportion of Chlamydia (19.5%) in the region as opposed to 4.8% in Newcastle PCT.

Bacterial vaginosis (BV) which is a cause of vaginal discharge was seen in 77,508 women. 553,640 HIV tests were performed annually. Even 35,934 family planning cases were seen in GUM clinics. At the end of 2005 an estimated 63,500 adults were living with HIV.[2] There is an unacceptable waiting time for the patients for GUM clinics in the country which is usually six to eight weeks and at some hospitals even longer.

To solve this problem the Department of Health invited the MedFASH (Medical Foundation for Sexual Health & HIV) to undertake a nationwide survey to find out the scale of the problem by visiting GUM clinics. The final report is awaited.

According to the HIV and STI report (November 2006) prepared by joint HPA in collaboration with BASHH, 69% of patients received an appointment to be seen at a GUM clinic in England within 48 hours. In the North East this figure was 59%. In Darlington only 23% received an appointment to be seen at the GUM clinic, at that time one of the worst clinics in the UK in respect of 48 hour access.[3]

The NHS Operating Framework for 2006/07 identified 48 hour access for GUM clinics as a priority and set a target to achieve 100% by 31st March 2008. The Department of Health produced a document called Ten High Impact Changes for GUM 48-hour access in 2006 recommending how to achieve this. In October 2006, the National Institute for health and Clinical Excellence (NICE) also published its first draft Public Health Intervention Guidance in October 2006 on how to identify high risk

patients in the community and deal with them promptly - especially under 18s.[4]

**Case for Darlington Memorial Hospital**

I was appointed in January 2007 as a Consultant Physician in genitourinary medicine and took up the post on 4th June 2007. I started planning from January 2007 and followed the recommendations in the DH document, 10 High Impact Changes for GUM.

Department of Health Document 2006

10 High Impact Changes for Genitourinary Medicine 48-hour Access

1. Measure demand and capacity
2. Redesign the service to increase capacity
3. Utilise multidisciplinary teams
4. Develop separate pathways to manage low risk patients
5. Easier access for patients to attend
6. Increase clinic opening hours
7. Maximise the space
8. Reduce unnecessary clinical activities by reducing Follow Ups / sending results by text messages
9. Effective commissioning
10. PbR (Payment by results) for STIs other than low volume, high cost HIV patients

I measured the demand and the capacity. The quarterly demand increased from 726 patients in the last quarter of 2005 to 993 in the second quarter of 2007 (Figure 1), a rise of 27%.

The trend of attending patients kept on rising - in the third quarter it was 1054, a rise of 31.1%. In terms of capacity there were only six clinics a week each running for 2 hours. There were four nurses - three part time - assisted by a half time health care assistant.

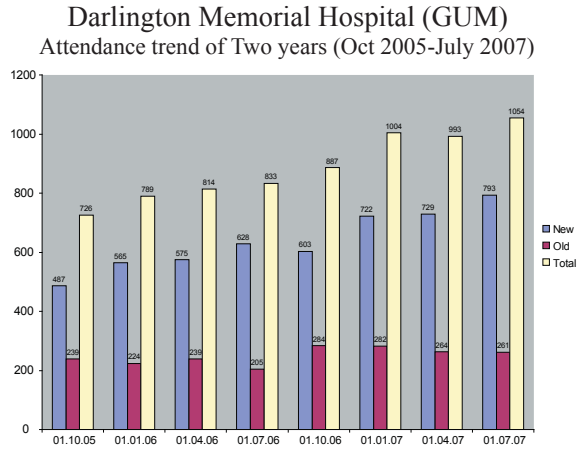


Figure 1.

The nurses were very experienced i.e. more than 10 years in service but they were not utilised in the clinical management of patients. The single-handed doctor was doing everything. After my appointment in January 2007, my immediate task was to write up Scope of Professional Practices and Patient Group Directions (PGDs) according to Royal College of Nursing (RCN) Competencies to involve the nurses more actively in providing the clinical service. With the liaison of the then locum consultant, all the senior Staff Nurses were trained on PGDs and on various Scope packages under his supervision over six months (January to June 2007). A capacity was built up to provide 30 clinics a week with each clinic of 3 ½ hours. The only additional resource was to increase the hours of the healthcare assistant from 20 hours to 37 ½ hours which was granted by the Trust in view of massive expansion of the capacity. On 4th June 2007 - the day I started - I called a multidisciplinary clinical governance meeting which was non existent before, to ratify the PGDs and Scope packages among various other issues of clinical governance.

Clinical Governance issues (Clinical Governance meeting)

1. Annual Patients' satisfaction survey
2. 48-hour access provision
3. Monitoring of 48-hour access
4. Risk Assessment
5. Monitoring of DNAs
6. Complaints and their management
7. Infection Control issues
8. Ratify PGDs and Scope packages
9. Joint care pathways with Primary care for GPs to initiate treatment for genital herpes and genital warts after competency training (DH 2005)
10. Joint clinical audits on PID and Epididymo-orchitis with Gynaecology and Urology departments respectively
11. GUM Clinic internal audits according to BASHH guidelines on auditable measures

The GUM service was redesigned. There was an immediate increase of outpatient clinics from six to 30 clinics per week. We found 70% of our patients were asymptomatic. For example; in a Monday morning we ran three clinics simultaneously i.e. one asymptomatic clinic by a female nurse for asymptomatic female patients, one asymptomatic male clinic by a male nurse for asymptomatic male patients and a symptomatic clinic for both sexes by the doctor. Therefore the workload was evenly distributed between doctor and nurses. Separate pathways were implemented to manage low risk asymptomatic patients through nurse-led clinics according to DH guidelines. In the past there was only one clinic manned by the only doctor but this was changed to three clinics running simultaneously during the same time. Thus 30 clinics were possible in a week.

One evening clinic and one walk-in clinic per week were started for easier access. Unnecessary clinical activities were reduced according to the UK National Clinical Guidelines[5]. In the past a large number of patients were brought in for unnecessary follow up and providing results. Previously patients were asked to ring up during clinic times for results - a major disruption to the smooth running of a clinic. Text messaging of test results to the patients' mobile phones was introduced. Robust clinical governance was introduced on clinical audit, patient satisfaction surveys, monitoring of 48 hour access, joint clinical audits, PCT and Level 3 joint care pathways on genital warts and genital herpes, risk assessment, complaints etc to maintain a high quality service with regular quarterly clinical governance meetings. Joint clinical audits were submitted on PID and epididymo-orchitis to improve patient care with the gynaecology and urology departments respectively. Competence training packages were provided to all GPs and community health care professionals in the catchment area to provide basic STI management in primary care according to the National Strategy5. Both theory and practical training in specialised STI services were offered to primary care healthcare professionals according to DH competency training guidelines published in 2005. Multidisciplinary meetings with the microbiology department and volunteer services were held to seek opinions to improve the service.

**Results of the implementation of change**

The above changes were implemented on 4th June 2007 backed up with clinical governance and by 11th June 2007 we achieved 100% 48-hour access. Only £3000 extra funding was invested with the healthcare assistant to increase the hours to full time. Three nurses were promoted from Band 5 to Band 6. There

was no extra funding as they had all achieved Band 6 salary with 10 years' service. There were two full time secretary/receptionists. Their hours of work were changed to meet the clinic times. The nurses are now very happy - their promotion and change in colour of uniform gives them increased job satisfaction. The healthcare assistant is happy as she was trying in the past to get more hours without any success. The receptionists are happy because of their involvement in clinical work involving text messaging. To achieve this success cost very little.

There is not a single patient now waiting more than 48 hours. In fact we are seeing any patient as a walk-in patient when ever they ring up for an appointment.

The sustainability of the success is maintained with the backing of robust clinical governance (Box.2). We have so far had three quarterly (June/September/December 2007) clinical governance meetings where the service provision was maintained at the highest level.

## Conclusion

The GUM Service at Darlington Memorial Hospital was one of the worst according to the joint Health Protection Agency (HPA) and MedFASH review, published in November 2006. In January 2007 the service was redesigned and changes were implemented in June 2007 according to the Department's recommendations. These changes were backed by robust clinical governance to maintain a high standard of service. The number of clinics was increased from six in a week to 30 with very minimal extra resources. As a result of these changes 48-hour access was achieved within a week. This achievement was ahead of the DH target of 31st march 2008 for all GUM clinics in England. The success has been sustained and staff satisfaction and morale are high. Although the primary care Level –1 service did not take up as expected it did not hinder achievement of the 100% 48-hour success.

## Acknowledgement

The results were presented at the Trust Innovation Day on 19th December 2007 held at the Hardwick Hall Hotel in Sedgefield under the title, "48 Hour Access and High Impact Changes in GUM"

### References

1. National Strategy for Sexual Health & HIV. Department of Health July 2001

2. A Complex Picture: HIV and other Sexually Transmitted Infections in UK:2006 published by Health Protection Agency, London www.hpa.org.uk.

3. National and Regional, Residence and Clinic-based results from a quarterly one-week sample survey, prepared by HIV & STI department, HPA in collaboration with MedFASH, Centre for Infections, 61 Colindale, London NW9 5EQ

4. NICE: Public Health Interventions Draft Guidance. Issue date October 2006, MidCity Place, 71 High Holborn, London WC1V 6NA www.nice.org.uk

5. British Association for Sexually Transmitted Infections and HIV (BASHH). www.bashh.org