Decision No 13/00022

By: Graham Gibbens, Cabinet Member Adult Social Care & Public Health

Meradin Peachey, Director of Public Health

To: Social Care and Public Health Cabinet Committee – 21 March 2013

Subject: To identify an interim solution for the Genito-Urinary Medicine service in Darent Valley Hospital

Classification: Unrestricted

Summary

Commissioning of Genito-urinary services will be the responsibility of the County Council from April 2013.

The current provider of the GUM service for part of Kent (Darent Valley Hospital) have served notice, therefore an interim arrangement has to be identified and implemented before the notice period expires on 1st April 2013.

The most feasible option is to hand over the GUM service to Kent Community Health Trust till the service can be tendered out.

The cost for GUM services at Darent Valley is £1,241,665.

The cost for all sexual health services for all of Kent is estimated to be £13,760,308.

1. Introduction

The purpose of this paper to set out the options for an interim arrangement for the Genito-urinary medicine service provided from Darent Valley Hospital (DVH).

2. Report Content

2.1 Background

In August 2012 Dartford and Gravesham NHS Trust served notice to NHS Kent and Medway with the intention to cease providing the Genito Urinary Service from DVH with effect from 1st April 2013. There had been previous discussions on the need to relocate the service as DVH required the premises for acute provision and had requested alternative space be found. This was

not possible in the requested timescale (4 weeks), and so the need to relocate imminently as an interim measure is imperative due to the pressing demands for space at DVH.

A decision was taken by the Director of Public Health to commission MBARC an external consultancy to

- Identify an interim solution for moving the GUM services in DVH to a new location
- Engage with users of the services, professionals and managers to identify views on the quality of services and potential changes

As part of this interim project, MBARC engaged with Key Informants (KI's), including NHS Kent and Medway (NHS K&M), managers and clinical professionals working both in DVH and with other providers, to agree a preference for an interim location, and to explore some recommendations for action. In the stakeholder event the option of relocating the service to the following three venues was discussed:

- Gravesham Community Hospital in Gravesend
- The Grand Health Living Centre in Gravesend
- The Livingstone Hospital in Dartford

The majority of KI's, including those currently working in a variety of sexual health premises at different locations across Kent expressed a preference for Gravesham Community Hospital.

2.2 Implications

Sexual Health is one of the mandated services, as outlined in the Health and Social Care Act that Local Authorities will be required to commission from April 2013. These include community contraception services, emergency contraception, pharmacy sexual health provision, GUM services, Local HIV prevention and sexual health promotion.

A lack of a GUM service in the North of West Kent will have huge implications for the HIV patients and other service users. Therefore there is an urgency in identifying an interim solution for the GUM service in DVH as the notice period will expire on 1st April 2013.

2.3 Options Appraisal

Site	Advantages	Disadvantages
Gravesham Community hospital (GCH)	GCH has good transport links and will provide ease of access Consultant cover can be provided by the KCHT GUM service lead	The Dartford residents have been used to having a service on their doorstep and moving the service to Gravesend may lead to a drop in the number of patients accessing the service from Dartford.

	The physical space is most suitable out of all the options and available without the need for major refurbishments or unnecessary financial outlays at this stage. DVH staff already worked closely with the clinicians as part of a supportive network in the physical absence of a lead clinician. A discreet service can be offered from this site Kent Community Hospital Trust (KCHT) are willing to accommodate the GUM\HIV service as an interim solution and to work closely with the staff to ensure seamless transition and to offer robust support and partnership working KCHT already offer a strong hub and spoke model which could be extended to include GUM/HIV outpatient care (including Dartford) offer opportunities to increase the provision of a "one stop shop" approach for service users maximise the opportunities for dual trained health professionals to practice across disciplines The service will become more accessible for the Gravesend patients	The number of treatment rooms available at Gravesham Community Hospital may not be perceived to be adequate (4) - as there are upwards of 700 patients per month accessing the DVH service and these numbers are unlikely to diminish, even in interim premises. (*currently DVH has 5 treatment rooms)*
The Grand Healthy Living Centre	Service could be integrated with young persons services The service will become more	There would need to be major investment in refurbishment The Grand is situated on the high

	accessible as the Grand has good bus routes and train connections Offer an opportunity to provide an integrated service as there is already a Contraception and Sexual Health (CASH) clinic provided from the site maximise the opportunities for dual trained health professionals to practice across disciplines Some patients may prefer a non-clinical setting	street and there may be difficulties in people openly accessing the building due to the perceived “culture” of some service users. Stigma and discrimination has long been recognised as a major barrier to people openly using sexual health services A new IT server would need to be set up to support the Lilli System Transport of pathology samples will need to be set up Infection control may pose a problem The Board members at the Grand see this as a take over of the premises by the GUM services Patients may perceive that there might be information governance issues
Livingstone Hospital	The service will remain geographically close to the existing service (half a mile down the road) It will provide the anonymity that is required for sexual health services	Livingstone Hospital is a step down for elderly patients (patients who have been discharged from hospital and are awaiting going home because they still require some nursing care) and it will not be appropriate to set up a sexual health clinic from the site The physical environment is not contusive to setting up a GUM clinic on the site. The cost of refurbishment will be prohibitively high. A new IT server would need to be set up to support the Lilli System

2.3.1 Options Appraisal for Providing the Service from Gravesham Community Hospital (GCH)

Option	Advantages	Disadvantages
Kent Community Health Trust to provide accommodation for the GUM service and agree a rent with DVH which DVH will pay directly to KCHT. The consultant cover could be provided through the network or by one of the consultants employed by KCHT . DVH to buy consultant time from KCHT or the network.	Probably more acceptable to the DVH staff as they can continue to work to existing contracts	The disadvantage of this option is the risk to governance associated by "Network" arrangements or having a consultant from other organisations overseeing / supporting services for a different trust which will have differing policies.
The service is handed over to KCHT in totality and is provided from GCH.	This option will allow developing a robust governance arrangement (consultant cover) The service can be integrated with the contraception service and have close links with outreach work. This will be an opportunity to fill in any gaps in service provision	The staff will need to be TUPE over and there will need to be consultation with the staff When the service is tendered it means that the staff will have to undergo yet another TUPE if KCHT is not successful in its bid.
DVH subcontract KCHT to provide the service from the GCH site	The transition will be smooth and the onus will be on DVH to set up a sub contract	This is not a feasible option because if DVH sub contract with KCHT then they will not be TUPEing their staff. KCHT would have to recruit additional staff to cover the service, this will means DVH will have staff surplus to requirements and therefore

		possible high redundancy costs.

3. Recommendations
• It is recommended that the GUM service in DVH is handed over to KCHT to provide it from Gravesham Community Hospital as an interim solution. As this is least likely to cause disruption to the service and does not require excessive startup costs. It will also provide an opportunity to fill some of the gaps in the service as outlined in appendix 1. • This arrangement will be only for a year and the service will be tendered out in 2014.

4. Contact Details

Dr Faiza Khan, Consultant in Public Health, 01732 375212 Faiza.Khan@wkpct.nhs.uk

5. Background documents

None

Appendix 1

1 Key Issues / Gaps Identified at the GUM Service in DVH

During the interviews in the stakeholder engagement, major gaps in provision were also identified which have implications for patients and service users and do not reflect a comprehensive range of sexual health services.

- Clinical governance arrangements currently at DVH are unacceptable as the incumbent consultant is retired and is only able to offer telephone advice and supervision. This is a less than satisfactory arrangement for all concerned, especially during this interim move,

- The current GUM/HIV clinic template is insufficient with no late evening or early morning clinics. There are currently no walk in sessions for DVH patients - all patients attend on an appointment basis and there are high DNA (did not attend) rates.

- No Electronic Patient Records (EPR) are available which disproportionately impacts on already limited administrative time

- No results text service is available which has resulted in the service being closed each day for an hour and a half at lunchtime whilst expensive nursing time is used to offer a results service to patients who phone in.

- No Hep B vaccine service

- No NAAT (nucleic acid amplified testing) testing

- No same day testing (4 Hours)

- No designated young people's services (4YP)

2 Issues that Require Addressing

It is highly recommended that these important gaps in provision are addressed by the interim provider and that they are commissioned as part of a comprehensive sexual health package of care for patients.

- A clinical lead must be identified who will be responsible for all clinical governance arrangements for the interim GUM/HIV service. Commissioners should consider funding the maintenance of a clinical network. Even meeting costs with some back up locum costs would be welcomed and supportive during transition. This would ensure that the clinical lead is appropriately supported during the transition and facilitate the development of new relationships as part of the interim provision.

- Review of the overall clinic template to spread sessions is essential and will lead to improved utilisation of the facilities

- Walk in and appointment sessions should therefore be established in order to offer choice to patients and increase access and choice.

- Extending opening to >1900hrs is helpful for access and consideration should be given to increasing this still further, staggering shift patterns and use of the SLOT system. Appointment and /or walk in opportunities for patients to attend the service pre- and post work should be considered as this also increases patient choice.

- Patient flow into and through the service needs to undergo a LEAN exercise to identify unnecessary activity. This should include registration, triage / streaming through to most appropriate staff member, results management and follow-up processes. This will establish the numbers of treatment rooms required.

- A Multi Disciplinary Team (MDT) of staff will be required to service all clinical sessions in order to provide optimum skill mix to meet client's needs, being cognisant of the need to delegate tasks to the lowest appropriately qualified competent practitioner. This can be achieved through a robust system of triage at the point of client contact.

- Given the need to maximise the skills and competencies of dual trained staff, an interim location within the contraceptive service hub would be an excellent opportunity to increase access to an integrated model of care for service users and would improve delivery and access for patients in the interim.

3 Essential Steps for a Smooth Transition

The logistics for the following have been identified as requiring urgent attention in interim premises and any new location will need to ensure that these are addressed immediately to ensure seamless access for patients:-

- The commissioners and interim providers will need to ensure that a lead commissioning role is identified within the Public Health team and one at KCHT to lead on the three key commissioning relationships across Public Health (PH), Clinical Commissioning Groups (CCGs) and Local Area Teams (LATs). This will avoid fragmentation, and ensure seamless pathways for patients during transition, particularly for HIV patients. The lead could act as conduit to the bodies responsible for the different elements of provision and ensure robust and transparent processes are in place.

- A clinical and service management representative, working alongside the sexual health commissioning and management team, is advisable to ensure robust communications are established and that patient's views and needs are fully met.

- The PCT could consider the short term interim appointment of a project manager to facilitate the transition and to work closely with, and support,

the current PH lead commissioner (as they await the new appointments to support the commissioning functions).

- The lead commissioner must work closely with the Human Resource Departments at DVH, KCHT and at the PCT to ensure that the TUPE arrangements are consulted on with the relevant staff teams as soon as practical, and that new contracts are in place by the date of transfer of responsibilities (May 1st 2013).

- A short term 'Task and Finish Group' should be established, led by Public Health and attended by the relevant professionals (in HR, Finance, procurement and contracting) to ensure seamless transition for staff and patients alike and to support the transition lead appropriately.

- Finance Directors (or delegates with clear lines of responsibility for GUM and HIV services) at DVH and KCHT must work closely with the commissioners to agree the totality of the budget and to identify cost pressures and additional funding required for the transition.

- The budgets must be organised in a meaningful and transparent way which reflects the new commissioning arrangements for sexual health and is clear at the outset. Working closely with the Finance Directors or delegated managers responsible for the complexity of the new arrangements for sexual health will be imperative during transition both within Public Health commissioning and with the interim provider at KCHT.

- Working closely with the service managers and clinical leads, NHS K&M commissioners should identify overarching priorities for how the interim provision of sexual health services and partnerships will proceed within the new contracting arrangements and current resources.

- IT systems at KCHT will need to be appropriately resourced and in place to monitor the activity data and disaggregate HIV and GUM activity as soon as possible.

- Discuss a basis for payment e.g. block contract versus GUM PbR or integrated sexual health tariff with the new commissioners in PH
  (NB. From April 2013, there will be an expectation on LAs to produce a Public Health Local Authority Contract. This will be used to support LA's in meeting their new public health function and enable LA's to use a standardised approach to contracting. NHS K&M commissioners may consider initiating discussion on the application of a sexual health tariff (although the rate will not be mandatory for public health).

- Ensure disaggregated data for the HIV patients

- Look at level of investment in IT and new technologies including telehealth solutions

- Ensure staff and service user engagement at all levels

- There is a need for improved communications between the DVH clinic staff team, KCHT as the interim provider and the Transition Lead for sexual health at PH. This is of particular importance during transition to ensure that there is clarity for staff being transferred, and reassurance for the new commissioning partners on the quality of service provision and the need to secure that provision for a vulnerable target population. The involvement of elected members will add a new dimension to the commissioning process.

- The relationship between the management team of the interim provider and commissioners will require an agreed code of transparency to ensure clarity of purpose, direction of travel and achievement of strategic and public health outcomes. This will be particularly important during transition to the new commissioning arrangements to ensure a "Business as Usual" approach and the continued standard of provision of care to patients. In theory, patients should not notice a difference. This will be crucial for governance arrangements.

- A formalised network or forum led by public health for these discussions is recommended. Data sharing with the relevant partners is essential to provide the evidence-base and ensure the allocation of appropriate resources. NHS K&M commissioners will therefore need to develop a robust performance management framework for the interim provision, with transparent access to data for commissioners and providers.

- An advertising budget must be identified to ensure that patients and future service users are well informed as to the new location, opening times and service availability and that a centralised booking number is established and widely advertised (including to GPs, VCOs and community groups etc.) to ensure that this happens.

- Human Resource issues must be resolved as a matter of urgency re: vacant clinical and health advising posts, extended sickness and backfilling of posts. The current timetable is inadequate and staff stretched.

- There should be a review of the interim multidisciplinary team, its structure, roles responsibilities, skills and abilities to ensure the workforce is skilled to deliver a seamless, integrated sexual health services as part of the interim provision.

- Consideration should be given to strengthening nurse leadership through reorganisation to create a lead role for the strategic direction for nursing and oversee a seamless nursing and (to develop) a health advising team. There also appears to be historic staff working patterns that are not conducive to improved service delivery, and need to be addressed as part of the workforce review for the interim provision.

- There are currently no Health Advisor roles within the existing GUM service although the Clinical Manager has been juggling this role with numerous other tasks. A Health Adviser role should play a pivotal role in the management of on-going risk, screening and crucially partner management but who provides these aspects should be explored. These skills along with enhanced behavioural interventions such as Motivational Interviewing should enable the team to robustly support the clinical services. Cross working and being independent in core skills such as phlebotomy, asymptomatic screening would enable a health adviser role to further embed their skills into the MDT.

- Priority should be given to identifying and skill-shifting aspects of asymptomatic screening and results management to HCA and administrative staff to free-up highly skilled nurses and health advisers to undertake more complex episodes of care. In tandem to this, medical and nursing staff could expand risk assessments of high-risk users as part of holistic care as sending all Men who have Sex with Men (MSM), Commercial Sex Workers (CSW), those with endemic risks and young people to a Health Adviser are historic ways of working. An effective triage system is required to ensure that this is workable.

- A triage form is recommended to identify service users who can be fast tracked rather than relying on referral from medical and nursing colleagues.

- The role of nursing and health advising needs to be working to a standard that is within the national guidance available from the Society for Sexual Health Advisers (SSHA), British Association of Sexual Health and HIV (BASHH) and the Faculty of Sexual and Reproductive Healthcare (FSRH), thus ensuring that robust clinical governance is evident and provides the public with assurances of quality. Educational development utilising the national programs such as BASHH – STIF FSRHC – Course of Five & the British HIV Association (BHIVA) / National HIV Nurses Association (NHIVNA) competencies in tandem with local Higher Education Institutions support will allow the workforce to be educated to a standard that the professions deem as required. This underpinned with routine and regular audit of practice will demonstrate the importance of MDT working whilst providing the commissioners with assurance of quality with patient focused outcomes.

- Support staff competent in phlebotomy and public relations could undertake well person screening with minimal intervention. Their role could also be cross trained to include reception skills flexing the team to manage supply and demand and in doing so support the professional staff providing more interventional screening and assessment. The role of the HCA could be further extended to offer ‘XpressCHECKOUT’ asymptomatic screening clinics where medical support is not required.

- Training, education and competency based assessments / reviews of practice are essential criteria in this interim solution. This needs to be service led – not staff preference led. A draft template of future staffing and skill mix requirements then needs to be drawn up, to ensure appropriate and adequate clinic cover at the reviewed opening times.

- The interim sexual health service will need to liaise with Higher Education Institution providers locally to develop integrated sexual health education courses, which encompass competency based outputs, within an academic framework. Where Higher Education Institutions do not provide local integrated sexual health education, partnership working to develop them should be fostered. However, service providers may be required to tender out such training if not available locally as these will be essential to the future success of the integrated sexual health model.

- There are major issues relating to inadequate support for the reporting requirements, management of clinic data and IT systems across the service. Whilst statutory data reporting requirements have been met, there has been a long history of inefficient provider support and lack of appropriate levels of IT funding. This has led to delays in implementing electronic patient records (EPR) and lack of timely service level data. Data management and reporting have been challenging as a result of these inadequate systems, and reporting mechanisms both internally and to commissioners were less robust as a result. HIV and GUM activity is not disaggregated.

- Given the protracted history in the development of an appropriate and updated IT infrastructure for the service, this needs to be rectified as soon as possible to ensure that a solid evidence base of activity at locality level is fit for purpose for the new interim location and contract arrangements with LA and HIV specialist commissioners.

- Additional IT support to ensure that the data requirements are up to date and can be provided in a timely manner, and without using expensive nurse time!

- A short term IT project role at KCHT to ensure that transfer of the IT systems from DVH to KCHT and to ensure support for all the different reporting requirements are met.

- The new reporting mechanism for HIV (HARS) should be an immediate priority as the coding has to be entered at diagnoses to ensure the relevant funding is allocated as well as the relevant reporting.

- Texting results is cost effective. The introduction of a text service should be a priority.

- Progressing the implementation of Electronic Patient Records (EPR) is essential to ensure best use of staff resources and a quality patient experience. It will also reduce the need for costly storage space.

4 Financial Consequences

Sexual health is one of the biggest Public Health budgets moving to the local authority. The cost of the GUM service in DVH is based on a payment by results (PbR) basis. The tariff for new appointments is £152.92 and for follow up appointments it is £116.13.

2011		
New Appointments	6954	£1,063,405
Follow Up Appointments	1535	£178,259
	Total	**£1,241,665**

It is envisaged that the service will be handed over to KCHT at the 2013/14 tariff.

There will be some costs linked to IT and setting up the service at GCH

Appendix 2

Sexual Health Services Factsheet

What are the services?

Local authorities will become responsible for commissioning comprehensive, accessible and confidential contraception and sexually transmitted infections (STIs) treatment services.

The sexual health service for Kent includes the following:

- CASH (Contraceptive and Sexual Health Services) – 37 clinics
- GUM services (Genitourinary Medicine including HIV services)
- EHC (Emergency Hormone Contraception) schemes through pharmacies – 130 services
- School-based sexual health clinics
- C-Card (condom registration and access points) – 222 services
- Outreach work.

Who are they for?

For the benefit of people across all age groups in Kent.

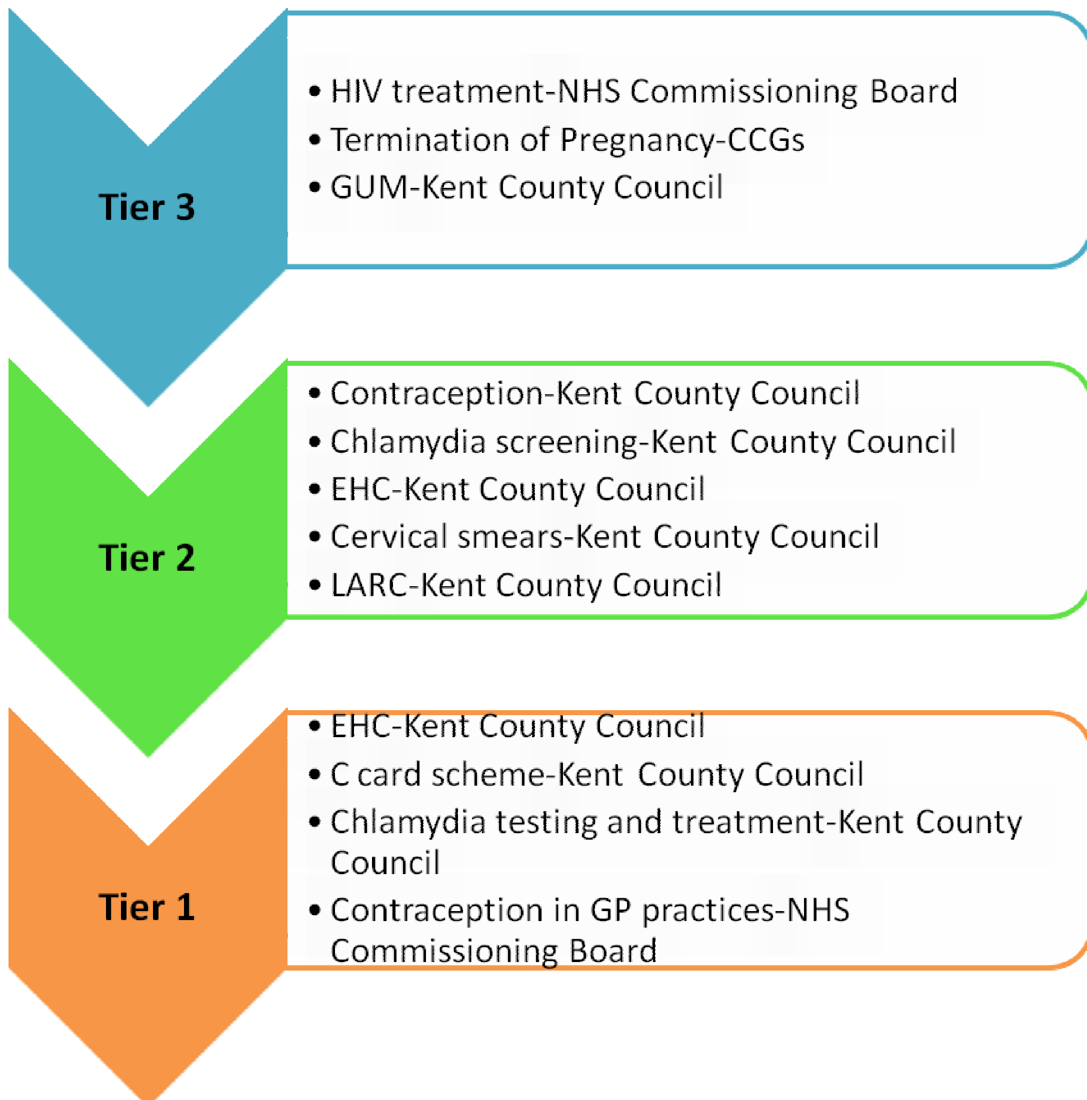
Who is the contracted provider or providers?

There are a number of providers commissioned for sexual health services across Kent.

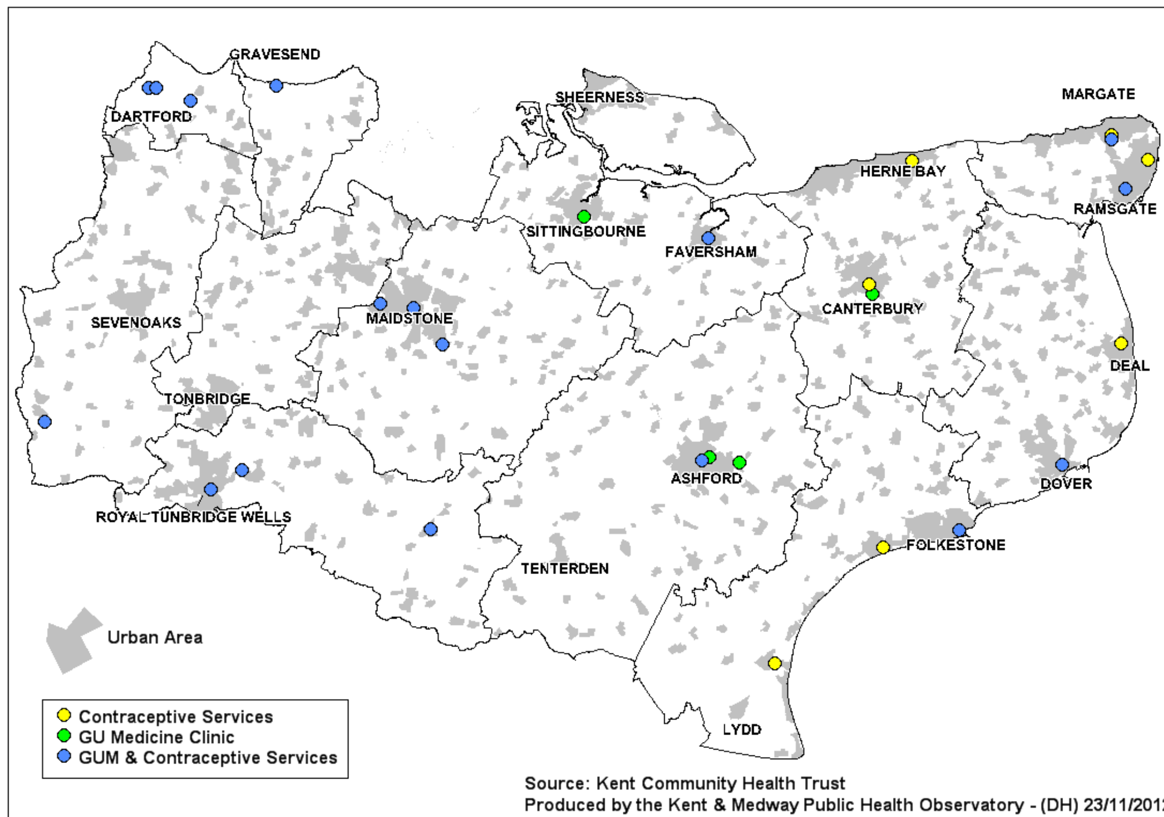
Provider name	Funding(£)
Darent Valley Hospital (DVH)	£950,171
Maidstone and Tunbridge Wells NHS Trust (MTW)	£1,369,781
Medway Foundation Trust (MFT)	£570,781
East Kent Hospitals University Foundation Trust (EKHUFT)	£248,927
Kent Community Healthcare Trust (KCHT)	£9,500,000
Total	£13,513,736

- All the CASH clinics in Kent are provided by Kent Community Health Trust
- Contracts are all annual with a 6-month notice period.

(Please see the diagram overleaf for an overview of how sexual health services are commissioned.)



The map below shows the location of the CASH [Contraceptive and Sexual Health Clinics] and the GUM [Genitourinary medicine] services.



The evidence background

Better Prevention, Better Services, Better Sexual Health: The National Strategy for Sexual Health and HIV. DH, July 2001-Refreshed 2008 by the Independent Advisory Group for Sexual Health (http://www.dh.gov.uk/assetRoot/04/07/44/86/04074486.pdf)

Choosing health: Making healthier choices easier. Department of Health, 16/11/04, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4094550

UK National Guidelines for HIV Testing 2008 www.bhiva.org

MEDFASH Recommended Standards for Sexual Health Services 2005, and MEDFASH Recommended Standards for HIV Services 2004 http://www.medfash.org.uk?

HIV in Primary Care 2004 http://www.medfash.org.uk?

NICE guidance Prevention of sexually transmitted infections and under 18 conceptions 2007 - http://www.nice.org.uk/PHI003?

Targets and outcomes

National Outcome Measures
3.2 Chlamydia diagnosis (15-24 year olds)
3.4 People presenting with HIV at a late stage of infection

Sexual Health Targets

48-hour access to GUM services – 100%

Chlamydia diagnosis 15 -24 year olds

Chlamydia screening is recommended for all sexually active people under 25, annually and on partner change. The Health Protection Agency (HPA) recommends that local authorities should be working towards achieving a diagnosis rate of at least 2,400 per 100,000(2.4%) population

For Kent this would mean diagnosing approximately **4,414** 15 to 24 year olds. Public Health Outcomes Framework baseline 2010 was **1,562** diagnoses per 100,000 population 15 to 24 years.

- Late diagnosis of HIV is defined as a CD4 count of less than 350. Late diagnosis has been mentioned in the Public Health Outcomes Framework but it hasn't been decided nationally what the target will actually look like

Issues , gaps and opportunities

- HIV commissioning will be the responsibility of the National Commissioning Board (NCB)
- GUM and CASH services will be the responsibility of Local Authorities
- Termination of pregnancy will be the responsibility of Clinical Commissioning Groups.

The challenge will be to ensure that the population of Kent receives the best sexual health outcomes in a consistent and equitable way.

GUM attendances are increasing yearly. We need to cap costs as the increase can no longer be funded within NHS contracts.

DVH have given notice that they no longer want to provide GUM services. This is an opportunity to review the strategic direction of sexual health services in West Kent, focus on transformation of young people services alongside youth services and develop community based services.

What it costs and what do we get for the money?

The sexual health budget is estimated to be £13,760,308.
This money pays for the provision of sexual health services detailed above.

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