An emerging clinical network for Hull and East Riding

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16-05-05

S&RHP

Established 2001

Founding Partners:

- G U Medicine
- Family Planning
- Community Gynaecology
- Specialist Health Promotion
- Young Peoples Support Services
- Voluntary Sector partners
- Counsellors
- Social Workers

Founding Organisations

- East Riding and Hull Health Authority
- Hull and East Riding Community Trust
- Hull and East Yorkshire Hospitals Trust
- Kingston upon Hull City Council
- Cornerhouse/ Aids Action
- Health Action Zone

‘Headquarters’ Conifer House (plus 19 peripheral sites)

Genitourinary Medicine	Lab, 2 consulting rooms, 7 consulting/exam rooms, counselling room
Community Gynae/ Family Planning/ Psychosexual/ED	Ultrasound, 1 minor ops, 5 consulting/ exam, Staff room, counselling room,
Main Clinic Reception	Triage rooms: administration rooms
Network Floor	Drop-in +2 counselling rooms; Seminar room; TPU & Surestart+; Chlamydia team: Health Promo.
Main Entrance	Vacant space

Services

Family Planning

Genitourinary Medicine

Community Gynaecology

Social Work

Counselling

Health Promotion

Young Peoples Support Services

Erectile Dysfunction

Psychosexual Service

‘ Network Floor’

network
and East Riding Sexual and Reproductive Healthcare Partnership

network
Hull and East Riding Sexual and Reproductive Healthcare Partnership

Service Structure & Referral Routes

SRHCP

GPs

Hospitals

FP Clinics

Outreach Clinics
Eg. ANC, Quays

Young Peoples Drop-ins

Conifer

Mental Health Services

Comm Gynae Clinics

GU Clinics

Self Referrals

Social & Community Services

NHS Changes led to

- Health Authority and 4 PCGs

  changed to

  4 PCTs (now 3 and about to become 2)

- Partnership left the Community Trust when became specialist Mental Health Trust

  and became

  an Agency, employer West Hull PCT.

S&RHP

reports to a

Partnership Board

which has subgroups e.g.
Commissioning Subgroup

Partnership Board Members

- Commissioners all PCTs
- Public Health
- TPU co-ordinators (LAs)
- Sexual Health GP Leads for PCTs
- Service Manager, Women and Children, Hospital Trust
- Clinicians and Manager S&RHP
- Co-opted as required e.g. Finance, HPA, ACPC

S&RHP problems

- Demand further outstripping capacity in number and complexity across the service
- Loss of medical staff to more lucrative GPSI posts
- Chronically under-resourced service plus budget cut when transferred out of Community Trust
- Overtrading in FP/ CG clinics
- Cannot attract Staff: shortage specialty + poor financial reward + unattractive location
- Increasing training demands
- Desire to progress integrated approach (1-stop-shop)
- Shift from patch-wide to PCT centric strategy (likewise funding)

Opportunities

- Capacity building in Primary care
- Increasing role /ability in Voluntary sector

partners (young people/ CSWs/ LGBT services)

- Liberation of the nurse

Solution

Clinicians solution: A clinical network.

‘A network of care that enables a patient to feel confident that the treatment and care they receive is of a uniformly high standard’ (Calman Hine: Report on Cancer Services)

‘A consistent quality of care wherever a patient lives can be achieved through the development of clinical networks with shared protocols, audit and education with cooperation between health professionals, medical and non-medical across Trust boundaries. This promotes good clinical governance and facilitates efficient deployment of limited specialist resources.’

Membership and Process

- Initially clinical director S&RHP and medical director and locality manager from 1 PCT
- Now includes hospitals Trust reps.
- 'Voyeur' clinician from 1 other PCT

Reports to Commissioning subgroup of Partnership Board

Policies, procedures and guidelines to go to Clinical Policy Forum then individual Trusts clinical governance committees

Membership and Process (cont.)

- Currently clinicians only, but no intention to keep it this way (only met properly 3 times!)
- Taking current local existing e.g. guidelines and sharing (‘off the shelf’)
- Rule is new ‘members’ have to accept adopted policies, procedures and guidelines. Can influence when reviewed (still to go through CPF so now is a good time to join).

Aims

- Be patient not service centred
- To redistribute the workload
- Safety, quality and best practice
- To ensure uniformly high standards no matter where the service is delivered
- Take best practice from elsewhere
- Do not re-invent any wheels
- Shared commitment to service development
- Deliver in an integrated and co-ordinated manner

So far:

- Implementation document (in process)
- Care pathways: Abortion (fast-track booking to clinic) and female sterilisation (direct booking to bed)
- Re-routing patients from FPCs and Maternity to GPSIs/ Enhanced rather than FP/CG for Level 2 services
- Establishing an Emergency IUD network
- Establishing GP training and supervision
- Establishing user involvement
- Shared headings to paperwork to
- show within Network/ quality stamp

So far: (cont.)

- Shared documentation:
- o Consent forms:
  Implanon insertion
  implant removal
  IUD/IUS insertion
  Implanon/IUD/IUS supplementary counselling /fitting record
- o crisis management protocol (IUD/ IUS fitting)
- o what to expect from the Abortion service (2 docs)
- o sexual health history/examination/management/ prescription chart casenotes, male and female
- o good reasons for not smoking doc
- o supporting information on Implanon

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- Patient details:
- **Patient/parental agreement to investigation or treatment**
- (procedures where consciousness not impaired)
- **Name of procedure:** **Removal of Implanon**
- **Statement of health professional** (to be filled in by health professional with appropriate knowledge of proposed procedure, as specified in consent policy)
- I have explained the procedure to the patient/parent. In particular, I have explained:
- The intended benefits: **Return of fertility**
- **Removal of any untoward effects**
- Serious or frequently occurring risks: **Bruising, infection, small scar. Uncommonly, need for 2nd attempt at removal if difficult.**
- I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of those involved. Y/N
- The following leaflet has been provided: **FPA Injections and Implants leaflet/ Other (state)**
- Signed: …………………………………… Date ……... ……………………………………..
- Name (PRINT) ……………………. ………. Job title ……………………………………….
- **Statement of interpreter** (where appropriate)
- I have interpreted the information above to the patient/parent to the best of my ability and in a way in which I believe s/he/they can understand.
- Signed ……………….………Date………..……….Name (PRINT)…………….……………………..
- **Statement of patient/person with parental responsibility for patient**
- **I agree** to the procedure described above.
- **I understand** that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience.
- **I understand** that the procedure will/will not involve local anaesthesia.
- Signature ……………………………………… Date ……………………….………………
- Name (PRINT) ………………………………… Relationship to patient ………………………
- **Top copy accepted by patient: yes/no** (please ring)

- Primary Care Trust
- **Implanon Counselling**

- **Client details:**
- **LMP …………..**
- **Current contraception ……………………..**
- **Wt.   BP**
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- **Contraceptive options discussed** □
- **Minor Surgery involved** □
- **Effective for 3y – then requires removal/replacement**
- **Allergy to Levonorgestrel/ Lidocaine/ Elastoplast**
- **Erratic/ unpredictable nature of bleeding with Implanon**

- **Other possible S/Es: wt. gain, mood changes, headaches, skin changes**

- **Implanon leaflet supplied**
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- **Possible insertion dates …………………**
- **Signed ………………………………………… Date …………………..**

Harsh realities

- Not achievable within any reasonable timescale without resource. Currently all done in ‘spare time’, and on existing documentation.
- Commissioners aware

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