



# An emerging clinical network for Hull and East Riding



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# 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 )



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





# Services



Family Planning

Genitourinary Medicine

Community Gynaecology

Social Work

Counselling

Health Promotion

Young

Peoples Support Services

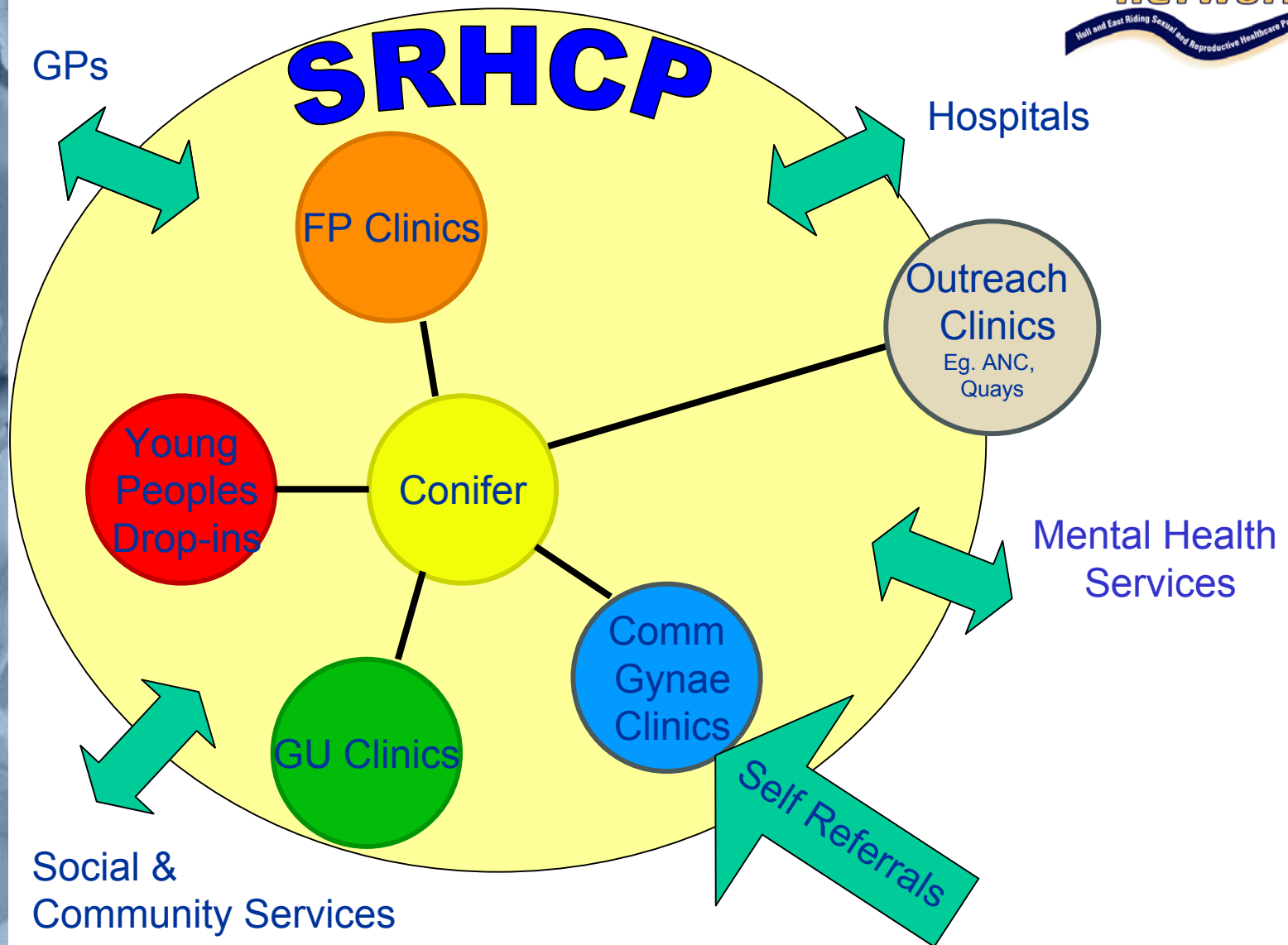
Erectile Dysfunction

Psychosexual Service

‘ Network Floor’



# Service Structure & Referral Routes



# 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:



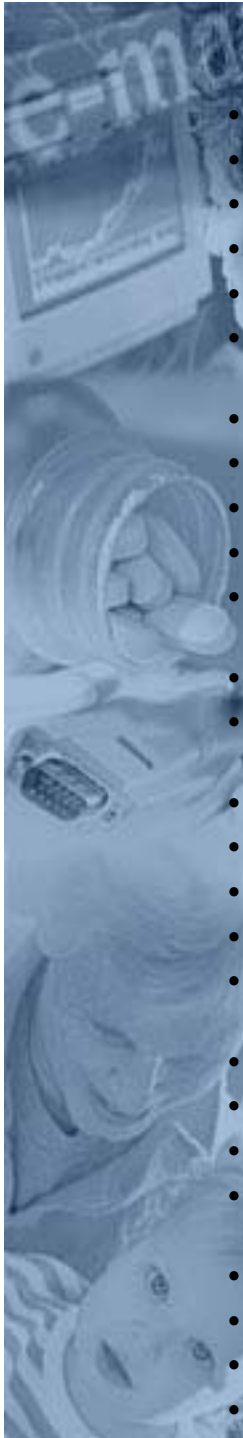
- Implementation document (in process)
- Care pathways: Abortion (fast-track booking to clinic) and female sterilisation (direct booking to bed)
- Re-routing patients from FPCs and Maternity to GPSIs/ Enhanced rather than FP/CG for Level 2 services
- Establishing an Emergency IUD network
- Establishing 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.

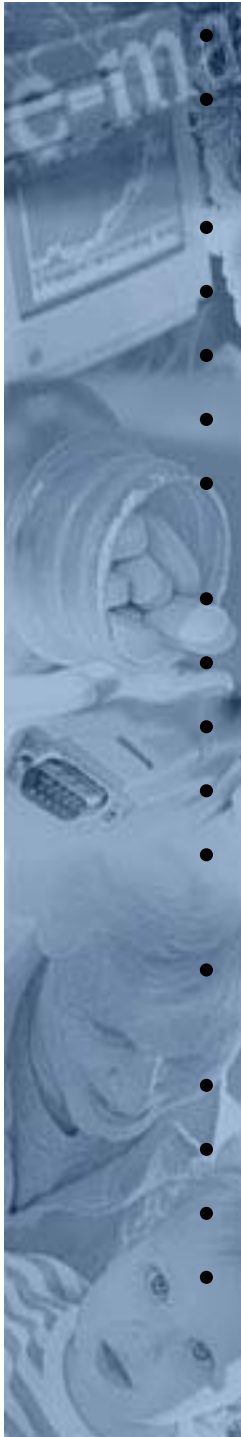
**I understand** that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience.

**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**



- **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**

• **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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