Specialty Specific Standards for Consultants in GU Medicine.

The Standards Committee of the Royal College of Physicians (chaired by Dr John Collins) has asked all medical specialties to produce two Speciality Specific Standards.

The initiative.

What is its purpose?

Firstly, it is probably worth pointing out that the motto of the RCP is "*Setting standards in medical practice*".

The following quotations are taken directly from communications from the College on this subject, and explain this initiative:

"The Department of Health has embarked on a comprehensive process which requires standards against which individuals, systems and Trusts can be judged. Our College, in common with others, believe that it is an advantage if the profession is responsible for offering standards rather than having them imposed from outside. In addition, there is a major initiative from the DoH to improve IT systems and data capture mechanisms. It seems inevitable that the performance of both individuals and organisations will in the future be judged against the data retrieved. Many of the specialist societies are well advanced in developing comprehensive standards relating to their own field of expertise, but in many instances the attainment of such standards is controlled by the availability of resources and the systems in operation. The College has undertaken to provide standards, which reflect the performance of individual physicians and as far as possible, should be independent of the limitations described.

In the first instance, we are asking for two standards from each specialty, the implication being that subsequently these will form the foundations of a rolling programme of standard setting initiatives by each specialty. The College anticipates that such physician specific standards would form a valuable measure for annual appraisal and the revalidation process."

What criteria should be met by these standards?

- *Applicability* – They should be applicable to the majority of physicians working within the specialty. "Standards relating to rare conditions or procedures are therefore not appropriate."

- *Clarity* – Each standard should be defined beyond possible ambiguity so that there is no doubt as to whether it has been met.

- *Measurability* – "Both a numerator and a denominator should be recordable so that comparative data can be easily collected".

- *Simplicity* – In order to avoid an onerous monitoring burden being created, it is desirable that the measures should be simple to record.

- *Meaningfulness* – The standards should capture some aspect of clinical care, and should not simply be a measure of resource. "Standards should be threshold standards, set at a level below which practice would be considered unacceptable".

Draft Standards and Rationale.

Standard 1. "A sexual history shall be obtained and documented in all persons presenting to a genitourinary medicine (GUM) service with a new clinical problem. The sexual history should be retaken and documented at least every 6 months in those being followed up for infectious conditions".

GUM physicians place special emphasis on the importance of obtaining a sexual history from their patients, without which correct management and advice is likely to be severely compromised. This standard also addresses a current area of increasing concern: that the sexual health of HIV-infected patients under clinical follow-up, and that of their partners, may be neglected.

Standard 2. "By the end of 2002, 80% of persons attending a GUM clinic shall be offered an HIV test on the occasion of their first screening for sexually transmitted infections, unless they are already known to be HIV antibody positive. This target to rise to 90% by the end of 2003, and 100% by the end of 2004".

This standard is in line with that set out in "The National Strategy for Sexual Health & HIV" (Department of Health, 2001). It should be noted that the sexual health strategy goes beyond the above standard, in setting targets for the uptake of the test by those offered it (to 40% by the end of 2004, and 60% by the end of 2007), and to reduce by 50% the number of previously undiagnosed HIV-infected people attended GUM clinics who remain unaware of their infection after their visit by the end of 2007.

Data from the PHLS Unlinked Anonymous HIV Prevalence Monitoring Programme indicated that in England, Wales & Northern Ireland in the year 2000:

- 65% of undiagnosed HIV+ homosexual/bisexual males, and 59% of heterosexuals, *remained undiagnosed after attending a GUM clinic*;
- 60% of homosexual/bisexual males without an acute STI, and 65% of heterosexuals, *were not offered an HIV test on attending a GUM clinic*.

Furthermore, it should be remembered that a challenging target for HIV testing uptake was imposed on antenatal clinics; an uptake of 90% to be achieved by the end of 2002. An interim report on the antenatal testing policy (conducted by the Institute of Child Health and the Communicable Disease Surveillance Centre) found that by the end of 2000, 52% of responding antenatal units in England which had implemented a routine testing policy achieved an uptake rate of at least 50%.

This standard is also in line with the movement in recent years towards normalisation of HIV-antibody testing with pre-test discussion; the essential elements of the latter being the provision of information and the opportunity to ask questions.

As so often when discussing standards, concerns may be raised over resources. Two points should be borne in mind: (a.) that every effort should be made to ensure that existing resources are being utilised as effectively as possible (e.g., greater use of nurse practitioners & health advisers, formatted notes to record HIV risk factors, use of leaflets for the giving of routine information); (b.) that consultants can not be expected to provide a service which falls below minimum acceptable standards.

Protocol for finalising standards

The Clinical Effective Group (MSSVD/AGUM) will lead a consultation exercise involving the following: AGUM Council; MSSVD Council; UK Regional GUM Audit Chairs. In addition, this document would be placed on the AGUM and MSSVD websites and this fact publicised, to solicit comment from the whole specialty.

The CEG will take into account all comments received, and will be responsible for amending the draft standards if indicated.

The final draft of the Standards will then be submitted to the RCP GUM Committee for ratification. The RCP GUM Committee will be the final arbiter on the content of the Standards.

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